

# Acknowledgements

The Santa Clara County Public Health Department gratefully acknowledges the assistance, support, and cooperation of the Mass Fatality Planning Executive Team and all who contributed to the development of this toolkit.

## MASS FATALITY PLANNING EXECUTIVE TEAM

Captain Chris Forrester, Medical Examiner/Coroner Division, Office of the Sheriff, Santa Clara County  
Captain Robert Dixon, Medical Examiner/Coroner Division, Office of the Sheriff, Santa Clara County  
Caroline Judy, Manager of Intra-governmental Support Services, Facilities and Fleet Department, Santa Clara County

Bruce Lee, Administrator, Emergency Medical Services Santa Clara County Public Health Department  
Rocio Luna, Senior Manager, Office of Disaster Medical Services, Santa Clara County Public Health Department

Trinh Nguyen, Advanced Practice Center Coordinator, Santa Clara County Public Health Department  
Marilyn Cornier, Advanced Practice Center Coordinator (previous), Santa Clara County Public Health Department

Molly Carbajal, Advanced Practice Center Coordinator, Santa Clara County Public Health Department

## SPECIAL THANKS TO

Martin Fenstersheib, M.D., Santa Clara County Health Officer/Interim Public Health Department Director

Sara Cody, M.D., Assistant Health Officer, Santa Clara County Public Health Department

Dolores Alvarado, Senior Manager, Santa Clara County Public Health Department

Joy Alexiou, Public Information Officer, Santa Clara Valley Health & Hospital System

Marta Lugo, Public Communications Specialist, Santa Clara County Public Health Department

Jack Herrmann, Senior Advisor, Public Health Preparedness, National Association of County and City Health Officials

John Linstrom, Region IX Commander, Disaster Mortuary Operational Response Team

Don Bloom, Deputy Commander, Family Affairs, Disaster Mortuary Operational Response Team

Lisa LaDue, Senior Advisor, National Mass Fatalities Institute at Kirkwood Community College, Ohio

Carina Elsenboss, APC Program Manager, Public Health Seattle-King County, Washington

## PREPARED BY:

Liz Coe

Consultant

701 Christine Drive

Palo Alto, California 94303

650-856-0312

[lizcoe413@aol.com](mailto:lizcoe413@aol.com)

May 2008

# Introduction

*Managing Mass Fatalities: A Toolkit for Planning* was created by the Santa Clara County Public Health Department Advanced Practice Center (APC) with the guidance of the Santa Clara County Medical Examiner-Coroner's Office for the National Association of County and City Health Officials (NACCHO). This guide has been developed to serve as a resource for local public health agencies and medical examiner/coroner offices to develop a plan to manage mass fatalities.

Several mass fatality incidents have occurred in recent years. Natural disasters like the Indian Ocean Tsunami on December 6, 2004 (~250,000 deaths) and Hurricane Katrina (1,464 deaths) and acts of terrorism such as the September 11, 2001 tragic events (nearly 3,000 deaths) and the bombing in Oklahoma City (169 deaths) have demonstrated that the fatality management infrastructure is vulnerable to overwhelming events. The need to recognize and strengthen fatality management planning and response is critical if we are to be prepared for the possibility of incidents like these as well as for a worst-case scenario pandemic influenza, a hazard from which no community will be immune.

This toolkit is consistent with the U.S. Department of Homeland Security's *National Response Plan*. The *National Response Plan* "is an all-discipline, all-hazards plan intended to establish a single, comprehensive framework for managing domestic incidents...Its premise is that while the combined expertise and capabilities of all levels of government will likely be required in the prevention of, preparedness for, and response to domestic incidents, the primary management of an incident should occur at the lowest possible geographic, organizational, and jurisdictional level."<sup>1</sup>

Emergency Support Function (ESF) # 8, the Health and Medical Services Annex of the *National Response Plan*, states that Federal assistance to supplement State and local mass fatality resources will be coordinated by the Department of Health and Human Services, the primary agency for ESF #8. The scope of ESF #8 includes: public health, medical, mental health services, and mortuary services, all of which have a role in mass fatality management.

At the local level, it is unusual to find public health, medical, mental health services, and mortuary services in one department or agency. Oftentimes, public health, medical, and mental health may be within one agency, but mortuary services, or the Medical Examiner/Coroner Office, may be located within the Sheriff's Department, as it is in Santa Clara County.

Medical examiners and coroners make up the medico-legal death investigation system in the

---

<sup>1</sup> U.S. Department of Homeland Security, *National Response Plan*, December 2004.

United States and are the lead organization in mass fatality management. A medical examiner is a public official who investigates by inquest any death not due to natural causes, is a qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), and is usually an appointed position. A coroner is a public officer whose primary function is to investigate by inquest any death thought to be of other than natural causes. The medico-legal death investigation system in the United States has coroner-only systems; medical examiner systems; mixed systems (some counties are served by coroners, others by medical examiners); and referral systems, in which a coroner refers cases to a medical examiner for autopsy. Identifying the medico-legal death investigation system in your jurisdiction and determining who is responsible for mass fatality management is critical to initiating mass fatality management planning.

This toolkit will assist you in mass fatality management planning at the local level. A mass fatality plan is the responsibility of the Medical Examiner and/or Coroner Office that is assigned that responsibility by State statute; however, partnership with other agencies, departments, and organizations that are involved in response is essential. Public Health has key roles in mass fatality management that include, at a minimum, health surveillance; worker health/safety; radiological/chemical/biological hazards consultation; public health information; and vector control. The Medical Examiner and/or Coroner Office and Public Health have the potential to be strong partners in leading community mass fatality planning. Effective planning is basic to building sound relationships with the other major players in a mass fatality scenario, to educating the response community regarding the medical examiner/coroner (ME/C) responsibilities and the responsibilities of other key departments and agencies, and to a successful response. Well-organized and realistic plans that involve key local stakeholders will:

- improve local capability, and
- facilitate quicker response and more effective integration of resources from all levels of government.

The end result will be more timely identification of victims and an enhanced, coordinated response to make it possible to meet the multiple needs of victims and families in the event of a mass fatality incident.

The care and management of the dead—the focus of this toolkit—is one of the most difficult aspects of disaster response and recovery operations. It is important for medical examiners, coroners and public health to understand that the expectations of family members of mass fatality incident victims—and by extension the general public, politicians, and the media—regarding identification, return of victims to family and loved ones, and information will be high.

# Mass Fatality 101

## Mass Fatality Definition

A mass fatality incident, by definition, is any situation where more deaths occur than can be handled by local medical examiner/coroner resources. There is no minimum number of deaths for an incident to be considered a mass fatality incident because communities vary in size and resources.

A mass fatality incident may be caused by natural hazards (e.g., earthquakes, floods and hurricanes), human-related hazards (e.g., airline accidents and bridge or tunnel collapses), and pro-active human hazards (e.g., terrorist acts).

A mass fatality becomes a catastrophic mass fatality when, as defined in California, the “loss of life overwhelms the state’s mutual aid system and requires extraordinary support from state, federal, and private resources.”<sup>2</sup> This definition may vary from state to state. However, in all states, a catastrophic mass fatality is likely to trigger disaster declarations at the state and federal level, and a federal disaster declaration will mobilize an array of resources to support state and local response and recovery efforts.

Regardless of the size of the mass fatality incident, the ME/C is the legal authority to conduct victim identification (or augment the lead investigative agencies to complete victim identification), determine the cause and manner of death, and manage death certification. The ME/C is also responsible for other medico-legal activities, such as notification of next of kin.

## Four Factors Impacting the Identification of Decedents in a Mass Fatality

There are four factors that impact the processing of human remains and identification of decedents in a mass fatality incident. The factors are:

- Number of fatalities.
- Decedent population (open or closed).
- Availability of antemortem information.
- Condition of remains (complete or fragmentary, commingled remains).

**Number of Fatalities:** The number of deceased is a significant driver in the amount and type of resources needed to search, recover and identify the dead. In general, the higher the number of decedents, the more resources required to manage and process the dead.

---

<sup>2</sup> State of California Governor’s Office of Emergency Services’ *The California Mass Fatality Management Guide: A Supplement to the State of California Coroners’ Mutual Aid Plan* (September 2007)

**Decedent Population:** There are two types of decedent groups—closed populations and open populations.

In a closed population, the number of victims and their names are known. A commercial airline accident is one of the few examples of a closed population. The combination of ticket purchasing procedures, positive identification checks, and airport security provide forensic responders with a reliable list of victims.

On the other hand, an open population is one in which neither the number of victims nor their names are known. A good example of an open population is the September 11, 2001 World Trade Center mass fatality. Determining those who were reported missing by friends or relatives (initially 10,000) from those who were confirmed missing (2,749) took time.

An open population will generally require more time and resources to process and identify the dead than a closed population.

**Availability of Antemortem Information:** Collection and examination of antemortem information to help identify decedents can begin immediately in a closed population incident, such as a commercial airline accident. In an open population incident, the process of examining antemortem information does not begin until those who are confirmed missing are identified.

**Condition of Remains:** Fragmented and commingled human remains require a significantly longer examination process. Whether the population is open or closed also makes a difference. With a closed population, forensic investigators work to identify all of the victims, with an understanding that not all remains will be identified due to the technological limitations of DNA. In an open population when there is high-fragmentation and commingling of human remains, the focus must be on identifying all remains as the number and names of the decedents are not known.

These four factors will drive the personnel and other resources that are needed, how long the identification will take, and the methods that are used for identification. The interplay of these factors reveals the potential for positive identifications and how the examination process will be conducted.

## Decedent Operations

Mass fatality decedent operations include specific ME/C responsibilities and decedent operations carried out by other organizations. Decedent operations—basically the mass fatality management infrastructure—entail a diverse group of stakeholders from public and private sectors that involve multiple agencies within government and multiple private businesses. At present there is no policy, regulation, or agency that unifies these stakeholders. Planning, and the relationships and partnerships developed through planning, facilitates mass fatality management.

ME/C decedent operations include:

- Human Remains Recovery.
- Morgue Services.
- Family Assistance (ME/C activities).

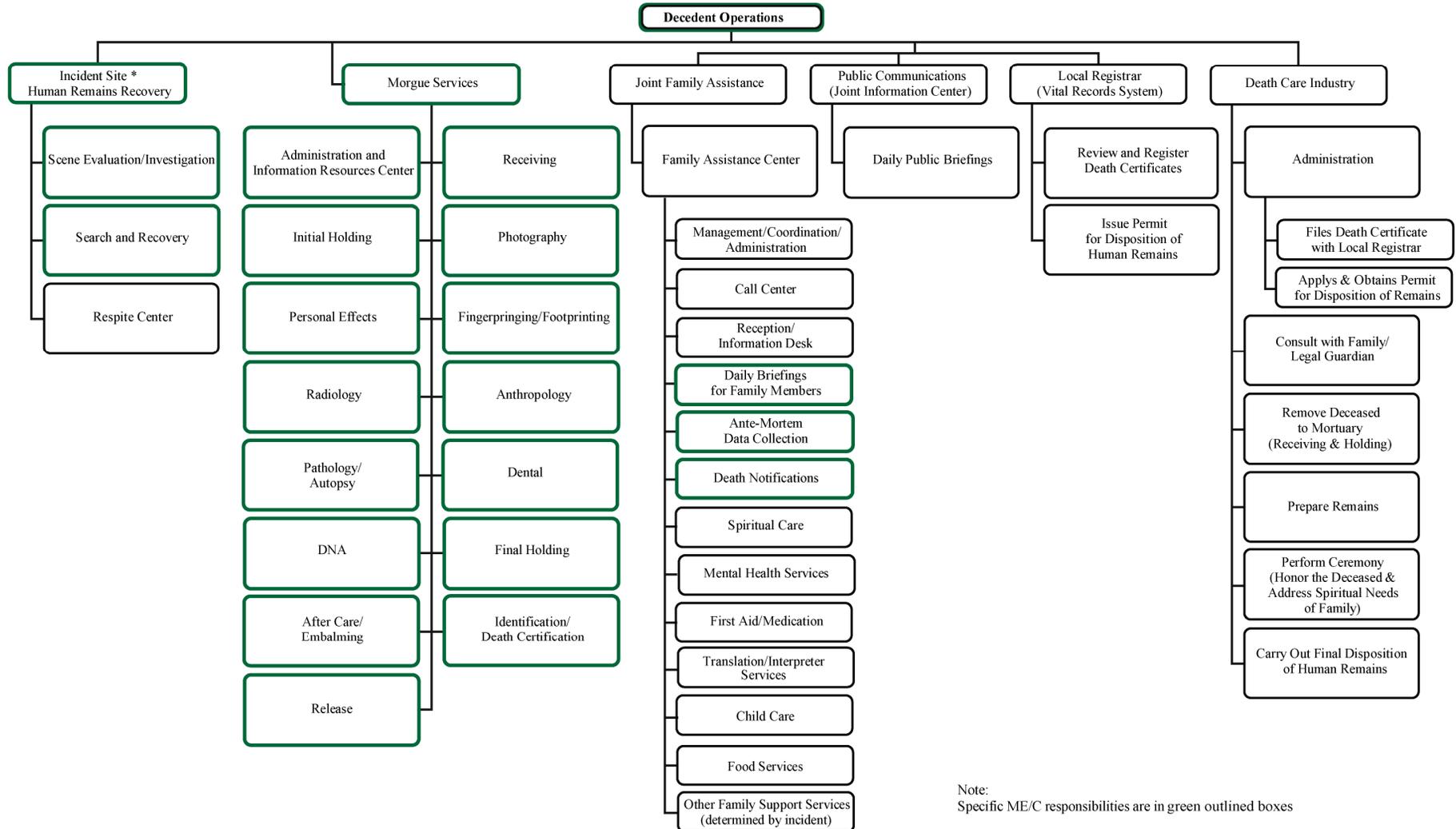
Other decedent operations which require coordination and cooperation include:

- Family Assistance (Non-ME/C activities).
- Public Communication.
- The Vital Records System.
- The Death Care Industry.

The chart on the following page depicts the mass fatality infrastructure—the range of decedent operations and activities that may be needed to manage a mass fatality incident.

If any part of the mass fatality infrastructure—human remains recovery, morgue services, family assistance, public communication, the vital records system, and the death care industry—is not prepared and able to carry out its critical function, the entire mass fatality infrastructure will be impacted.

Example Organization Chart Depicting the Decedent Operations that May Be Required in the Event of a Mass Fatality



\* In a worst case pandemic influenza or similar infectious disease, there is no single incident site.

Note:  
Specific ME/C responsibilities are in green outlined boxes

Responsibilities of other organizations that are not under the direct control of the ME/C Office are in black outlined boxes

The planning process is a time when all organizations involved in decedent operations at the local level can begin to build the collaboration and partnership that will be essential to managing a mass fatality incident.

## **Mass Fatality Management**

Adherence to the National Incident Management System (NIMS), is a federal government requirement for all emergency planning, response, and recovery. It was adopted in order to achieve unified, single-agency and interagency management in emergency response. The central purpose of NIMS is to ensure a comprehensive national framework designed to efficiently support incident management, regardless of the size, nature, or complexity of the event. In California, integration of the Standardized Emergency Management System (SEMS) with NIMS is required.

Under NIMS and SEMS, the framework of operations is the Incident Command System (ICS). NIMS requires the use of the ICS by all levels of government and by healthcare organizations.

The purpose of the ICS is to provide an interdisciplinary and flexible management system that is adaptable to an incident of any kind or size. The ICS defines a clear chain-of-command and provides logistical and administrative support to operational staff responding to an incident.

The ME/C Office manages and organizes response to a mass fatality incident by using the Incident Command System. This allows:

- The ME/C Office to integrate its operations with other local agencies and departments.
- Responding Federal, State, and regional agencies deployed to the local jurisdiction to integrate into the local command and control structure.
- Eligibility for federal preparedness assistance and for reimbursement after a mass fatality incident.

Use of the ICS contributes significantly to multiple agencies and organizations working successfully together.

## **Local Agencies Involved in Mass Fatality Response and Recovery**

Mass fatality response and recovery will involve a wide range of local government agencies. The number of local agencies involved in a mass fatality incident will depend on the nature of the incident—the number of anticipated deaths; the number of injured survivors, the scope of destruction/level of difficulty of recovery; and whether or not there are possible biological, chemical, physical, or radiological hazards.

Local agencies and departments in the jurisdictional area that will be involved are:

- Law enforcement.
- Fire and Rescue/Hazardous Materials.
- Emergency Medical Services.
- Hospitals.
- Public Health.
- Mental Health.
- Social Services.
- Environmental Health.
- General Services Agency/Facilities and Fleet/Public Works.
- Procurement.
- Public Affairs.
- Office(s) of Emergency Services.

In addition to these governmental agencies and departments, the private sector plays a critical role. Private sector involvement includes:

- Death Care Industry (funeral homes, crematories and cemeteries).
- Spiritual Care Community.
- Nonprofit organizations.
- Volunteers.

## **Support for Mass Fatality Workers**

The physical, mental, emotional, and spiritual demand placed upon mass fatality workers involved in the search and recovery, transportation, morgue services, and family assistance operations exceeds that of any event typically encountered in daily life and work. Providing appropriate support and care for staff who are involved in a mass fatality is critical.

Support for workers includes:

- Work practice and administrative controls (e.g., time off, breaks, and monitoring how staff and volunteers are holding up over time).
- Providing personal protective equipment appropriate to the hazard and level of exposure.
- Helping staff and volunteers cope with the common stress symptoms that result from mass fatality work and preventing/mitigating traumatic stress and its symptoms—physical illness and disease, mental and psychological disorders, and relationship problems.

Research shows that the closer an individual works with traumatized victims, the more likely he or she will experience secondary trauma. Emotional and spiritual support can help minimize the vicarious trauma impact on personnel who are directly supporting victims.

## Four Guiding Principles for Mass Fatality Response

There are four guiding principles in response:

- Provide honest and accurate information at every stage.
- Respect the deceased and the bereaved.
- Maintain a sensitive and caring approach that values addressing the needs of families and loved ones.
- Follow procedures and protocols that will lead to confirmed identifications of decedents and avoid mistaken identifications.

## Mass Fatality Management Toolkit Objectives

*Managing Mass Fatalities: A Toolkit for Planning* provides scalable, operational direction and tools for developing a mass fatality management plan, including:

- An organizational structure for a mass fatality plan.
- Guidance in determining a plan's purpose, objectives, applicability and scope.
- A sample concept of operations.
- Guidance regarding incident notification and criteria for determining activation levels.
- A sample description of command and control.
- Critical information for mass fatality management's decedent operations:
  - Human Remains Recovery.
  - Morgue Services.
  - Family Assistance.
  - Public Communications.
  - Death Registration and Disposition Permits.
  - Final Disposition of Human Remains.
- Suggestions for Mass Fatality Plan responsibilities for maintenance and future development.
- Security requirements.
- Information on mass fatality management software.
- Staff and volunteer management guidance.
- Family concerns and cultural/religious considerations.
- Infection and other health and safety threats guidance.
- Pandemic influenza considerations.

## How to Use this Toolkit

This toolkit is organized so that planning can be organized by section with the primary stakeholders involved where their experience and expertise is most relevant.

## Sections

The organization of this toolkit mirrors the organization of an emergency preparedness plan for managing mass fatalities. It is organized as follows:

<b>Mass Fatality Plan Section</b>	<b>Lead Stakeholder(s)</b>
Planning Context (Purpose and Objectives; Applicability and Scope; Assumptions, and Authorities and References)	Mass Fatality Planning Executive Team
Concept of Operations	
Incident Notification and Plan Activation	
Command and Control	Mass Fatality Planning Executive Team and jurisdiction's Office of Emergency Services
Human Remains Recovery	ME/C Office and Emergency Operations Center (EOC) Logistics*
Morgue Services	ME/C Office and EOC Logistics*
Family Assistance	ME/C Office, the organization that will manage family assistance (e.g., Social Services Agency/Human Services Agency, Public Health or American Red Cross), and EOC Logistics*
Public Communications	Public Information Officer in charge of jurisdiction's risk communication plan and jurisdiction's Office of Emergency Services*
Vital Records System	ME/C Office and agency responsible for the jurisdiction's vital records system
Death Care Industry	Local funeral directors, funeral homes, cemeteries, cremation services, and the state funeral director's association
Mass Fatality Plan Maintenance	ME/C Office
Security	Local law enforcement agencies
Mass Fatality Information Systems	ME/C Office
Staff/Volunteer Processing Center	EOC Logistics
Family Concerns and Religious/Cultural Considerations	ME/C Office with assistance from local spiritual care community
Infection and Other Health and Safety Threats	Public Health
Pandemic Influenza Considerations	Public Health

\*Public Health may also be involved regarding Emergency Support Function #8 responsibilities: worker health/safety, radiological/chemical/biological hazards consultation, public health information, and vector control.

## Subsections

The **Overview** of each toolkit section for decedent operations includes **Key Assumptions** and a general description of the **Proposed Approach**. The key assumptions are planning and operational assumptions specific to the section. The proposed approach provides a summary of the recommended approach based on the local Advanced Practice Center’s experience and state and federal guidance.

The overview is followed by a subsection that instructs local agencies on how to develop the section. This subsection titled, **Developing Your...** includes step-by-step directions for completing the applicable section for your local plan.

Under the **Developing Your...** subsection you will find, for each of the ME/C decedent operations, guidelines and a separate section on logistics.

- The guidelines are prepared for each function or station that is part of the decedent operation. It has been designed this way so that in the event of a mass fatality, the guidelines can be ‘pulled out’ and distributed to the station or function’s supervisor and provide preliminary support in establishing procedures.
- The logistics section for the ME/C decedent functions includes information on staffing requirements, communications and information systems, equipment and supplies, and facility requirements. The logistics section can also be ‘pulled out’ and distributed to the Officer in Charge, Logistics Officer, and the Emergency Operations Center Logistics Officer to facilitate logistics planning and operations.

## Icons Used in This Toolkit



This icon alerts you to the stakeholders that need to be involved when developing a particular section of the plan.



This icon highlights when research is needed. No need to worry... what to look for will be explained.



This icon flags information that you can use when making decisions regarding mass fatality management scalability.



Many of the steps in *Developing Your...* subsection include samples of sections that can be modified for inclusion in your plan. The samples are denoted by a note-page frame at the beginning of the sample text. Whenever you see this frame at the beginning of text under a decedent operation, language is presented that can be adapted for your own plan.

The informational sections—Security, Mass Fatality Information Systems, Staff/Volunteer Processing Center, Family Concerns and Religious/Cultural Considerations, Infection and Other Health and Safety Threats, and Pandemic Influenza Considerations—can be used as is, or customized for your plan’s appendices.

## Associated Tools and Resources

Operational tools and resources are mentioned throughout this toolkit. These tools and resources are listed at the end of each section under **Associated Tools and Resources**. You may choose to replicate or adapt these tools for local use.

## Before You Get Started

An effective mass fatality plan cannot be written in isolation. The importance of partnership and collaboration in planning and in emergency response cannot be overemphasized. Developing a plan through a collaborative process:

- Encourages organizations to get involved and to take ownership of the plan.
- Expands the knowledge and expertise base of the organization responsible for the plan.
- Promotes and establishes professional relationships with responding organizations.

Begin by reviewing your state law to confirm the agency responsible for mass fatality planning. The medical examiner and coroner systems in the United States range from the professionally trained, board-certified forensic pathologists to the rural county elected coroners with little medical background. In addition, some states have a state medical examiner/coroner and some do not. How ME/C operations for a mass fatality are organized in your jurisdiction is key to the development of your mass fatality plan.

While the ME/C is responsible for mass fatality management and the mass fatality management plan is a ME/C Office plan, consider teaming with another key local agency to co-lead the planning process. For example, *Managing Mass Fatalities: A Toolkit for Planning* was developed through a collaborative planning effort spearheaded by the Santa Clara County Public Health Department and the Santa Clara County ME-C Office. Based on Santa Clara County’s experience, the Medical Examiner/Coroner Office and Public Health are strong co-leaders to lead a local mass fatality planning process. The ME/C Office is the organization authorized to

develop a mass fatality plan. Public Health has a role in several areas of mass fatality management and brings its experience in community planning to the table. Together, these two organizations can lead a successful planning process.

Consequently, the next step is for the ME/C Office and Public Health to meet and discuss co-leading the mass fatality planning process. If they have not developed a working relationship in the past, for example through your jurisdiction’s system for health surveillance, now is the time to initiate a working relationship.

Once local planning co-leaders have committed to their roles, review this toolkit. When you finish, you should have a good understanding of the stakeholders and why their involvement is important. You will also be aware of the wealth of information that is provided to make your job easier.



There are many local stakeholders to include in the planning process. The following is a list of key stakeholders that will work with the ME/C Office in the event of a mass fatality. In addition to identifying the stakeholder, the table includes their roles in a mass fatality incident.

You may use this table to identify participants in the planning process.

<b>Local Mass Fatality Planning Stakeholders</b>	
<b>Agencies/Organizations</b>	<b>Representative(s) for Planning</b>
<b>Local law enforcement:</b> to assist in evaluating incident/scene safety, to provide ongoing security for mass fatality management operations, and to assist the ME/C with scene investigation and identification of the deceased.	
<b>Public Health:</b> to serve as a first responder in medical disasters (Presidential Directive) and carry out Emergency Support Function #8 responsibilities: worker health/safety (assist in monitoring health and well-being of emergency workers; perform field investigations and studies addressing worker health and safety issues; and provide technical assistance and consultation on worker health and safety measures and precautions); radiological/chemical/biological hazards consultation (assist in assessing health and medical effects of radiological, chemical, and biological exposures on the general population and on high-risk population groups; conduct field investigations, including collection and analysis of relevant samples; advise on protective actions related to direct human and animal exposure, and on indirect exposure through radiological, chemically, or	

<b>Local Mass Fatality Planning Stakeholders</b>	
<b>Agencies/Organizations</b>	<b>Representative(s) for Planning</b>
<p>biologically contaminated food, drugs, water supply, and other media; and provide technical assistance and consultation on medical treatment and decontamination of radiologically, chemically, or biologically injured/contaminated victims); <b>public health information</b> (assist by providing public health and disease and injury prevention information that can be transmitted to members of the general public who are located in or near areas affected by a major disaster or emergency); <b>health surveillance</b> (assist in establishing surveillance system to monitor the general population and special high-risk population segments; carry out field studies and investigations; monitor injury and disease patterns and potential disease outbreaks; and provide technical assistance and consultations on disease and injury prevention and precautions); and <b>vector control</b> (to assist in assessing the threat of vector-borne diseases following a major disaster or emergency; conduct field investigations, including the collection and laboratory analysis of relevant samples; provide vector control equipment and supplies; provide technical assistance and consultation on protective actions regarding vector-borne diseases; and provide technical assistance and consultation on medical treatment of victims of vector-borne diseases); and to maintain the Department’s Emergency Operations Center.</p>	
<p><b><i>Fire and Rescue/Hazardous Materials:</i></b> to assist with evaluation of the incident site/scene safety; to provide life saving operations (assist in search, rescue, and transport to care for injured survivors); to protect property from fire and fire hazards; to assist with decontamination of remains (if required) and/or to provide guidance regarding hazards at the incident site and consultation on decontamination (as required).</p>	
<p><b><i>Emergency Medical Services:</i></b> to assist in recovery and transport to care for injured survivors.</p>	
<p><b><i>Vital Records System:</i></b> to provide/assist in providing emergency supplies of death certificates, disposition forms and training in their use; and to register deaths and issue disposition permits.</p>	
<p><b><i>Hospitals and Health Care Facilities:</i></b> to care for injured survivors; to assist ME/C in providing morgue storage space, human remains pouches, and personnel who are accustomed to handling human remains; to assist in providing medical staff for first aid/medication at</p>	

<b>Local Mass Fatality Planning Stakeholders</b>	
<b>Agencies/Organizations</b>	<b>Representative(s) for Planning</b>
the mass fatality operations sites; and to assist family members of possible victims as they arrive at their doors.	
<b>Mental Health and Social Services:</b> to provide family assistance, including assessing mental health needs, mental health services, family support, and staffing call centers/hotlines; to provide disaster mental health training materials for disaster workers; to provide mental health services for staff and volunteers involved in the mass fatality response; to provide liaison with assessment, training, and program development activities undertaken by Federal, State, and local mental health officials; to provide mass care and shelter (as needed); and to provide consultation on cultural/religious considerations.	
<b>Environmental Health:</b> to assist in assessing and managing environmental hazards (e.g., help contain contaminated water run-off, establish a decontamination station, supply personal protective equipment, and provide consultation on chemical agents).	
<b>General Services Agency/Facilities and Fleet/Public Works:</b> to provide public services to include the collection and disposal of solid waste, recycling, and cleaning of streets, alleys, and waterways; to monitor and secure high quality drinking water; to operate storm and wastewater treatment systems; to maintain city owned buildings and vehicles; to perform engineering tasks; to provide assets that can support specific mass fatality operations (e.g., buildings—for temporary morgue storage, the respite center at the incident site, a temporary morgue, morgue storage space for morgue services, and family assistance—and vehicles, equipment, and drivers/staff—to provide transportation for staff and to transport human remains); and, if specialized teams are available, to deal with hazardous waste or decontamination.	
<b>Procurement:</b> to procure materials, supplies and equipment required to support mass fatality operations.	
<b>Public Affairs:</b> to establish a Joint Information Center; to serve as the principal public spokesperson for the mass fatality event; and to assign	

<b>Local Mass Fatality Planning Stakeholders</b>	
<b>Agencies/Organizations</b>	<b>Representative(s) for Planning</b>
field public information officers to mass fatality operations' sites to inform and manage the media.	
<b>Office of Emergency Services:</b> to support the local ME/C; to coordinate the integration of local, regional, state, and federal resources into the local response and recovery operations; to identify and obtain assets required in the fatality management effort; to function as the main contact for each asset; and to maintain the Emergency Operations Center.	
<b>Death Care Industry</b> (funeral homes, crematories and cemeteries): to manage the final disposition of human remains and to assist ME/C Office operations with staff for such support duties as transcribing case file data in the morgue, collecting antemortem data at the family assistance center, assisting with grieving families and gathering information from families regarding final disposition wishes at the family assistance center, and escorting bodies from station to station in the morgue; to assist with transportation of human remains, and to provide supplemental morgue storage.	
<b>Spiritual Care Community:</b> to comfort victims' families and friends, to provide religious services, and to provide consultation on cultural/religious considerations.	
<b>Nonprofit organizations:</b> to provide family assistance services; to assist with translation; and to provide consultation on cultural/religious considerations.	
<b>Volunteers</b> (both pre-registered in existing systems and spontaneous): to assist in providing services for which they are qualified.	

## ***Setting Up the Planning Process***

There are many stakeholders involved in mass fatality management. Involving these stakeholders is extremely important to developing an effective mass fatality management plan.

The stakeholders represent a wide range of people with diverse areas of expertise and tend to be

very busy managing their organizations' daily operations. It is important to design a planning process that respects this reality. Developing a mass fatality plan takes time and commitment, but there are ways to streamline the process.

Identify potential planning partners by completing the stakeholder table above. Assemble a core group of stakeholders that will function as an executive team to review materials, develop strategies, and make decisions. Bring in people (or go to them) when their expertise is most relevant. This toolkit has been designed so that key stakeholders can focus on the sections of the plan for which they have a role. Detailed substantial information is provided to assist the stakeholders in their jobs.

## ***Your Jurisdiction's Mass Fatality Management Plan***

The final product of the planning process will be a mass fatality management plan for your jurisdiction.

### **Plan Outline**

The toolkit sections are based on the sections of a mass fatality management plan. The following is a proposed outline for the final plan.

- Introduction.
- Purpose and Objectives.
- Applicability and Scope.
- Assumptions.
- Authorities and References.
- Concept of Operations.
- Incident Notification and Plan Activation.
- Command and Control.
- Human Remains Recovery.
- Morgue Services.
- Family Assistance (ME/C functions or all family assistance functions).
- Public Communications (ME/C responsibilities).
- Vital Records System (changes in ME/C standard operating procedures).
- Death Care Industry (changes in ME/C standard operating procedures).
- Mass Fatality Plan Maintenance.

#### Appendices:

- Security.
- Mass Fatality Information Systems.
- Staff/Volunteer Processing Center.
- Family Concerns and Religious/Cultural Considerations.
- Infection and Other Health and Safety Threats.
- Pandemic Influenza Considerations.

## Caution

This toolkit was developed in Santa Clara County, California. Many of the examples throughout the toolkit are examples that are applicable to Santa Clara County (e.g., California law regarding mass fatality management and the Coroner Mutual Aid System). While it is acknowledged several times throughout the toolkit that determining what your state's laws and regulations are is important to doing accurate planning, it is important enough to mention it again here. You will need to determine the Medical Examiner/Coroner Office and Emergency Operations Center—city, county, parish, operational area, region or state—that will have jurisdiction in the event of a mass fatality in your community.

## Final Comments

A mass fatality plan must be scalable to incorporate the different needs that will depend on the nature of the mass fatality incident.

The final product—your plan—should be well organized so that users will be able to understand it, be comfortable with it, and use it to extract the information they need.

Value the byproduct of effective mass fatality management planning—the development of improved cooperative relationships and partnerships among agencies and the increased understanding of each agency's role in mass fatality management. This will mean a great deal in the event of a mass fatality in your jurisdiction.

Consider developing memorandums of understanding or informal agreements that represent planning decisions. This will allow your community to be more prepared to facilitate a timely and organized response to manage a mass fatality incident.

## Beginning the Planning Process

A PowerPoint slide show is included in this toolkit. It is provided as a tool that can be used for a planning process kickoff and orientation meeting. Customize it for your jurisdiction so that it reflects the planning process you have designed.

The following pages will provide substantial information and guidance to make mass fatality planning easier. The partnerships and collaboration you develop in the planning process will make a world of difference in your response and recovery effort if your jurisdiction ever experiences a mass fatality incident.

# Planning Context

## Overview of Section

The planning context section sets the direction and context for planning. It covers the Purpose and Objectives; Applicability and Scope; Assumptions; and Authorities and References. Each of these will become sections in your mass fatality plan.

The **Purpose and Objectives** in a mass fatality plan present the overall purpose of the plan and its specific objectives.

**Applicability** describes the relationship of the mass fatality plan to other emergency plans and addresses the organizations to which the plan applies. The plan's **Scope** defines the major operational areas covered in the plan. It is also where plan performance expectations (e.g., the expected response time) are presented.

The **Assumptions** section in a mass fatality plan presents the assumptions that underlie the planning process.

**Authorities and References** presents the laws and regulations that support the mass fatality plan and the authority of the lead agency/department to develop the plan and implement it. It is important to understand local laws that govern mass fatality response and recovery for they govern your plan's operations and activities.

## Key Assumptions

Key assumptions underlying the Planning Context section of this guide are:

- The ultimate purpose in a mass fatality response is to recover, identify and effect final disposition in a timely, safe, and respectful manner while reasonably accommodating religious, cultural and societal expectations. Under certain circumstances, this will be challenging and require support and leadership from all levels of government.
- The Medical Examiner/Coroner (ME/C) is responsible for managing mass fatalities; however, there are many other organizations that are involved in a mass fatality incident.
- A mass fatality plan will be activated in concert with a multiple patient management plan (to ensure care for survivors), and normally be activated in concert with jurisdictional emergency operations center(s) and the public health department emergency operations center.
- Supporting laws and regulations provide guidance for mass fatality response by specifying: the organization responsible for mass fatality management, response requirements; organizational authority and responsibilities; how to request assistance; and how to organize response efforts to ensure coordination and reimbursement eligibility.

## Proposed Approach



Creating these parts of your plan—the Purpose and Objectives, Applicability and Scope, Assumptions, and Authorities and References requires research. Substantial research has been provided. However, to complete these sections it is important to have a basic understanding of what is involved in mass fatality management in your jurisdiction, especially your state’s role and local government codes relevant to ME/C and death industry operations.



The executive team you’ve identified are your key stakeholders. However, welcoming all interested stakeholders will be beneficial in the long run.

Even if stakeholders do not participate in the development of this part of your plan, it is important to have them read it prior to beginning work on the section(s) most relevant to them.

If this section is done well, it will help focus planning stakeholders on the task at hand—mass fatality management. Examples of each plan section are provided and can be customized to become your jurisdiction’s plan.

*Recommendation:* Do the research and draft the Purpose and Objectives, Applicability and Scope, Assumptions, and Authorities and References sections for your stakeholders. Then meet and solicit their input. This will save everyone’s time and get you off to a productive start.

## Developing Your Purpose and Objectives

### Step 1: Describe the purpose of the plan.



The purpose defines what a mass fatality incident is, specifies the organization that has primary responsibility in your jurisdiction, and affirms your commitment to manage a mass fatality incident with dignity and respect for the dead. Applicable Federal and State guidance should be also discussed.



The following is an example of a mass fatality plan’s purpose.

The purpose of the mass fatality plan is to provide a framework to facilitate an organized and effective response to mass fatality incidents that treats the dead and their loved ones with dignity and respect. A mass fatality incident, according to California Health and Safety Code §103451, is “an incident where more deaths occur than can be handled by local Coroner/M.E. resources.”

It may be caused by natural hazards (e.g. earthquakes, floods and hurricanes), human-related hazards (e.g., commercial airline crashes and bridge or tunnel collapses), or pro-active human hazards (e.g. terrorist acts).

In Santa Clara County, the Medical Examiner-Coroner is in charge of local mass fatality management. California Government Code §27490-27512, California Health and Safety Code §102850-103490, and Santa Clara County Code §A18-90 specify ME/C responsibilities.

Decedent operations for which the Medical Examiner-Coroner is responsible include incident site human remains recovery, morgue services, and family assistance. Public communication, the vital records system, and death care industry operations are also important to effective mass fatality management. If any one of these operational areas is not able to carry out its critical function, the entire mass fatality infrastructure will be impacted. Cooperation and collaboration among all mass fatality response organizations is critical to effective mass fatality management.

This plan is compatible with the State of California Governor's Office of Emergency Services' *Coroners Mutual Aid Plan* (2006), the State of California Governor's Office of Emergency Services' *The California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan* (September 2007), and the Emergency Management Assistance Compact. This plan is intended to be utilized within California's Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS).

## **Step 2: Specify the plan's objectives.**

Describe what you want to achieve with development of a mass fatality plan.



The following is an example of objectives for a mass fatality plan.

The primary objectives for the mass fatality plan are:

- To ready the jurisdiction for managing a mass fatality.
- To identify decedent operational areas, the stakeholders and organizations responsible for these operational areas, and develop a plan for providing and for coordinating operational activities.
- To specify the command and control structure, who will activate the plan, and criteria for levels of activation.
- To present information on and guidelines for the decedent operational areas.
- To provide logistics information that enables readiness and scalability.
  - Supplies and equipment.
  - Staffing requirements.
  - Facility requirements.
- To provide information on infection and other health and safety threats; mass fatality

information systems, pandemic influenza considerations, security requirements; family, cultural and religious considerations; and staff and volunteer management.

- To describe how the plan will be exercised, updated and maintained.

## Developing Your Applicability and Scope

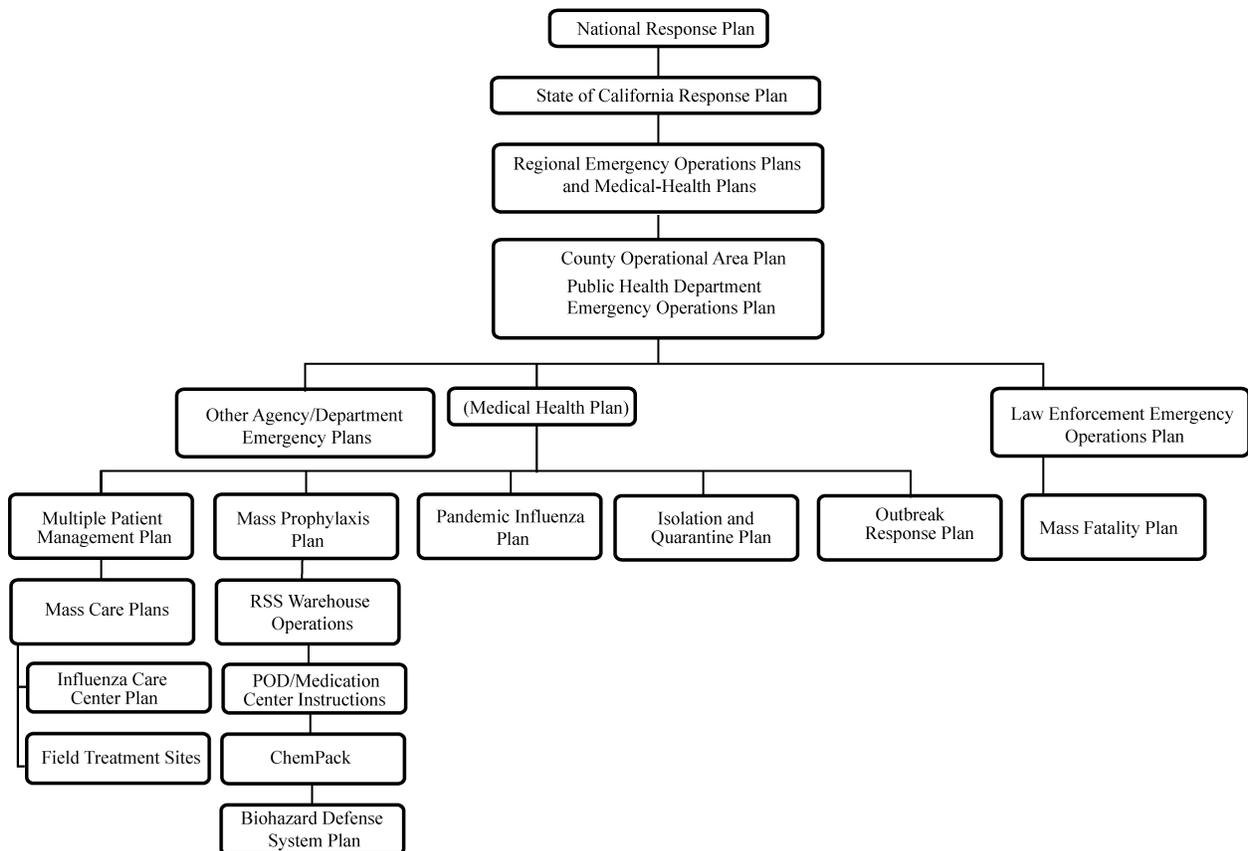
### Step 1: Determine Applicability.

- Identify other jurisdiction emergency plans and their relationship to the mass fatality plan.**



Describe the relationship of other plans to the mass fatality plan. Begin by identifying other existing plans. Determine how the mass fatality plan relates to the other emergency plans. Then consider creating an organizational chart to illustrate how the plans relate to each other. The following is an example from Santa Clara County.

Relationship of Santa Clara County Mass Fatality Plan to other Emergency Plans



**b. Specify the agency and/or specific groups to which the plan applies.**



The mass fatality plan applies to the Santa Clara County Medical Examiner-Coroner Office.

**Step 2: Determine the scope of the mass fatality plan.**

The major operations involved in managing a mass fatality incident comprise the scope of the plan. These major operational areas can also be referred to as decedent operations or the fatality management infrastructure.

When determining the scope of your plan, consider the major areas of operations involved in decedent operations, from the incident site to the final disposal of remains. Each of the major operational areas have multiple functions/activities that are described later in the plan.



Once decedent operations have been identified, determine the lead agency/organization for each operational area.



The following is an example of how to present your mass fatality plan’s scope.

<b>Mass Fatality Decedent Operations</b>	
<b>Decedent Operations</b>	<b>Lead Agency/Organization</b>
Incident Site/Human Remains Recovery	ME/C Office
Morgue Services	ME/C Office

The local jurisdiction’s emergency operations center and the Public Health Department Emergency Operations Center will be activated in response to a mass fatality incident to provide overall coordination to the multiple agencies and departments involved in the incident (local, regional, state and federal resources) that support and work with the lead agencies and organizations. This plan will operate alongside other emergency plans that are activated to respond to the incident.

Note: A mass fatality plan does not address the needs of injured survivors. A jurisdiction’s multiple patient management plan attends to the needs of injured survivors. The multiple patient management plan’s goal—to ensure adequate and coordinated efforts to minimize loss of life, disabling injuries, and human suffering of those who survive the incident—will operate alongside the mass fatality plan.

### Step 3: Identify plan response time performance expectations.

A mass fatality plan addresses mass fatality incidents that occur both with and without warning and during on-duty or off-duty hours.



When determining plan performance expectations or expected response time, determine what operations for which you want to specify response time and the many organizations involved in those operations. Some of the organizations may already have specified response times in their existing plans and protocols for their area of responsibility. This can be noted when specifying response time performance expectations for applicable agencies.



The following provides guidance for determining plan performance expectations and a few examples. All performance expectations regarding response times should be in reference to the incident's time of onset.

- **Arrival at Incident Site:** Indicate a reasonable time by which first responders (local law enforcement, fire and rescue, and public health) will arrive at a disaster site (if one exists). First responders will assess the safety of the scene and give clearance before the ME/C Office can evaluate the scene. The time needed to assess scene safety will depend on the nature and complexity of the incident.
- **Notification of the ME/C:** Indicate a reasonable time by which the ME/C Office will be notified of the incident.
- **ME/C Scene Evaluation and Organization:** Indicate a reasonable time by which the ME/C will begin to evaluate the scene once clearance is given. Once clearance is given the ME/C will evaluate the scene and formulate an initial plan for documentation, body recovery and transportation. The length of time it takes to evaluate the scene will depend on the complexity of the incident and if an act of terrorism is involved.
- **Family Assistance:**  
 Indicate a reasonable time (within 12 hours) by which basic family assistance center services and a call center/hotline will be set up. A center for families and friends is set up in the immediate aftermath of the incident along with a call center/hotline.  
 Indicate a reasonable time (24+ hours) by which a fully functioning Family Assistance Center will be operating. A Family Assistance Center is typically fully operational once federal, state and local resources have been coordinated and arrive at the incident.
- **Communication:**  
 Indicate a reasonable time by which the first briefing for the public will be held.  
 Indicate a reasonable time by which the first briefing for family members and loved ones will be held.
- **Notification of Non-ME/C Decedent Operations Lead Agencies/Organizations:**  
 Indicate a reasonable time by which that agency in charge of family assistance, hospitals, vital records system, and the death care industry are notified of the mass fatality incident.

## Developing Your Assumptions

### Step 1: Identify basic assumptions.



In your final plan, all assumptions will be in this section. In this guide and toolkit, the assumptions relevant to each section are with that section.

To identify all of your assumptions, you can begin by collecting all of the assumptions in this guide from every section in one place. Then review them and determine if they are appropriate for your plan. Modify, delete, and add assumptions to make the assumptions section relevant to your jurisdiction. Remember, the effectiveness of your plan is based on the validity of the assumptions.



*Assumptions that focus on necessary partnerships for mass fatality management:*

- Evaluation of a mass fatality incident site may require specialized assistance from local agencies and the state, special chemical, biological, radiological detection equipment, and personnel with personal protective equipment.
- The multiple organizations involved with a mass fatality incident will work within the Incident Command System and cooperate and collaborate with the ME/C, the Emergency Operations Center, and the Public Health Department Emergency Operations Center to facilitate effective management of the mass fatality.
- Mass fatality incidents create widespread traumatic stress—for responders, families that are impacted, and, at times, the community-at-large. Traumatic stress can lead to physical illness and disease, precipitate mental and psychological disorders, and can destroy relationships and families. Attending to behavioral health needs of victims' and responders is critical.
- The Social Services Agency will manage and coordinate Family Assistance (except in the event of a commercial airline and some transportation accidents).
- Under certain circumstances (e.g., commercial airline accident or terrorist act) select federal agencies will have critical on-scene responsibilities, thus requiring close and on-going coordination with the ME/C Office, local and state agencies.
- In the event of pandemic influenza or similarly contagious disease, external resources will not be available and some services will need to be delivered differently to minimize spread of the disease.

*Note:* Additional assumptions specific to decedent operations are, for the purpose of this guide, presented in the section to which they apply. Assumptions specific to a pandemic influenza are in the section on pandemic influenza considerations. The assumptions above and those in other

sections of this guide can all be considered for the Assumptions section of your mass fatality plan.

## ***Developing Your Authorities and References***

### **Step 1: Identify and list key authorities and references.**



Identifying the authorities and references relevant to your jurisdiction is a research task. Your jurisdiction's counsel may be able to assist you in this task.

It is important to develop the Authorities and References part of your plan early in the process. The medical examiner and coroner systems in the United States range from the professionally trained, board-certified forensic pathologists to the rural county elected coroners with little medical background. In addition, some states have a state medical examiner/coroner and some do not. How ME/C operations for a mass fatality are organized in your jurisdiction is key to the development of your mass fatality plan.



Areas of Authorities and References to include are identified below. Some of the areas include examples from information in Santa Clara County's plan.

The authorities and references are preceded by a statement on ME/C authority to develop a mass fatality plan, consistency with your state's mass fatality related plans, and commitment to adhere to the National Incident Management System. The following is an example of an Authorities and References section.

The ME/C is the legal authority to conduct victim identification (or assist the lead investigative agencies to complete victim identification), determine the cause and manner of death, and manage death certification for a mass fatality. This mass fatality plan derives its authority from that legal responsibility and from the related plans with which it is consistent.

This plan is consistent with:

- The U.S. Department of Homeland Security's *National Response Plan*, which states that the primary management of an incident should occur at the lowest possible geographic, organizational, and jurisdictional level.
- The State of California Governor's Office of Emergency Services' *Coroner Mutual Aid Plan* (2006),
- The State of California Governor's Office of Emergency Services' *The California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan* (September 2007), and
- The Emergency Management Assistance Compact.

It is intended to be utilized within California's Standardized Emergency Management System

(SEMS) and the National Incident Management System (NIMS).

**Definition of a Mass Fatality.** A mass fatality incident as “an incident where more deaths occur than can be handled by local Coroner/M.E. resources.” (California Health and Safety Code §103451).

**ME/C Responsibilities.** The ME/C has the primary responsibility for fatality management—the recovery, identification, and disposition of mass fatality incident victims. (CA Code §27491). It is the duty of the coroner to inquire into and determine the circumstances of death for reportable deaths. Reportable deaths include: known or suspected homicide; known or suspected suicide; accident/injury, either old or recent; result of a criminal act; no history of medical attendance; no physician attendance within the last 20 days; when a physician is unable to state cause of death; poisoning; occupational disease or injury; operating room/major surgery deaths; recovery room deaths; all solitary deaths; patients comatose throughout the period of physician’s attendance; all deaths of unidentified persons; all suspected SIDS deaths; all deaths in secured facilities under control of law enforcement; all deaths of patients in mental facilities; all deaths where there is no know next of kin; deaths related to contagious disease; and drug/alcohol related deaths. (Government Code §27491). The Santa Clara County ME-Coroner shall exercise the powers and perform the duties of the Coroner as specified by Chapter 10 of Part 3 of Division 2 of Title 3 of the Government Code and other laws and regulations. (Ord. No. NS-300.601, § 1, 6-24-97; Ord. No. NS-300.732, § 1, 6-22-04). All post mortem examinations shall, except in the case of extreme emergency, be performed at the Department’s forensic facility (Ord. No. NS-300.601, § 1, 6-24-97).

**Confidentiality of Medical/Dental Records.** Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191 covers the requirement to maintain confidentiality of all missing person/victim records in mass fatality response. Medical and dental providers of suspected victims are relieved of confidentiality restraints by the Health Insurance and Portability and Accountability Act (HIPAA) Exemption for Medical Examiners (CFR 164.512).

**Coroner Mutual Aid.** The California Coroner Mutual Aid Plan is a companion of the California Law Enforcement Mutual Aid System and Plan which derives its authority from the CA Emergency Services Act (Govt. Code §8550, §8569, §8615-8619, §8632, §8668) and the CA Disaster and Civil Defense Master Mutual Aid Agreement. The Emergency Management Assistance Compact (EMAC) is the mutual aid agreement and partnership between member states (Public Law 104-32, 1996).

**Public Health Responsibilities.** Public Health is a first responder in medical disasters (Presidential Directive) and is charged with providing leadership with regard to biological-chemical-radiological incidents (Congressional Order).

#### **Federal Assistance.**

The U.S. Department of Homeland Security’s *National Response Plan* (December 2004) developed in response to Homeland Security Presidential Directive 5 (HSPD-5) on February 28, 2003.

The Disaster Mortuary Operational Response Team (DMORT) is a federal level response team designed to provide mortuary assistance in the case of a mass fatality incident or cemetery

related incident. It is managed by the U.S. Department of Health & Human Services, Office of Public Health Emergency Preparedness, Office of Preparedness & Emergency Operations, National Disaster Medical System Section (NDMS).

***Family Assistance for Commercial Airline Accidents.*** The Family Assistance Act (1996) requires all airlines operating in the United States to have a plan to assist families in the case of an accident.

***Hazardous/Toxic Waste.*** Title 22 of the California Code of Regulations.

***Death Care Industry.*** Include regulations/ordinances relevant to death care industry operations in a mass fatality and to staffing that may impact assisting in ME/C decedent operations.

***Death Registration and Final Disposition Permits.*** California, Health and Safety Codes §102175 through 102250. Identify regulations/ordinances in your state for the vital records system that specify requirements for death registration and final disposition permits that may impact mass fatality management.

***Recommendation:*** A summary of key authorities and references can be referenced in the body of the plan. You can include an extensive list of authorities and references in the Appendix.

## ***Associated Tools and Resources***

For *Assumptions*, The State of California Governor's Office of Emergency Services' *The California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan* (September 2007), has an extensive list of assumptions for coroner responsibilities: planning, notification, scene evaluation and organization, recovery of remains, holding morgue, Level 1 transportation and temporary storage, morgue operations, Level 2 transportation and temporary storage, and final disposition for catastrophic mass fatality incidents. is available at:

<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. Click on Coroner's Mutual Aid.

In addition, your jurisdiction's pandemic influenza response plan may include assumptions related to pandemic influenza that you want to refer to in this plan.

# Concept of Operations

## ***Overview of Section***

The Concept of Operations is a brief overview of how mass fatality management operations will flow.

## **Key Assumptions**

The following are the key assumptions underlying the Concept of Operations.

- A diverse pool of local public and private resources will be available to assist with/support mass fatality decedent operations. For example, local hospitals and mortuaries may provide additional morgue storage; the vital records system may operate at surge capacity to register deaths and issue final disposition permits; the Death Care Industry may operate at surge capacity to provide for final disposition of human remains.
- Regional, state and federal resources may be required to effectively manage a mass fatality incident.

## **Proposed Approach**

Present an overview of mass fatality management operations. The following sample Concept of Operations can be modified for your plan.

## ***Developing Your Concept of Operations***

### **Step 1: Briefly describe mass fatality management operations.**

Define the overall goals and summarize how you conceptualize the flow of decedent operations.



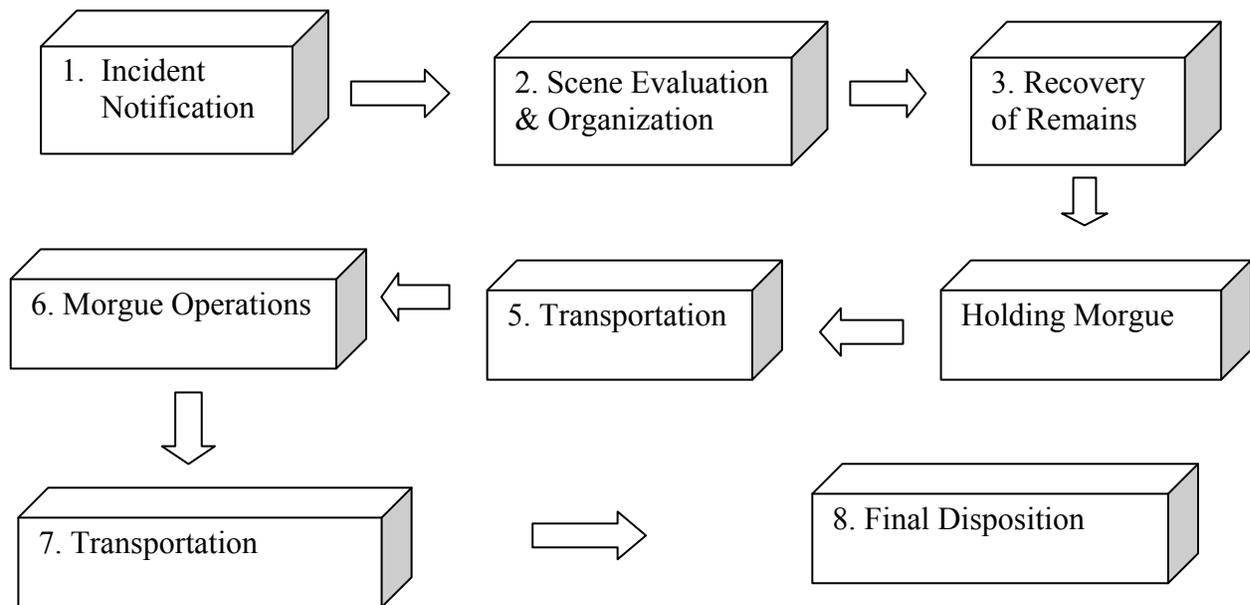
The following is example of a mass fatality plan concept of operations.

## Mass Fatality Management

The overall goals of mass fatality management are to recover, identify and effect final disposition of human remains in a dignified and respectful manner; preserve the scene and collect evidence (as needed); and provide family assistance to victims' relatives and loved ones.

- In a mass fatality, the standard process for managing human remains will be used. Figure 4 presents the standard process.

### The Processing Flow of ME/C Management of Remains



*Source: The California Mass Fatality Management Guide:  
 A Supplement to the State of California Coroners' Mutual Aid Plan  
 (State of California Governor's Office of Emergency Services)*

- The jurisdiction's Office of Emergency Services will be notified and the Emergency Operations Center will be activated.

Santa Clara County's Emergency Operations Center (EOC) will be activated when a mass fatality incident meets the EOC's criteria for activation. When the EOC is activated due to a mass fatality incident, the ME/C reports to the EOC to serve as Coroner's Services Branch Director and oversees and coordinates mass fatality decedent operations. The EOC plays a major role in coordination of local, state and federal resources.

- The Public Health Department's Emergency Operations Center will be activated.

The Public Health Department Emergency Operations Center (DEOC) is activated for a mass fatality incident when medical/health needs meet DEOC criteria for activation. Examples

include mass fatality incidents when 1) there is a possible biological-chemical-radiological incident; 2) there is a possible worst-case pandemic influenza and/or infectious disease of similar seriousness; 3) surge capacity is needed in the Vital Records System to register deaths and issue final disposition permits; and 4) multiple patient management is needed for survivors injured in the incident. When the EOC is activated, the Health Officer reports to the EOC to serve as the Medical/Health Branch Director.

- Family Assistance will be provided separately, but at the same time, as the processing of human remains.

Family Assistance begins with setting up a call center/crisis hotline and a center for families to gather. The call center/crisis hotline provides information for victim identification and emotional support and referrals for family members and loved ones. A family assistance center is opened in a centralized location close to the incident site, but out of view, for information exchange, emotional support and basic first aid in the immediate aftermath of a mass fatality incident.

Once federal, state and local resources have been coordinated, a Family Assistance Center becomes fully operational.

If the incident is the result of a commercial airline crash, the airline is responsible for providing assistance to families (Family Assistance Act, 1996).

- The Local Registrar for the Vital Records System will add surge capacity to facilitate the registration of deaths and issuance of final disposition permits.
- The Death Care Industry and spiritual care providers will add surge capacity to provide for timely mortuary, crematory and burial services.
- Local, state and federal resources assistance will be requested as needed based on the nature and complexity of the incident.

## **Key local, state and federal resources that will be requested are:**

### **Coroners Mutual Aid**

The CA Coroner Mutual Aid Plan provides guidance for requesting mutual aid. It is a companion of the CA Law Enforcement Mutual Aid Plan, both of which derive their authority from the CA Emergency Services Act and from the State Master Mutual Aid Agreement.

When a mass fatality incident is beyond the resource capability of the Santa Clara County ME/C Office, the ME/C requests mutual aid from the Region II ME/C Mutual Aid Coordinator. The Regional Coroner/ME Mutual Aid Coordinator fulfills the mutual aid request from Coroner/ME resources within the region.

The California Dental Identification Team (Cal DIT) is also requested through the CA Mutual Aid Plan process.

If the ME/C resources within the impacted region are not sufficient, the Region II ME/C Mutual Aid Coordinator requests additional mutual aid assistance from the CA OES Law Enforcement Branch ME/C Mutual Aid Coordinator. Other mutual aid regions are called upon by the State Coordinator to assist.

When further assistance beyond ME/C Mutual Aid within California is needed, out-of-state mutual aid is coordinated by the CA OES ME/C Mutual Aid Coordinator through the Emergency Management Assistance Compact.

### **Federal Resources (Department of Homeland Security, Federal Emergency Management Agency (FEMA) and the Federal Bureau of Investigation (FBI))**

FEMA is responsible for coordination and application of federal agency resources.

Federal resources, including the Disaster Mortuary Operational Response Team (DMORT), may be requested through FEMA by the CA State OES ME/C Mutual Aid Coordinator at any time during the emergency upon the local ME/C's consultation with the Regional Coroner's Mutual Aid Coordinator and the CA OES Law Enforcement Branch ME/C Mutual Aid Coordinator (CA Coroner Mutual Aid Plan).

#### **Disaster Mortuary Response Team (DMORT)**

DMORT is part of National Disaster Medical Services (NDMS) and is the federal resource most likely to be required in a mass fatality. DMORT works to support local authorities and provide technical assistance, personnel, and temporary portable morgue facilities (as needed). DMORT teams aid in the evaluation of the incident; in the assessment of personnel and equipment needs; in the recovery, identification, and processing of deceased victims; and in setting up, assisting and advising on family assistance best practices.

**Federal Bureau of Investigation (FBI)** assistance may be requested at any time by the ME/C or EOC through the nearest FBI field office.

#### **Additional Local, State and Federal Resources (not mentioned above)**

**Local Resources:** Local Law Enforcement, Fire/Hazmat, General Services Agency/Fleet and Facilities/Public Works, Environmental Health, etc.

**State Resources:** Office of Emergency Services, Office of Homeland Security, Department of Health Services, Department of Justice (DOJ) Missing/Unidentified Persons Section, DOJ Bureau of Forensic Services Section, DOJ DNA Analysis, Department of Motor Vehicles, National Guard, State Coroners Association, State Sheriff's Association, and CA Funeral Directors Association.

**Federal Resources:** Department of Homeland Security Disaster Medical Assistance Team, and Nuclear Incident Support Teams, Department of Health and Human Services Center for Disease Control and Prevention, Environmental Protection Agency, Department of Transportation, American Red Cross, Agency for International Development Office of Foreign Disaster Assistance, Urban Search and Rescue Response System, Department of Veteran Affairs, Department of Justice Office Justice Programs Office of Victim Assistance, Department of Defense, National Transportation Safety Board’s Office of Transportation Disaster Assistance, Interpol, The Salvation Army, and the International Critical Incident Stress Foundation.

**Recommendation:** Maintain a hard and soft copy of a table of local, state and federal resources that includes specific resources available and contact information. If you elect to do so, note location in the ME/C Office where it is maintained in your plan.

Although separate mutual aid agreements are in place, every effort must be made to coordinate requests for resources through the Emergency Operations Center. Incoming resources will need to be coordinated by the EOC Logistics Section.

## ***Associated Tools and Resources***

*California Mass Fatality Management Guide: A Supplement to the State of California Coroners’ Mutual Aid Plan*, The State of California Governor’s Office of Emergency Services, September 2007 is available at:

<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. Click on Coroner’s Mutual Aid.

Appendix M – Activating DMORT (pages 223-224) provides information on methods to activate DMORT.

# Notification and Activation

## Overview of Section

The Notification and Activation section presents who is responsible for activating the mass fatality plan, how notification of the mass fatality incident is made, and levels of activation. Different levels of activation allow the response to be scaled to the needs of the event.

## Key Assumptions

The following are the key assumptions underlying Notification and Plan Activation.

- The ME/C will find out about the incident through a call from the local first responder at the incident site, various media outlets, and/or government emergency notification systems.
- The local jurisdiction’s ME/C Office capacity for managing a mass fatality event determines the first activation level. Local capacity is a combination of morgue storage capacity, available personnel, and available equipment and supplies. Thresholds for levels of activation are based upon local capacity.
- The level of activation will depend on the anticipated number of deaths, the scope of destruction/level of difficulty in recovery, and whether or not there are possible biological, chemical, physical, or radiological hazards.

## Proposed Approach



Involve the stakeholders that have a role in ME/C surge capacity for mass fatality response. This includes hospitals (possible morgue storage space), the death care industry (possible morgue storage space, vehicles for transporting human remains, staff), local law enforcement (coroner investigation staff), the local jurisdiction’s General Services Agency/Fleets and Facilities/Public Works (for facilities, transportation and drivers), and the local jurisdiction’s Procurement Department (for equipment and supplies).



Identify and describe the mechanisms that are in place for notifying the ME/C of mass fatalities. Then describe how the ME/C will notify staff and other stakeholders involved in mass fatality management.



Determining activation levels requires an inventory of existing local capacity for morgue storage, personnel, and equipment/supplies. Stakeholder decisions regarding levels of activation are based on this information.

## ***Developing Your Incident Notification Plan***

### **Step 1: Confirm who is responsible for mass fatality management.**

The Coroner or Medical Examiner that is responsible for mass fatality incidents in your jurisdiction is the one that is authorized to activate the plan and carry out ME/C operations described in this guide.

This guide follows the California model—where the local or Santa Clara County ME/C is responsible for a mass fatality. Unlike other states, California does not have a State Coroner or Medical Examiner. Primary responsibility for the investigation, recovery, and management of the dead resides within the authority of the local coroner or medical examiner. If it is different in your jurisdiction, your plan needs to reflect that.

### **Step 2: Describe how the responsible ME/C will be notified.**

As the first responder at a mass fatality, local law enforcement is responsible for immediately notifying the ME/C Office per Government Code. The ME/C Office may also find out about the incident through various media outlets, and/or a government emergency notification system.

In the event of a worst-case scenario pandemic influenza, activation will be triggered by the status of the pandemic as communicated by the World Health Organization, the Centers for Disease Control and Prevention, your state department of public health, and your local health officer. Activation will occur as part of your overall emergency response structure.

At the incident site, the ME/C will complete the *Notification of Mass Disaster* form.

### **Step 3: Describe how ME/C's staff will be notified.**

Describe the notification process used in your jurisdiction. For example, the ME/C staff will be notified by landline, cell phone and/or other Emergency Operations Center notification systems.

Once all ME/C staff have been notified, the agency/organization that will manage the Family Assistance Center for the ME/C Office will be notified by landline, cell phone and/or other Emergency Operations Center notification systems.

### **Step 4: Describe how stakeholders involved in decedent operations in a mass fatality will be notified.**

The key areas of decedent operations outside of the ME/C's Office are:

- Hospitals and mortuaries for morgue storage space,
- Agencies/organizations that will provide family assistance services,

- Local Registrar for the Vital Records System for death registration and issuance of final disposition permits, and
- The Death Care Industry for final disposition of human remains.

Develop a system for notifying key organizations with these responsibilities in the event of a mass fatality incident.



*Recommendation:* Create a table with services, description of services, name of provider/organization and contact information (include 24/7 access phone number and e-mail address) for each of these areas of decedent operations and note where this is located in the ME/C Office in your plan. Your jurisdiction’s ME/C Office may already have this information available.

## ***Developing Your Activation Plan***

### **Step 1: Determine who has the authority to activate the mass fatality plan.**



The following is an example of how you can present who has the authority to activate the mass fatality plan.

The local ME/C is responsible for a mass fatality incident and has the authority to activate the mass fatality plan.

In the event of a worst-case scenario pandemic influenza or infectious disease of similar gravity, the Health Officer will consult with the ME/C regarding activation of the mass fatality plan.

### **Step 2: Determine local surge capacity for managing a mass fatality incident.**



To determine local surge capacity, the following must be assessed:

- Morgue storage space.
- Qualified personnel that are available.
- Availability of equipment and supplies.

The following is a proposed approach for determining local surge capacity.

**Morgue Storage Capacity Assessment.** Begin to determine local capacity by determining your jurisdiction’s morgue’s storage capacity and its average census.

The first step is to identify your Medical Examiner/Coroner morgue capacity.

The second step is to identify all hospitals in the jurisdiction and their refrigerated storage capacity. If hospitals are willing to assist the ME/C by providing refrigerated storage space in

the event of a mass fatality, note that in the chart below with an asterisk.

The third step in identifying local capacity is to identify all funeral homes/mortuaries in the jurisdiction and their refrigerated storage capacity. If they are willing to assist the ME/C by providing refrigerated storage space in the event of a mass fatality, note that in the chart below with an asterisk.

The fourth step is to determine the average number of deaths in your jurisdiction in an average week.

Once all of the information is gathered, determine the average refrigerated storage space available at any given time (the local surge capacity) by subtracting the average number of deaths in a week from the total refrigerated storage capacity.

To organize this information, you might want to create a table such as the following.

<b>Decedent Storage Capacity Information</b>		
<b>ME/C Morgue</b>		
		<b>Refrigerated Storage Capacity</b>
<b>Hospitals</b>		
<b>Name</b>	<b>Contact Name &amp; 24 Hour Number</b>	<b>Refrigerated Storage Capacity</b>
<b>Funeral Homes</b>		
<b>Name</b>	<b>Contact Name &amp; 24 Hour Number</b>	<b>Refrigerated Storage Capacity</b>
<b>Surge Capacity = xxx</b> (total refrigerated storage capacity minus average number of weekly deaths)		

It is important to recognize that hospital and funeral home refrigerated storage capacity may only be available in the beginning of a mass fatality event. Hospitals may be providing care to large numbers of patients critically injured in the incident. And, once identifications are made, the

funeral homes will need their morgues for funeral service operations.

**Qualified Personnel Capacity Assessment.** The first step is to determine the ME/C Office personnel capacity. Identify a few key positions that would be needed immediately to begin human remains recovery at the incident site. The focus is on beginning human remains recovery operations since based on the assumption that regional, state, and/or federal assistance will be available once the incident site is evaluated, needs are identified, and requests are made.

The second step is to identify positions within your jurisdiction that could fill these positions to assist with a mass fatality. This may include:

- Law enforcement forensics/crime scene investigation staff as Coroner Investigators/Assistants.
- Death care industry staff to assist as Human Remains Transport Personnel and Drivers.
- General Services Agency/Fleets and Facilities/Public Works staff assistance to assist as Human Remains Transport Personnel and Drivers.

The third step is to create a table that identifies staff for a few critical positions and alternates that may be available locally in a mass fatality.

<b>Personnel Capacity Assessment to Initiate Response</b>	
<b>ME/C Personnel</b>	<b>Possible Local Alternates for ME/C Personnel</b>
Coroner Investigators	
Human Remains Transport Personnel	
Drivers	

**Equipment and Supplies Assessment.** For an assessment of equipment and supplies capacity, focus on the most critical supplies and equipment that will be needed immediately to begin human remains recovery—until Coroner’s Mutual Aid and/or DMORT are available to provide assistance.

The first step is to determine ME/C Office capacity regarding most critical supplies and equipment that would be needed immediately. This includes number of body bags, bags for personal effects, vehicles to transport human remains.

The second step is to consult with funeral homes and your jurisdiction’s General Services Agency/Fleets and Facilities/Public Works to determine the number of vehicles that meet ME/C requirements for transporting human remains that would be available. The refrigerated vehicles can be used as temporary holding morgues at the incident site.

<b>Equipment and Supplies Needed Immediately—Capacity Assessment</b>		
<b>Item</b>	<b>ME/C Office Number Available</b>	<b>Alternate Source and Number Available</b>
Body Bags		
Personal Effects Bags		
Refrigerated Vehicles to Transport Human Remains		

**Local Surge Capacity.**



Once you have determined refrigerated storage space capacity, personnel capacity, and equipment and supplies capacity, the ME/C will need to review the information with other planning stakeholders and a decision will have to be made regarding the maximum number of decedents the jurisdiction can manage and/or that the jurisdiction believes would require activating the mass fatality plan.

Some jurisdictions may determine the local surge capacity based on what the ME/C Office thinks it can handle on its own. Others may want to utilize more local resources in determining its local surge capacity. Some jurisdictions may want to extend their assessment of local capacity by determining morgue services capacity. It will depend on the jurisdiction.

The number of decedents identified as your jurisdiction’s surge capacity will become the number of anticipated decedents that will result in a level one activation of the mass fatality plan. Ultimately what you determine to be your local surge capacity should resonate with the definition of a mass fatality—any situation where more deaths occur than can be handled by local medical examiner/coroner (ME/C) resources.

**Step 3: Determine and describe activation levels.**

Developing activation levels allows for scalability in the mass fatality response. Needs will differ for a mass fatality incident involving participation by local resources and regional mutual aid versus a catastrophic mass fatality event that will require extraordinary support from state, federal, and private resources.



Determining levels of activation requires involvement of all of the stakeholders involved in mass fatality response.

Your level one activation will be based on your local surge capacity to respond to a mass fatality incident.

The only exception will be a partial activation of the plan—the family assistance center—when family assistance is needed even though the number of deaths is less than can be handled by available local surge capacity.

All other levels of activation will be based on:

- the anticipated number of deaths,
- the scope of destruction/level of difficulty in recovery, and
- whether or not there are possible biological, chemical, physical, or radiological hazards.



Some examples of activation levels follow:

### Level 1 Activation

- Anticipated number of deaths is xxx *OR* anticipated number of deaths is less, but family assistance will need to be activated.
- Human remains are not contaminated by any toxic or hazardous materials and are generally intact.
- No criminal or terrorist involvement is suspected.
- The normal day-to-day ME/C Office response system is functional and requires reinforced response (e.g., additional morgue space and staff).
- Coroner Mutual Aid from at least one jurisdiction within the region is required.

### Level 2 Activation

- Anticipated number of deaths is xxx.
- Human remains are not contaminated by any toxic or hazardous materials and are generally intact.
- No criminal or terrorist involvement is suspected.
- The normal day-to-day ME/C Office response system is functional and a mandatory 12-hour shift is initiated.
- Coroner Mutual Aid from several jurisdictions within the region is required.

### Level 3 Activation

- Anticipated number of deaths is xxx.
- Human remains are fragmented, but do not require decontamination.
- The scope of destruction/level of difficulty in recovery is significant. It is difficult to locate and remove human remains.
- There is risk of biological, chemical, and/or physical hazards.
- Criminal or terrorist involvement may be suspected.
- The normal day-to-day ME/C Office response system is functional and a mandatory 12-hour shift schedule for personnel is initiated.
- Coroner Mutual Aid outside of the jurisdiction is required.

### Level 4 Activation

- Anticipated number of deaths is xxx.
- Human remains are fragmented or contaminated and require decontamination.

- The scope of destruction/level of difficulty in recovery is significant. It is difficult to locate and remove human remains.
- There is risk of biological, chemical, and/or physical hazards.
- Criminal or terrorist involvement is suspected.
- The normal day-to-day ME/C Office response system is functional and a mandatory 12-hour shift schedule for personnel is initiated.
- Coroner Mutual Aid (regional, state, and possibly federal—DMORT) is required.
- This may be a catastrophic mass fatality event.

### Level 5 Activation

- Anticipated number of deaths is xxx *OR* there is a worst-case scenario pandemic influenza or infectious disease of similar gravity.
- Human remains may be fragmented or contaminated and require decontamination.
- The scope of destruction/level of difficulty in recovery is significant. It is difficult to locate and remove human remains.
- Criminal or terrorist involvement may be suspected.
- There is risk of biological, chemical, physical, and/or radiological hazards.
- The normal day-to-day ME/C Office response system may not be functional. A mandatory 12-hour shift schedule for Coroner’s Office personnel who are able to work is initiated.
- Coroner Mutual Aid outside of the jurisdiction (regional, state, and federal) is required. However, in the case of a worst-case scenario pandemic influenza, external assistance may be very limited or not available.
- Non-traditional death care methods, as coordinated by the Emergency Operations Center, may be required.
- This is a catastrophic mass fatality event.

### Step 4: Describe Coordinated Response.



Effective coordination among local, state, and federal responders in a mass fatality event is a key factor in ensuring successful responses to major incidents. The ME/C Office response will be coordinated with other involved disaster response systems that may be involved, such as law enforcement, fire and rescue, public health, on-scene hospital and Emergency Medical Services personnel, the Emergency Operations Center, individual city emergency operations centers, and other state and federal resources that assist with the response. The Incident Command Structure/Unified Command, an efficient on-site tool to manage emergency response incidents and facilitate effective coordination, will be used in the event of a mass fatality.

### Step 5: Define the Operational Period.



An operational period is generally 12 hours.

## Step 6: Describe how the plan will be deactivated.



The ME/C will deactivate the mass fatality plan or parts of the plan when the ME/C Office mass fatality operations have been completed. Deactivation will be coordinated with deactivation of the Public Health Department Emergency Operations Center (DEOC) and/or the Emergency Operations Center (EOC).

Deactivation will be in compliance with SEMS and NIMS procedures.

**Demobilization.** Officers in Charge and Team Leaders at the incident site and morgue will keep notes during the mass fatality response indicating challenges, changes that were made to guidelines/procedures, unique circumstances and other pertinent information and submit these notes to the ME/C Office. The ME/C Office will compile these notes and create an After Action Report. The After Action Report will be completed no later than xxx month(s) after the mass fatality plan has been deactivated.

The ME/C Office will follow procedures for demobilization as required by organizations that have loaned facilities, refrigerated vehicles, equipment, and supplies. In the absence of specific procedures, the ME/C Office will adhere to DMORT procedures for demobilization.

All original records pertaining to identification, postmortem documentation, and antemortem records will be transferred to the ME/C Office.

The ME/C Office will ensure that all personnel paperwork has been completed.

**Long-Term Examination Center.** A Long-Term Examination Center may continue to operate after this plan is deactivated. When the Long-Term Examination Center is deactivated, deactivation will be in compliance with SEMS and NIMS procedures and demobilization will follow procedures used for demobilization of the incident site and morgue.

## ***Associated Tools and Resources***

*Notification of Mass Disaster form.*

# Command and Control

## Overview of Section

Command and Control of a mass fatality incident is exercised through the Incident Command System, which is the backbone of the National Incident Management System (NIMS). It is also the backbone of the Standardized Emergency Management System (SEMS), which is required in California. The Incident Command System (ICS) provides an interdisciplinary and flexible management system that is adaptable to incidents of any kind or size and enables integration and coordination of all responding organizations. Compliance with NIMS/SEMS is required to meet all federal and state funding and reimbursement requirements.

## Key Assumptions

The key assumption for Command and Control is:

The Incident Command System will be used in the event of a mass fatality, complying with the National Incident Management System (NIMS) and the Standardized Emergency Management System (SEMS). Note: compliance with SEMS is only required in California.

## Proposed Approach



Present your jurisdiction's Emergency Operations Center (EOC) organization and highlight the ME/C Office operations.



Then develop a Coroner's Service Branch or ME/C Office mass fatality organization that adheres to NIMS and SEMS (California only).



Review this section with the people responsible for emergency planning in your jurisdiction and with your planning executive team.

## ***Developing Your Command and Control***

### **Step 1: Describe use of an ICS and adherence to NIMS and SEMS.**

The Incident Command System (ICS) is a framework for managing emergency events that can be scaled to meet incident requirements. Its standardized structure allows for the integration of other agencies and organizations.



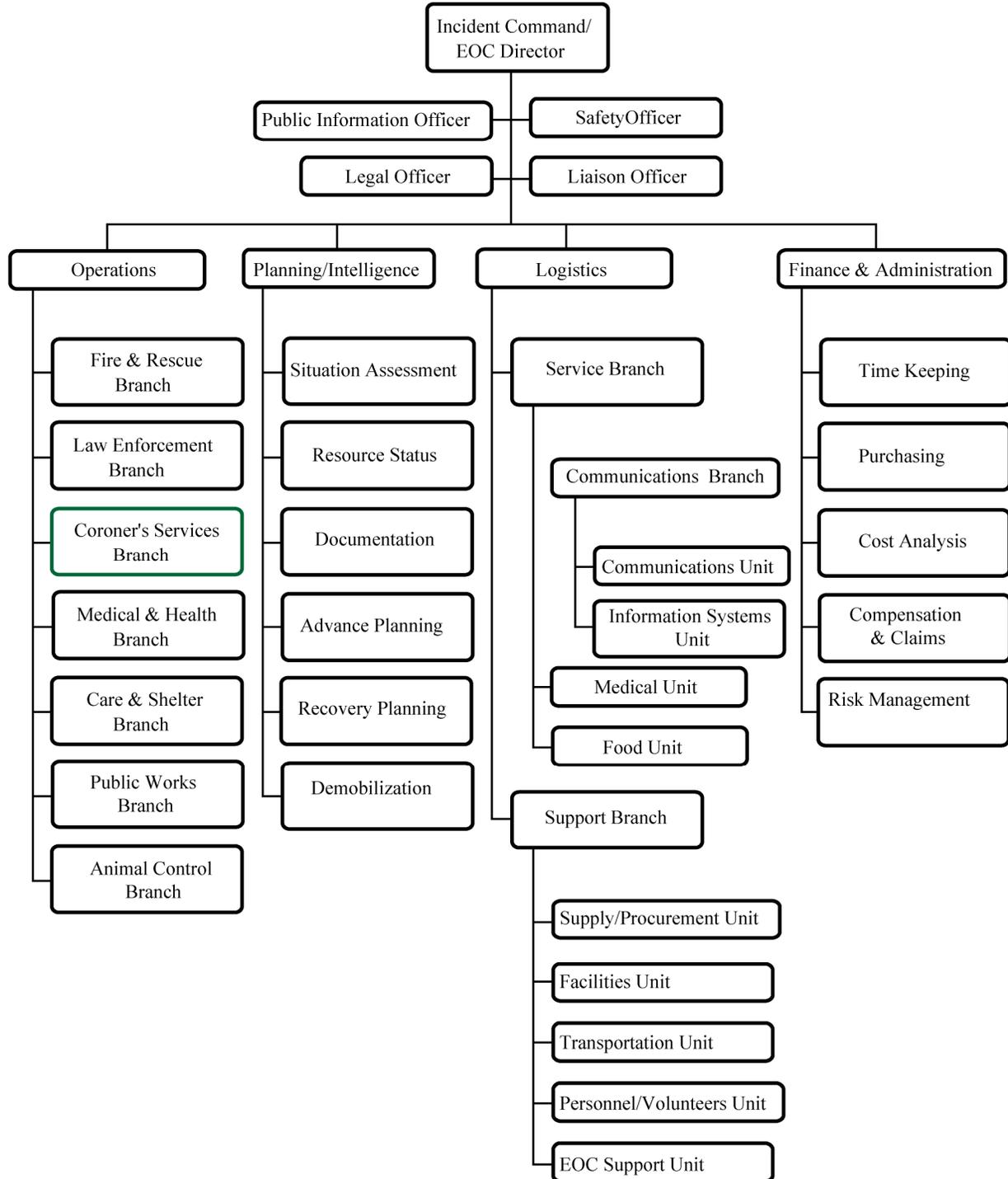
The following is an example of how you can describe your plan's adherence to ICS.

The Santa Clara County Mass Fatality Plan uses the Incident Command System (ICS) for operational management and coordination. It is in compliance with the National Incident Management System (NIMS) and the Standardized Emergency Management System (SEMS), which is required in California.

### **Step 2: Present your jurisdiction's Emergency Operations Center organization.**

Present your jurisdiction's Emergency Operations Center organization and highlight the of ME/C Office mass fatality operations.

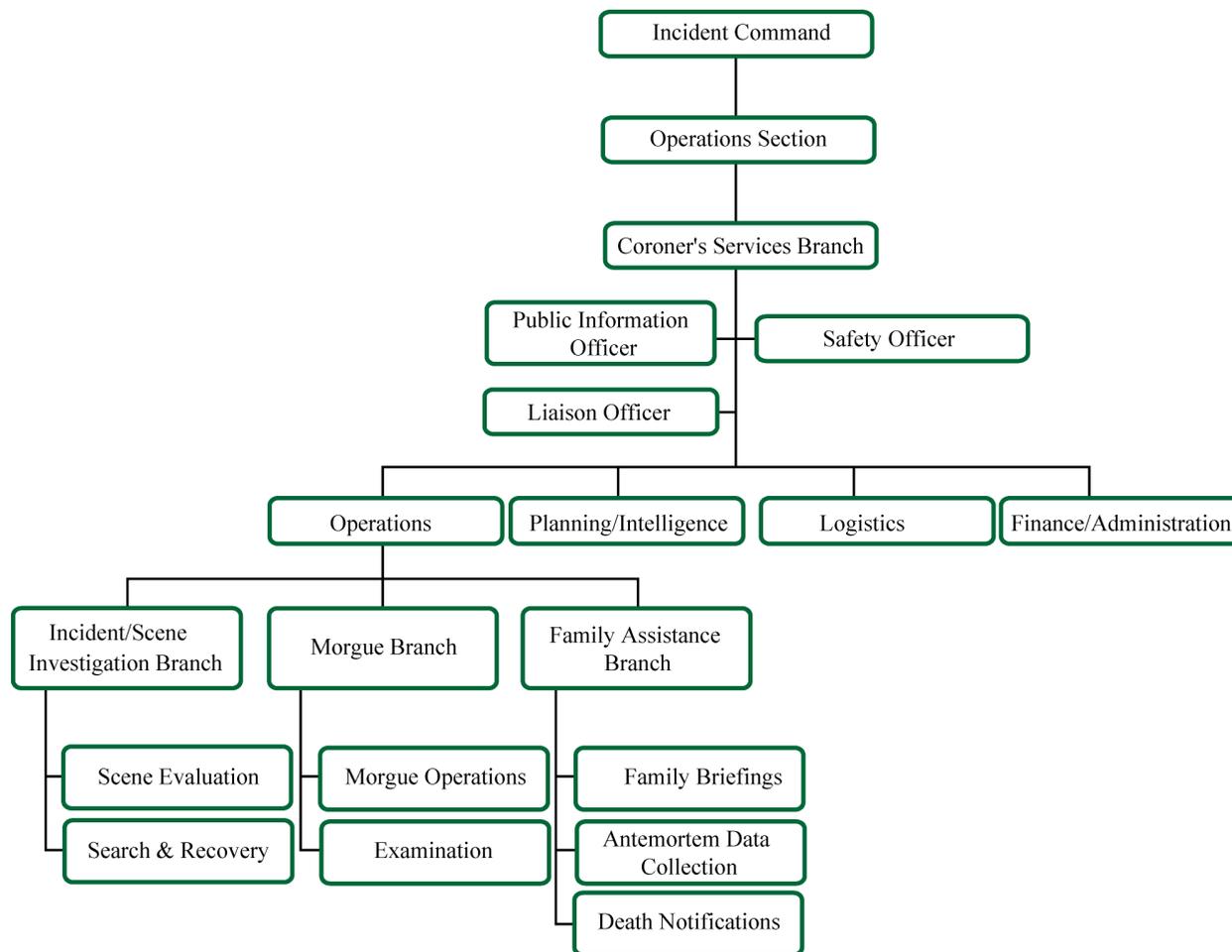
### Example Emergency Operations Center (EOC) Organization



### Step 3: Describe the Coroner’s Services Branch Organization.

An example of an organization for the Coroner’s Services Branch follows.

#### Example Coroner's Services Branch Organization



ICS is used for all incidents, whether large or small. Positions are activated and staffed only if needed for incident response. One person may be tasked with more than one area of responsibility. If a unit is not activated, the unit’s duties will remain with that section’s officer in charge. If there is a need to expand response, additional positions exist within the ICS framework to meet virtually any need.

When the EOC and Coroner’s Services Branch are activated, the ME/C organization presents the functions and activities under the Coroner’s Services Branch.

## ***Associated Tools and Resources***

### **Job Responsibility Checklists**

The job responsibility checklists in this toolkit present a general summary of actions. It should be understood that:

- Some required actions may not be listed, but must be identified and assumed by the appropriate position.
- Some actions may be the primary responsibility of a particular position, but may require assistance and coordination from other position(s).
- The actions are listed in a general chronological order, but deviation may be required to meet incident objectives.

The Common Responsibilities Job Checklist presents general actions that pertain to ALL personnel of the Mass Fatality Branch. In addition to instructions listed in their respective job responsibility checklists, all personnel are responsible for the Common Responsibilities.

The Common Responsibilities Job Checklist is only included with this section. It should be copied and distributed to planners developing the Human Remains Recovery, Morgue Services, and Family Assistance sections of your plan.

The following job responsibility checklists are attached.

- Coroner's Services Branch Director Job Responsibility Checklist.
- Deputy Coroner's Services Branch Director Job Responsibility Checklist.
- Common Responsibilities Job Checklist.

# Human Remains Recovery

When a disaster or major incident occurs, the first on-site responders are the local fire department, law enforcement, and emergency medical technicians. If the incident involves mass fatalities, the Medical Examiner/Coroner Office is notified and responds with a scene evaluation team and search and recovery teams. The next level of responders can include county, state, federal and out-of-area groups, such as specialized search and rescue teams. In incidents involving chemical, biological, or radiological contamination, specialized teams are called in to manage search, recovery and decontamination of remains at the incident site. As the response continues, it is also likely to expand to include public works employees and construction companies that have specialized equipment needed to remove debris.

Coordination of incident site operations is critical and is accomplished through a unified command. If roles and responsibilities of responding agencies have not been predetermined, the on-scene commander will need to define them at the earliest possible moment.

The first priority at any incident site is to save and protect lives. Establishing a command post, external perimeter, and a site ID system are also priorities. A “hard perimeter,” such as a chain link fence, is recommended to make sure only essential personnel operating under the direction of the scene commander are on-site. In determining the perimeter, be sure to allow for access by heavy equipment and evacuation of victims. It is easier to contract a perimeter than to expand it.

This section of the toolkit focuses on the Medical Examiner/Coroner (ME/C) Office responsibility at the incident site—human remains recovery. Recovering human remains is a process in which the ME/C is very familiar. What is different in a mass fatality is the scale of the event and the organization that is required to respond effectively.

## Overview

ME/C human remains recovery operations are:

- Investigation (scene evaluation, investigation, and action plan development);
- Search and Recovery (collection and documentation of post-mortem human remains, property, and evidence at the incident site); and
- Transportation (transportation of post-mortem human remains, property, and evidence to the incident morgue).

A respite center for ME/C operations personnel and all other incident site workers will be required.

This section includes:

- The purpose of ME/C incident site operations.
- Who is in charge of human remains recovery.
- A proposed organization for ME/C incident site operations.
- Guidelines for ME/C operations at the incident site.
- Logistics (staffing, communications and information systems, equipment and supplies, and facility requirements).

The information provided will allow for variations and scalability based on the nature, size and complexity of the mass fatality.

Key resources used to develop this section are:

- *California Coroners Operations Guide, Part 2*, State of California Law Enforcement Branch, California Office of Emergency Services, 2003.  
(<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. And, then clicking on Coroner's Mutual Aid)
- *Coroners Mutual Aid Plan*, State of California Law Enforcement Branch, California Office of Emergency Services, 2006.  
(<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. And, then clicking on Coroner's Mutual Aid)
- *California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan*, The State of California Governor's Office of Emergency Services, September 2007.  
(<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. And, then clicking on Coroner's Mutual Aid)
- *DMORT Standard Operating Procedures for National Transportation Safety Board Activations*, Disaster Mortuary Operational Response Team, 2006.  
(<http://www.dmort8.org/DMORT%20NTSB%20SOP%20Nov%202006.pdf>)
- *Mass Fatality Plan*, National Association of Medical Examiners.  
(<http://www.dmort.org/FilesforDownload/NAMEMFIplan.pdf>)
- *Mass Fatality Recovery Plan Hurricane Katrina* (Draft v5.0), John Linstrom, Commander, DMORT IX.  
([www.dmort.org](http://www.dmort.org)...click on 'Contact Us' and then on Region IX)
- *Oklahoma City—Seven Years Later: Lessons for Other Communities*, Oklahoma City National Memorial Institute for the Prevention of Terrorism, 2002.  
(<http://www.terrorisminfo.mipt.org/okc7toc.asp>)

## Key Assumptions

The following are the key assumptions underlying ME/C Human Remains Recovery.

- There will be multiple responders at the incident site.
- The incident site will be treated like a crime scene until it has been formally determined that it is not one.
- A mass fatality scene that is contaminated or extremely hazardous may prohibit ME/C

responders from evaluating in a timely manner and may require additional local, state or Coroner Mutual Aid assistance and special chemical, biological, radiological detection equipment and personnel with personal protective equipment.

- Select federal agencies will be involved at the incident site under certain circumstances, e.g., a commercial airline accident or terrorist act.
- Incident Site operations will be performed according to professional protocols to ensure accurate identification of human remains and, under certain circumstances (e.g., commercial airline accident and criminal or terrorist act), to preserve the scene and collect evidence.
- An accurate and reliable numbering system for all human remains is crucial to an effective response mission and will be implemented by the ME/C at the onset of the incident.
- Contaminated deceased victims may require decontamination on-scene prior to admitting to a temporary morgue. Local assistance or Mutual Aid from the fire department, Hazmat unit, DMORT, military, or other non-ME/C discipline may be needed.
- The collection, inventory, and return of personal effects to the decedent's family is important, especially in transportation incidents (land, air, sea) that involve mass fatalities.
- Depending on the natural or manmade disaster that produces the mass fatalities, the infrastructure may be severely impacted causing significant delays and progress in recovering and managing the dead.
- Access to the scene and other fatality management operations will be controlled by law enforcement/security. A credentialing system to monitor access will be employed.
- The bio-waste and other bodily fluids from human remains during phases of recovery may become a hazardous and toxic issue requiring collaboration with the Health Officer and a request to the State to amend/suspend Title 22 of the California Code of Regulations dealing with hazardous/toxic waste.
- The state, upon request, may assist in obtaining portable or fixed clear span facilities that can be used for temporary human remains storage purposes.
- Refrigerated vehicles for the transportation and/or temporary storage of human remains may be in short supply. Caution will be taken when using food, beverage or other consumer types of commercial vehicles to store and transport human remains. In most cases, these types of vehicles should not be returned to their prior service function. The local jurisdiction is responsible for replacement.
- Responding to a mass fatality incident can be overwhelming, leading to traumatic stress. Support for responders is essential to monitoring and minimizing the impact.

## Proposed Approach



Describe the key components of human remains recovery and logistics requirements. To do this,

- Use information that your jurisdiction collected when assessing local capacity to manage a mass fatality;
- Review mass fatality planning your ME/C Office has already done in this operational area and build on that as needed; and

- Use the substantial research below that has been done for you and can be customized for your jurisdiction's plan.



The key stakeholder for this section is the local jurisdiction ME/C Office—a Coroner Investigator and Medical Examiner or Autopsy Technician. Consultation with EOC Logistics is also needed.

## ***Developing Your Plan for Search and Recovery***

### **Step 1: What is the purpose of human remains recovery?**

The purpose of human remains recovery is:

To recover human remains by:

- Investigating the scene.
- Participating in unified command and development of the field action plan for the incident site with police, fire, rescue personnel, etc.
- Locating and removing, at minimum, bodies, body parts, and personal effects.

### **Step 2: Who is in charge of human remains recovery?**



The Medical Examiner/Coroner Office is in charge of human remains recovery.

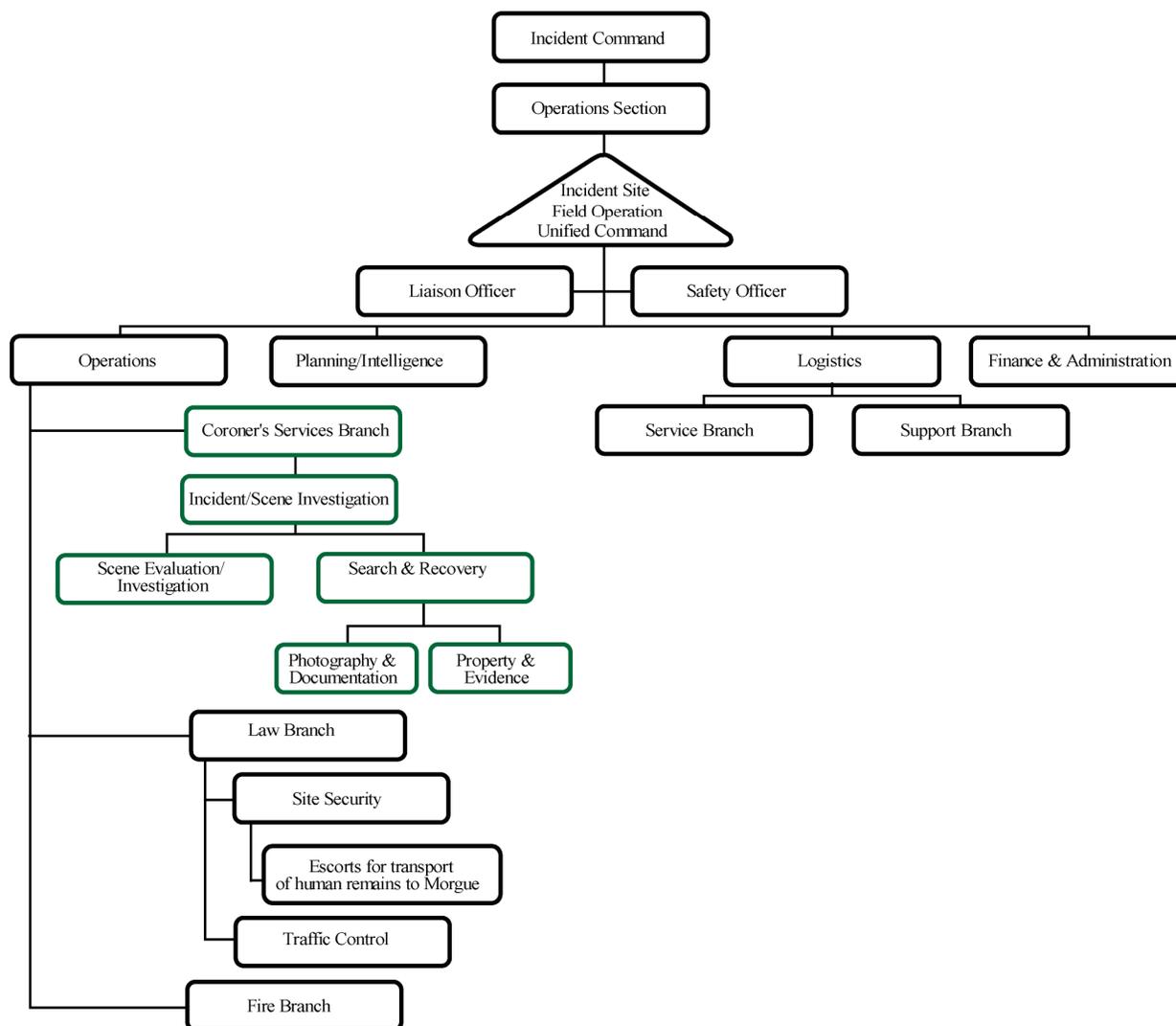
The only exceptions are incidents involving commercial airline accidents and when domestic terrorism is suspected. For commercial airline accidents and suspected domestic terrorism, the FBI Evidence Response Team provides personnel and management for the search and recovery of human remains, personal effects, and accident-related wreckage, with the local jurisdiction augmenting response.

### **Step 3: How is human remains recovery organized at the incident site?**



An example of an organization for mass fatality human remains recovery operations is on the following page.

### Example of Field Organization for Mass Fatality Human Remains Recovery Operations



#### Step 4: What are the guidelines for human remains recovery?



Human remains recovery operations at the incident site, as presented in this guide, are also referred to as Scene Investigations Branch operations (see Emergency Operations Center organization under the *Command and Control* section). Its two primary functions are:

- Scene evaluation and investigation.
- Search and recovery.

Guidelines for these two functions, that you can customize as needed, are presented below.

## Guidelines for Scene Evaluation

Scene Evaluation includes evaluation and investigation of the scene and development of a field action plan.

In every day instances, the scope of the situation is clear to the ME/C and may only require the input of a coroner investigator. In a mass fatality, the ME/C will need to establish an evaluation team, who may then need to work in conjunction with other agencies depending on the nature of the incident.

### Scene Evaluation

The ME/C Office Evaluation Team, at a minimum, will consist of the ME/C, the ME/C Chief Investigator and an ME/C Coroner Investigator for the initial evaluation. One of the initial Evaluation Team members should be the person who will serve as the Coroner's Services Branch Deputy Director.

Their first task is to determine the jurisdiction to clearly identify the lead and supporting agencies. Based on the jurisdiction and the incident itself, the team may be expanded to a multi-disciplined evaluation team and also include law enforcement, Hazmat, the FBI, Public Health, Environmental Health, and other agencies as determined necessary based on the incident.

- The FBI is the lead investigating agency for any credible threat or other situation that could potentially threaten the public, e.g., commercial airline accidents and suspected domestic terrorism.
- The Health Officer, Environmental Health, Hazmat, and, if needed, the Disaster Mortuary Operational Response Team (DMORT) Weapons of Mass Destruction Team are involved when remains are chemically, biologically, or radiologically contaminated.

For ongoing investigation/evaluation, the Coroner's Services Branch Director will appoint two ME/C personnel serve as the Team.

Prior to entering the site to perform the evaluation, the site must be assessed and cleared for safety by the appropriate agency, based on the nature of the incident.

#### ***The Evaluation Team will assess the site to determine:***

- Potential or real number and location of remains.
- Condition of the bodies.
- Locations of atypical cases.
- Potential number of remains for autopsy.
- Complicating factors or level of difficulty in recovery—types and numbers of personnel and equipment needed.
- Accessibility of the incident site.
- Possible biological, chemical, physical or radiological hazards.
- Level of personal protective equipment required.

The Evaluation Team will also ensure that initial pictures of the site are taken.

***The ME/C Office Evaluation Team members will begin planning for all ME/C mass fatality operations.*** This includes addressing how each phase of the mass fatality operation will be carried out, determining where and in what order the tasks will be performed, and identifying who will be performing the tasks. To initiate this process, the ME/C Evaluation Team members will:

- Formulate a plan for incident site documentation, body recovery, and transportation.
  - Recovery of remains is a crucial phase that can affect other phases of the operation. Consequently, the ME/C will consider allocating more resources for the recovery process when decomposition is an issue or when overall resources are limited. If remains are recovered and placed in cold storage in a time-critical manner, then the ME/C can process remains at a rate that coincides with available resources and personnel.
- Select a site for a temporary holding morgue and estimate personnel needs. This morgue can be used as a holding area until the incident morgue is prepared to receive additional bodies.
- Select a site for the incident morgue and estimate personnel needs.
- Select a site for the Family Assistance Center and estimate personnel needs for ME/C operations.
- Recommend that the site selected for the Joint Information Center be distant from the incident site and the family assistance center.
  - Assign a trained and experienced Public Information Officer from the ME/C Office to the Joint Information Center if possible. The ME/C has a significant role in the approval of information released regarding the mass fatality operation, determining the sensitivity of information releases and how they affect the surviving families.
- Formulate a plan for:
  - Site security and credentialing systems.
  - Site communications and data management systems.
  - Determining fiscal and material requirements.
  - Identifying the deceased.
  - Issuing death certificates.
  - A system for disposition of human remains.

***Once preliminary requirements for personnel and resources are determined, the ME/C Evaluation Team will determine if Mutual Aid and/or the Disaster Mortuary Operational Response Team (DMORT) assistance is advisable.*** Note: maximum use of locally existing resources is required prior to the initiation of a mutual aid request.

California Mutual Aid can assist by providing:

- Medical Examiner/Coroner personnel from other California jurisdictions, and
- Equipment as determined by the requirements of the mass fatality event.
- California Dental Identification Team (CalDIT) to assist with body recovery procedures to insure that dental evidence is not lost or damaged and with dental identification in the morgue.

DMORT teams include:

- Assessment Team to assist with the incident site evaluation and make recommendations.
- Search and Recovery Teams to perform search and recovery.
- Weapons of Mass Destruction Team (DMORT WMD) to recover and receive contaminated remains, collect personal effects and document process. DMORT WMD decontaminates the remains at the incident site to avoid cross contamination of other areas and people, making remains safe to be received at the incident morgue.
- Morgue Services (DMORT can staff the entire portable morgue for months with every position filled).
- Family Assistance Center Team.

## Action Plan Development

All incidents require some form of an action plan. On smaller incidents, the action plan may be verbal or in the form of the Incident Briefing (ICS Form 201). On larger, or more complex incidents involving multiple jurisdictions, a NIMS compliant written Incident Action Plan is required. The action plan should be reviewed and updated for each Operational Period (typically 12 hours). The incident action plan will most likely be developed by the jurisdiction's emergency operations center and will incorporate field action plan(s).

The ME/C will determine incident objectives and strategy in coordination with Unified Command at the incident site to develop a field action plan. The information gathered by the initial evaluation team will serve as the basis from which the ME/C and all the agencies involved in incident site operations can collectively agree on an organized approach to processing the incident site.

- It is the primary role of the ME/C to determine the best approach to managing remains.
- The local Health Officer (or Medico-legal Authority) and supporting agencies are responsible for determining the best approach for mitigating hazardous material agent(s) while preserving remains, personal effects, and evidence.

The incident site field action plan will include, but not be limited to:

- Human Remains Recovery Plan,
- Transportation and Storage Plan (which minimizes the number of times remains are moved),
- Safety Plan (which includes personal protective equipment requirements (PPE) for all personnel, the agency responsible for enforcing PPE use, hazard monitoring and mitigation), and
- Security Plan (which includes site security and credentialing systems).

The nature of the incident will dictate priorities in the field action plan. Saving lives is the priority and will take precedence over human remains recovery. In some situations, a full focus on human remains recovery may not begin until rescue operations are terminated.

The ME/C will also formulate preliminary plans for:

- Morgue services and victim identification.
- Issuing death certificates.
- Providing ME/C services at the family assistance center.
- Disposition of human remains (if the mass fatality is beyond the capacity of the death care industry).

## Sites of Operation Under the Direction of the ME/C Office

Incident Site	(human remains and personal effects recovery, initial evidence recovery from the remains, and temporary morgue, as needed)
Incident Morgue	(human remains processing and identification)
Family Assistance Center	(antemortem data collection, family briefings, and death notifications)
Long Term Examination Site	(processing of biological specimens and evidence not assessed at the incident site or incident morgue)

## Setting Up Response

Institute the Incident Command System (ICS) for all ME/C operations.

Establish a Coroner Incident Command Post or co-locate in Unified Command at the incident site.

Assign:

- Scene Investigation/Human Remains Recovery Officer in Charge (OIC) to oversee ongoing investigation, evaluation, and collection and documentation of human remains, property, and evidence at the incident scene.
- Morgue Services OIC to oversee all morgue services including body processing, examination, positive identification, and receiving and release.
- ME/C Family Assistance OIC to oversee family briefings, antemortem data collection, and notifications.

and give each OIC information from the scene evaluation and field action plan relevant to their responsibilities.

- Immediately place Coroner Investigators and Autopsy Technicians on a 12 hour work schedule, 24/7 for long-term recoveries.
- Prepare morgue/autopsy facilities and/or arrange for incident morgue.

The Scene Investigation Branch Officer in Charge will ensure that the following steps are taken prior to initiating search and recovery:

- Request mission number assignment from the Emergency Operations Center. Set up systems to maintain all documentation required for emergency reimbursement.
- Establish tactical and support resource needs.
  - Assign a Logistics Officer.  
The Logistics Officer will be responsible for working with EOC Logistics on the acquisition, storage, issue, and accountability of all supplies, equipment, facilities, personnel and services necessary to support the incident site/human remains recovery operation. Requirements for staffing, communications and information systems, and equipment and supplies are presented later in this section.
  - Equipment/Supply Management:
    - Have a system in place to track supplies requested, loaned and used for human remains recovery,
    - Establish inventory management system not track rate of use for re-supply,
    - Supplement electronic system (if used) with a paper system, and
    - Assure re-supply and billing information.
  - Personnel:
    - Identify staff needs, alert staff and request assistance (Coroner Mutual Aid and/or DMORT), as needed. Staffing requirements are presented later in this section.
    - Maintain daily attendance rosters and time worked logs.
    - To ensure worker safety, have health provisions in place (includes ensuring that appropriate immunizations for all staff—Tetanus, Hepatitis B—are up to date).
    - Arrange for necessary Personal Protective Equipment (PPE)—see Incident Site Safety Plan.
- Human Remains Tracking System: Determine the human remains tracking system that will be initiated from the onset of the incident.

Consider where remains are found, how fragmented portions are tracked, how case numbers are correlated, how evidence will be tracked, and how antemortem data (obtained from family members) can be cross referenced with other case numbers assigned to recovered remains.

At a minimum, the system should include a means for distinguishing disaster cases from other ME/C caseloads and should enable the cross sharing of data between several field functions (the incident site, incident morgue, Family Assistance Center and any location where the data is entered).

Note: The State of Florida Emergency Mortuary Operations Response System's (FEMORS) *Numbering System for Human Remains Policy* is provided as a tool with this section.

- Allocate personnel, equipment, and resources or select a private company (most likely a contractor that specializes in the processing of personal effects) to manage personal effects from the incident.  
Managing personal effects can be very complicated (recovered from remains at the incident site by both officials and civilians and often difficult to associate with the right victim, making it very difficult to return to the families). As a result, personal effects operations may take a long time to resolve and may require long-term storage. State law mandates how long unclaimed personal effects must be retained.
- Scene Data Entry: Arrange for scene data entry into the electronic record system chosen by the ME/C (e.g., Victim Identification Profile by DMORT and/or ME/C's electronic information system).

## Guidelines for Search and Recovery

**Search and Recovery** is the locating, collecting and documenting of postmortem human remains, property and evidence at the incident site. It requires a standardized approach to ensure that the location of remains and materials at the scene are documented.

*Consider arranging to have a chaplain(s) present for the recovery of human remains to bless remains (following traditions begun during 9/11 World Trade Center and following Hurricane Katrina).*

Search and Recovery will be organized by teams. These teams will complete the difficult physical removal, extraction, disentanglement and collection of human remains in whatever condition they may be found and wherever they are located.

- The **Search and Recovery Team** oversees the search, evaluation, removal, and transfer of human remains from the incident site to the incident morgue.
- The **Photography and Documentation Team** is deployed by the Search and Recovery Team to provide written and photographic documentation of remains, property and evidence at the incident site prior to any movement. Documentation may include video, Polaroid, 35mm, digital images, and notes and sketches of remains, property, and

evidence. This team maintains the documentation in incident files.

Scene documentation, photographs, and other processes must be completed before human remains are removed. This ensures the integrity of the chain of custody for evidence and improves the ability to make rapid and accurate identifications of the deceased.

- The ***Property and Evidence Team*** responds to requests from the Search and Recovery Team to record, collect, package and transfer property, and evidence found at the incident site using standardized ‘chain of custody’ methods and ensures that documentation is complete.
- The Search and Recovery Team coordinates human remains transportation needs and requests with Logistics.

**Contaminated Remains.** Contaminated remains will not be transported to the incident morgue until they are decontaminated.

When remains are contaminated (from a chemical, biological or radiological incident) Hazmat and/or the DMORT Weapons of Mass Destruction Team (WMD) will be called in to manage search, recovery, and decontamination of remains at the incident site. DMORT WMD operations provide an example of the decontamination process. It includes:

- **Red Zone**—Remains are brought to the site where remains are to be decontaminated. Body numbers are assigned, personal effects and clothing are removed, and photographs are taken.
- **Yellow Zone**—Remains undergo a full body examination, including notating significant features. Gross decontamination takes place by thorough scrubbing with an appropriate cleaner. A solution of sodium hypochlorite and soapy water are the best cleaning agents.
- **Part Yellow and Part Green Zone**—Chemical Agent Monitor (CAM) is used to determine if the Yellow Zone performed its job completely. The body is returned to the Yellow Zone if the CAM detects any remaining contaminants.
  - If the remains cannot be “cleaned” after the number of attempts designated by the ME/C in consultation with DMORT WMD, the team will report to the ME/C for determination of disposition of remains.
  - When remains cannot be adequately decontaminated, arrangements with the receiving funeral service may need to be coordinated to provide for a sealed container that can be externally decontaminated and must not be reopened prior to final disposition in accordance with incident directives.
- **Green Zone**—Remains are placed in a clean refrigeration unit and sent to the morgue.

When decontamination teams cannot be arranged immediately, if feasible, place potentially contaminated human remains into a segregated refrigerated holding area until decontamination teams arrive. Potentially contaminated human remains must be decontaminated prior to introducing them into the morgue facility.

## Search and Recovery Team Guidelines

- Establish procedures consistent with professional protocols and appropriate for the incident.
- Confirm overall security of the area.
- Confirm issuance of access credentials that require government issued identification to insure scene security.
- Assign Search and Recovery personnel:
  - Assign Search and Recovery Team Leader.
  - Assign Search and Recovery, Photography and Documentation, and Property and Evidence Team members.
    - Ensure that all photographers have signed the *Release of Copyright* form.
  - Assign forensic dentist (e.g., CalDIT) as needed.
  - Assign a Scene Registrar to coordinate the numbering of victims (a critically important process to document the location where the decedent is found and insure that a rapid and accurate identification can be completed).
  - Assign a Scribe to maintain the Scene Log in addition to individual case records and paperwork.
- Follow all safety protocols and PPE requirements as outlined in the Incident Safety Plan.
- Conduct a briefing at the beginning of each shift that includes review of the Incident Safety Plan.
  - Ensure that search and recovery teams are prepared for dealing with the stress of recovering dead bodies. Resource: *Just the Facts...Dealing with the Stress of Recovering Human Dead Bodies* is included as a tool with this section.
- Establish and execute an adequate search pattern.
  - Incorporate search and rescue intelligence that has been gathered during rescue missions.
- Conduct a comprehensive search of assigned grid or search patterns and consider the use of aides such as global positioning devices for each body or body part discovered *early* in the process.
- Utilize engineering/surveying consultants, as needed.
- Document, process and recover bodies, fragments and associated evidence.
  - Deploy Photography and Documentation Team to provide documentation.
  - Collect, package and preserve potential human remains.
    - Protect craniofacial remains by wrapping to preserve dental evidence.
  - Deploy Property and Evidence Team to collect, package and secure all potential items of property and evidence, utilizing standardized ‘chain of custody’ methods.
  - Ensure all documentation for incident files is complete, including completion of the *Death Investigation Record* or *DMORT Site Recovery Record*.
- Set up temporary holding morgue (35-38° F)—a permanent or semi-permanent structure or refrigerated trucks or trailers near the incident site—to store human remains at the incident site.
- Transport decedents to and store in temporary morgue and/or refrigerated truck/trailer pending transportation to the incident morgue:
  - Up to four transport personnel are needed to move each decedent from location

- where found to the temporary morgue or transport vehicle at the incident site.
- Maintain log of remains at temporary morgue.
- The Scene Registrar will arrange for:
  - Scene data entry into the chosen software.
  - Monitoring and tracking of personnel, supplies and equipment. The National Disaster Medical Services (NDMS) can have acquisition programs rapidly in place to assist.
- Coordinate with Logistics transportation of human remains to incident morgue.

Note: Every effort should be made to treat the deceased with dignity and respect. How the response is handled and how it is perceived by the public can have long term impact.

## Transportation Guidelines

Transportation includes transportation of human remains, property and evidence to the incident morgue as well as transportation of personnel and equipment to and from the incident site. Transportation is tasked and staffed through EOC Logistics based on needs identified by the ME/C Office.

To transport human remains from the incident site to the morgue:

- Refrigerated vehicle is parked in a secure area near the site with easy access to load remains.
- Remains that have been bagged and tagged are loaded into the vehicle (never stack remains).
- Driver fills-in the *Transportation Log* as refrigerated vehicle is loaded and reviews for completeness prior to leaving the incident site.
- When not in use, vehicle doors are locked and remain locked while human remains are inside.
- Driver transports remains following assigned route to the incident morgue with no deviations. Police escort may be arranged.

## Human Remains Recovery Logistics

Human Remains Recovery logistics requirements include:

- Staffing,
- Communications and information systems,
- Equipment and supplies, and
- Facility requirements.



You will have to make decisions in your planning process to complete your logistics planning. The information below can be modified for your jurisdiction. You will need to complete the column for alternate sources to include resources that are available in your jurisdiction. The exact number of resources required will depend on the nature of the incident and can only be determined at the time of the incident.

### Procedures for Managing Logistics/Support Requirements

The Human Remains Recovery Logistics Officer will identify ME/C incident site service and support needs and will work closely with Emergency Operations Center Logistics to procure and allocate service and support needs. The Human Remains Recovery Logistics Officer will also work closely with human remains recovery staff leadership to track and maintain required documentation for supplies, equipment, and personnel.

### Step 5: Describe Staffing Requirements.

Human remains recovery is a complex and technical operation. Trained and experienced personnel must lead this process to ensure accurate identification of human remains, preserve evidence, and resist the pressure to prematurely remove the deceased from the location where death occurred.

Team members should have prior training and expertise in the removal process, including lifting, bagging and carrying to the transport vehicle. Funeral service personnel, body transport technicians and autopsy technicians are the preferred vocational set to develop a roster of personnel to perform these duties.

It is always important to begin incident site investigation and human remains recovery with the assumption that the incident site is a crime scene.

## Guidelines for Additional Human Remains Recovery Staffing

When additional human remains recovery personnel are needed:

- Request California Coroner Mutual Aid, Emergency Management Assistance Compact (EMAC), and/or DMORT, if needed. Requests are made to California’s Region II Coroner Mutual Aid Coordinator by the ME/C Office in accordance with the State of California Coroners Mutual Aid Plan.
  - CA Coroner Mutual Aid can provide
    - Search and Recovery staff from other CA jurisdictions and from other states through EMAC.
    - California Dental Identification Team (CalDIT) personnel to assist with body recovery procedures to insure that dental evidence is not lost or damaged.
  - DMORT can provide:
    - Assistance with site/scene evaluation.
    - Staff for Search and Recovery (six person teams).
    - Teams to decontaminate human remains.

Mutual Aid and DMORT requests need to be coordinated with the Emergency Operations Center. EOC Logistics will track requests, deploy Mutual Aid/DMORT personnel once they arrive, and provide housing and food for Coroner Mutual Aid and DMORT staff.

- Request assistance of the American Red Cross by contacting the local Red Cross chapter to request assistance with staff support operations at the site—providing food and support services for the search and recovery workers.
- Request local alternate staff through EOC Logistics.

Human Remains Recovery required staff and some possible alternate staff are presented in the following table. A column for number of staff requested is included and can be filled in to request staff for human remains recovery in the event of a mass fatality.

<b>Human Remains Recovery: Required Staff and Alternates</b>		
<b># of Staff Requested</b>	<b>Required Staff</b>	<b>Alternate Staff</b>
	Scene Investigation Branch Officer in Charge	
	Human Remains Recovery Logistics Officer	
	Logistics Team (as needed)	
	<b>ME/C Evaluation Team</b>	CA Coroner Mutual Aid and DMORT
	ME/C	
	Chief Coroner Investigator	

<b>Human Remains Recovery: Required Staff and Alternates</b>		
<b># of Staff Requested</b>	<b>Required Staff</b>	<b>Alternate Staff</b>
	Coroner Investigator	
	Scribe	
	<b>Search and Recovery Team—Evaluation</b>	CA Coroner Mutual Aid and DMORT
	Coroner Investigator—Team Leader	
	Investigator Assistant(s)	Police, Fire, Military (ID required, if not uniform)
	Physical Anthropologist	
	Evidence Technician	Sheriff’s Office or local law enforcement staff
	Engineering/Surveying Consultants (as needed)	
	Forensic Dentist (as needed)	Local forensic dentists and CalDIT
	<b>Search and Recovery Team—Removal and Transfer</b>	CA Coroner Mutual Aid and DMORT May want to have chaplain available to bless remains
	Human remains transport personnel	
	<b>Photography &amp; Documentation Team</b>	CA Coroner Mutual Aid and DMORT
	Photographer (no personal cameras allowed)	Sheriff’s Office or local law enforcement crime scene investigation staff
	Person to stake or number body for photograph identification	
	Scribe(s) (for scene log and individual case records and paperwork)	Sheriff’s Office or local law enforcement crime scene investigation staff
	<b>Property &amp; Evidence Team</b>	CA Coroner Mutual Aid and DMORT
	Personnel to record, collect, package and transfer property and evidence	Sheriff’s Office or local law enforcement crime scene investigation staff
	<b>Administrative Tasks to Support Human Remains Recovery</b>	CA Coroner Mutual Aid and DMORT
	Scene Registrar	

<b>Human Remains Recovery: Required Staff and Alternates</b>		
<b># of Staff Requested</b>	<b>Required Staff</b>	<b>Alternate Staff</b>
	Scene Data Entry Clerk(s)	
	<b>Transportation of Human Remains</b>	CA Coroner Mutual Aid and DMORT
	Drivers to transport human remains to incident morgue	Military, other government drivers, contract services, and funeral homes

### **Respite Center Support/Service Requirements**

Respite Center staff, who will support all responders at the incident site, are not included in the above table. A respite center for all recovery personnel at the incident site is required. The purpose of the respite center is to support worker health and safety. The respite center provides the following services:

- Basic first aid.
- Food and beverages.
- Mental health services (Psychological First Aid or PFA\*).
- Spiritual care services.
- Other support services, such as massage therapy.

for workers at the incident site.

\*The literature suggests that psychological debriefing may have adverse effects on some disaster survivors and first responders. As a result, many disaster response organizations have chosen to utilize PFA as the supportive intervention of choice for responders in the early aftermath of disaster.

### **Step 6: Describe communication and information system requirements.**

Human Remains Recovery will need communications and information systems.

### **Guidelines for Determining Communications and Information Systems Requirements**

- Develop a strategy for establishing lines of communication and managing information flow and for meeting information system needs.
- Secure redundant communications systems (interoperable with other systems being used at the site—especially radios) and information systems equipment.

- Train personnel in equipment use as needed.
- Implement safeguards and regulate access to information to ensure integrity of sensitive victim information.
- Have alternate backup systems in case there are problems with main communication lines, Web-based or area networks, electronic database systems or if these systems are not available.

### **Planning Considerations**

- Establish key points of contact and phone lists of staff and of responding organizations and agencies.
- Identify the communications needs of human remains recovery personnel.
- Identify the methods of communication that will be used and how they will be integrated into human remains recovery functions.
- Identify redundant communications systems to meet the needs of human remains recovery personnel (Scene Evaluation Team, Search and Recovery Teams, temporary morgue holding personnel, and drivers transporting human remains).
- Determine what information is essential to support the operation.
- Establish an information management system that provides standard and centralized processes and procedures for collecting, processing, retrieving, controlling, and reporting information.
- Identify information systems that will be used.
- Identify critical information for after action reports, records preservation, and historical documentation of the operations.
- Produce diagrams and signage to communicate important information and manage traffic flow.

### **Step 7: Describe Equipment and Supply Requirements.**

Equipment and supplies needed for human remains recovery in a mass fatality are needed in much greater quantities than the ME/C Office normally orders and some supplies and equipment are different from that which is typically used.

### **Guidelines for Human Remains Recovery Equipment and Supplies**

The Logistics Officer (or a member of the Logistics Team) at the incident site manages equipment and supplies.

- Requests for additional supplies are made to EOC Logistics.
- Requests for California Coroner Mutual Aid and DMORT supplies/equipment are made to California's Region II Coroner Mutual Aid Coordinator by the ME/C in accordance with the State of California Coroners Mutual Aid Plan.

Mutual Aid and DMORT requests need to be coordinated with the Emergency Operations Center. Once requested EOC Logistics follows-up to track, manage receipt, delivery and setup of supplies and equipment.

The following is a table of equipment and supplies to initiate planning for human remains recovery operations in a mass fatality. This was developed since these are not all typical supplies and equipment purchased by the ME/C Office.

You can complete this or you may want to attach a copy of your jurisdiction's ME/C Office supplies list that provides purchasing information (e.g., description, manufacturer/vendor, catalogue number, unit of measure, and price). The mass fatalities resource list in the National Association of Medical Examiners' *Mass Fatality Plan* is another resource that can be used.

<b>Search and Recovery Equipment and Supplies</b>	
<b>Equipment/Supplies</b>	<b>Alternate Sources</b>
Protective Clothing (gloves, boots, coats, hard hats, rain suits, and respirators, etc., as dictated by the situation)	Public Health and Environmental Health
Body bags (number and type)	
Refrigerated (35 - 38° F) trucks with ramps, metal floors which allow decontamination, and shelves no higher than waist height (20 bodies per 40 foot trailer). Caution will be taken when using food, beverage or other consumer types of commercial vehicles to store and transport human remains. In most cases, these types of vehicles should not be returned to their prior service function.	Funeral Homes & Thermo-King of Northern CA (refrigerated cargo trailers)
Tents and storage	
Paint for numbering (1, 2, 3; P1, P2, P3; E1, E2, E3...)	
Flags for marking locations	
Plastic toe tags and Sharpie permanent pens	
Biohazard bags and boxes	
Photography and filming equipment (No personal cameras allowed!)	Law Enforcement Crime Scene Investigation
Gridding, laser survey, GPS systems	
Communication devices, e.g., radios and cell phones	
Writing or computer equipment with software (specified by ME/C) for scene data maintenance	
ME/C Forms for individual case records, scene log, etc.	

Search and Recovery Equipment and Supplies	
Equipment/Supplies	Alternate Sources
<ul style="list-style-type: none"> <li>▪ <i>Release of Copyright</i></li> <li>▪ <i>Disaster Scene: Death Investigation Record or DMORT Site Recovery Record</i></li> <li>▪ <i>Transportation Log</i></li> </ul>	
Identification badges for volunteers or employees not in uniform (log with ID number, name and job function)	
Body boards	

A list of registered trauma scene practitioners is maintained with contact information at the ME/C Office (note location).

Furniture, equipment and supplies for the respite center, where responders will seek rest, emotional and spiritual support, medical aid, and mental health services, will also be needed.

## Step 8. Describe Facility Requirements.

The facility requirements are a temporary holding morgue and a respite center.

The purpose of the temporary holding morgue is to store remains until they are transported to the incident morgue.

The purpose of the respite center is to support worker health and safety by providing an area for rest, food, mental health, spiritual care, and other supportive services. Total respite center needs will depend on the nature of the incident and be a compilation of each responding organizations requirements for the respite center.

The ME/C Office will advise EOC Logistics on ME/C temporary holding morgue and respite center needs. EOC Logistics will:

- Set up the temporary holding morgue/arrange for refrigerated trucks for temporary holding.
- Set up and arrange management of the incident site respite center based on ME/C and other first responder needs that have been forwarded to EOC Logistics. The respite center is for all authorized incident site workers—ME/C staff, fire and rescue, law enforcement, and others—based on the requirements of the incident.

## Guidelines for Human Remains Recovery Facilities

### Temporary Holding Morgue Requirements

The temporary holding morgue is where remains are held until transported to the incident morgue.

- A permanent or semi-permanent structure near the incident site, which can be a tent or vehicle(s)/trailer(s).
- Consistent 35-38° F temperature.
- Shelves (no higher than waist height) to store remains. Remains will not be stacked.
- Locked and/or with ongoing security.

The size of the temporary holding morgue will depend on the anticipated number of decedents. Refrigerated vehicles that will be used to transport remains to the incident morgue may be adequate for short term storage.

### Respite Center Facility Requirements

The respite center needs to be located in close proximity to the incident site and designed to preserve the privacy of workers. It is organized and managed by EOC Logistics based on needs identified by the ME/C Office and other agency's/department's with personnel at the incident site.

- Location in close proximity to the disaster site.
- Security.
- Privacy of workers protected.
- Showers and bathrooms.
- Space for:
  - storing supply of Personal Protective Equipment (as required by nature of incident).
  - donning and cleaning/decontaminating and doffing PPE that is appropriate to the nature of the incident.
- Capability for safe disposal of used Personal Protective Equipment (PPE) and decontamination, based on the nature of the incident.
- Large room for briefings and debriefings at beginning and end of shifts.
- Lockers or space for storing workers' personal belongings.
- Areas for rest.
- Areas for food and beverages.
- Areas to support/maintain the readiness and optimal capabilities of the site's most valued resource—its staff and volunteers:
  - basic first aid.
  - mental health services (trained in providing Psychological First Aid).
  - spiritual care services.
  - other support services, such as massage therapy.

The size, amount of space, and number of services needed at the respite center will depend on the nature of the incident and the requirements of the responding agencies.

## ***Associated Tools and Resources***

### **Job Responsibility Checklists**

The job responsibility checklists in this toolkit present a general summary of actions. It should be understood that:

- Some required actions may not be listed, but must be identified and assumed by the appropriate position.
- Some actions may be the primary responsibility of a particular position, but may require assistance and coordination from other position(s).
- The actions are listed in a general chronological order, but deviation may be required to meet incident objectives.

The Common Responsibilities Job Checklist presents general actions that pertain to ALL personnel of the Coroner's Services Branch. In addition to instructions listed in their respective job responsibility checklists, all personnel are responsible for the Common Responsibilities. The Common Responsibilities Job Checklist is only included with the *Command and Control* section of this toolkit.

The following job responsibility checklists are attached.

- Scene Evaluation Team.
- Scene Investigation Branch/Human Remains Recovery Officer in Charge.
- Human Remains Recovery Logistics Officer.

Responsibilities of the:

- Search and Recovery Team.
- Photography and Documentation Team.
- Property and Evidence Team.

are available in the California Governor's Office of Emergency Services Law Enforcement Branch's *Coroner Mutual Aid, California Coroner Operations Guide* at:

<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. Then click on Coroner's Mutual Aid.

### **Forms**

*Death Investigation Record* or *DMORT Site Recovery Record*.  
*Release of Copyright*.  
*Transportation Log*.

## Resources

*Mass Fatality Plan* by the National Association of Medical Examiners has a mass fatality resource list (pages 15-18). It is available at:  
<http://www.dmort.org/FilesforDownload/NAMEMFIplan.pdf>.

*Just the Facts...Dealing with the Stress of Recovering Human Dead Bodies*. U.S. Army Center for Health Promotion and Preventive Medicine. This is a two page document that can be distributed to personnel involved in human remains recovery. It is available at: <http://chppm-www.apgea.army.mil/dhpw>.

*California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan*, Appendix G—Guidelines for Establishing a Human Remains Reference System. The State of California Governor's Office of Emergency Services (September 2007) Pages 115-117.

This document contains excerpts from *Numbering System for Human Remains Policy* by the State of Florida Emergency Mortuary Operations Response System (FEMORS). It is available by going to:

<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. And, then clicking on Coroner's Mutual Aid.

# Morgue Services

This section of the toolkit focuses on mass fatality morgue services. As a normal function of the Medical Examiner/Coroner's Office, morgue services are very familiar. What is different in a mass fatality is the scale of the event and the organization that is required to respond effectively.

## Overview

Morgue Services is organized to support the highest standards for morgue operations, decedent identification, and data management. This is critical to ensuring the efficient, accurate, and timely identification of the deceased.

Guidelines are provided for:

- Administration.
- Information Resource Center.
- Receiving.
- Initial holding.
- Photography.
- Personal effects.
- Fingerprinting/foot printing.
- Pathology/autopsy.
- Dental identification.
- Radiology.
- Anthropology.
- DNA.
- Identification confirmation.
- Final holding.
- After care (embalming and/or casketing).
- Release of human remains for final disposition.
- Logistics (staffing, communications and information systems, equipment and supplies, and facility requirements).

The information provided will allow for variations and scalability based on the nature, size, and complexity of the mass fatality.

Information on a Long-Term Examination Center/Sifting Site is also presented. This site will normally operate after the temporary incident morgue is closed and the disaster is officially over. It is needed for mass fatality events in which there is extensive property destruction with commingling of remains.

Key resources for this section are:

- *California Coroner Operations Guide, Part 2*, State of California Law Enforcement Branch, California Office of Emergency Services, 2003.  
(<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. And, then clicking on Coroner's Mutual Aid)
- *California Dental Identification Team Operations Manual*, March 2003.  
([http://www.oes.ca.gov/Operational/OESHome.nsf/0d737f261e76eeb588256b27007ac5ff/a3f586fd13d795c788256b7b0029bbff/\\$FILE/CalDITplan.pdf](http://www.oes.ca.gov/Operational/OESHome.nsf/0d737f261e76eeb588256b27007ac5ff/a3f586fd13d795c788256b7b0029bbff/$FILE/CalDITplan.pdf))
- *California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan*, The State of California Governor's Office of Emergency Services, September 2007.  
(<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. And, then clicking on Coroner's Mutual Aid)
- *DMORT Standard Operating Procedures for National Transportation Safety Board Activations*, Disaster Mortuary Operational Response Team, 2006.  
(<http://www.dmort8.org/DMORT%20NTSB%20SOP%20Nov%202006.pdf>)
- *Flight 93 Morgue Protocols*, DMORT III protocol to document morgue operation for the United Airlines Flight 93 response.  
(<http://www.dmort.org/forms/index.html>)
- *Lessons Learned from 911: DNA Identification in Mass Fatality Incidents*, National Institute of Justice, 2006.  
(<http://www.massfatality.dna.gov/>)
- *Mass Fatality Plan*, National Association of Medical Examiners.  
(<http://www.dmort.org/FilesforDownload/NAMEMFIplan.pdf>)

## Key Assumptions

The following are the key assumptions underlying Morgue Services.

- The expectations of family members, the general public, politicians and the media concerning identification of victims and morgue services are high.
- Morgue services are performed according to professional protocols to ensure accurate identification of human remains and, under certain circumstances (e.g., commercial airline accident and criminal or terrorist act), to preserve the scene and collect evidence. Waiving professional protocols will be a last resort that would only be used in extreme situations.
- The State Department of Justice, upon request, may assist in the identification of the deceased through their missing persons database using physical, dental, and fingerprint identification and/or through DNA testing.
- The California Office of Emergency Services, upon request, may authorize the mutual aid use of the California Dental Identification Team (CalDIT) to assist the ME/C in decedent identification through forensic odontology.
- Notification of death may require:
  - For out-of state deaths, the involvement of the state to assist the ME/C in sending

- death notification information to the appropriate out-of-state law enforcement agency for notifying next of kin.
- For deaths of citizens of other countries, the Agency for International Development, Office of Foreign Disaster Assistance to assist in contacting a deceased foreigner's family through the appropriate embassy.
  - The state, upon request, may assist in obtaining portable or fixed clear span facilities that can be used for field morgue and temporary human remains storage purposes.
  - Refrigerated vehicles for the transportation and/or temporary storage of human remains may be in short supply.
  - Additional Local, Regional, State and Federal resources may be required to effectively perform morgue services.
  - Responding to a mass fatality incident can be overwhelming, leading to traumatic stress. Support for responders is essential to monitoring and minimizing the impact.

## Proposed Approach



Describe the key components of morgue services and logistics requirements. Review mass fatality planning that your Medical Examiner/Coroner (ME/C) has already done in this operational area and build on that as needed. Substantial research regarding morgue services in a mass fatality has been done for you and is presented in the information below.



The key stakeholder for this section is the local jurisdiction ME/C Office. It is essential that the Medical Examiner/pathologist participate in the development and review of this section. Consultation with Logistics is also needed.

## *Developing Your Morgue Services Plan*

### **Step 1: What is the purpose of morgue services?**

The purpose of Morgue Services is to determine the cause of death and to identify the victims.

### **Step 2: Who is in charge of morgue services?**

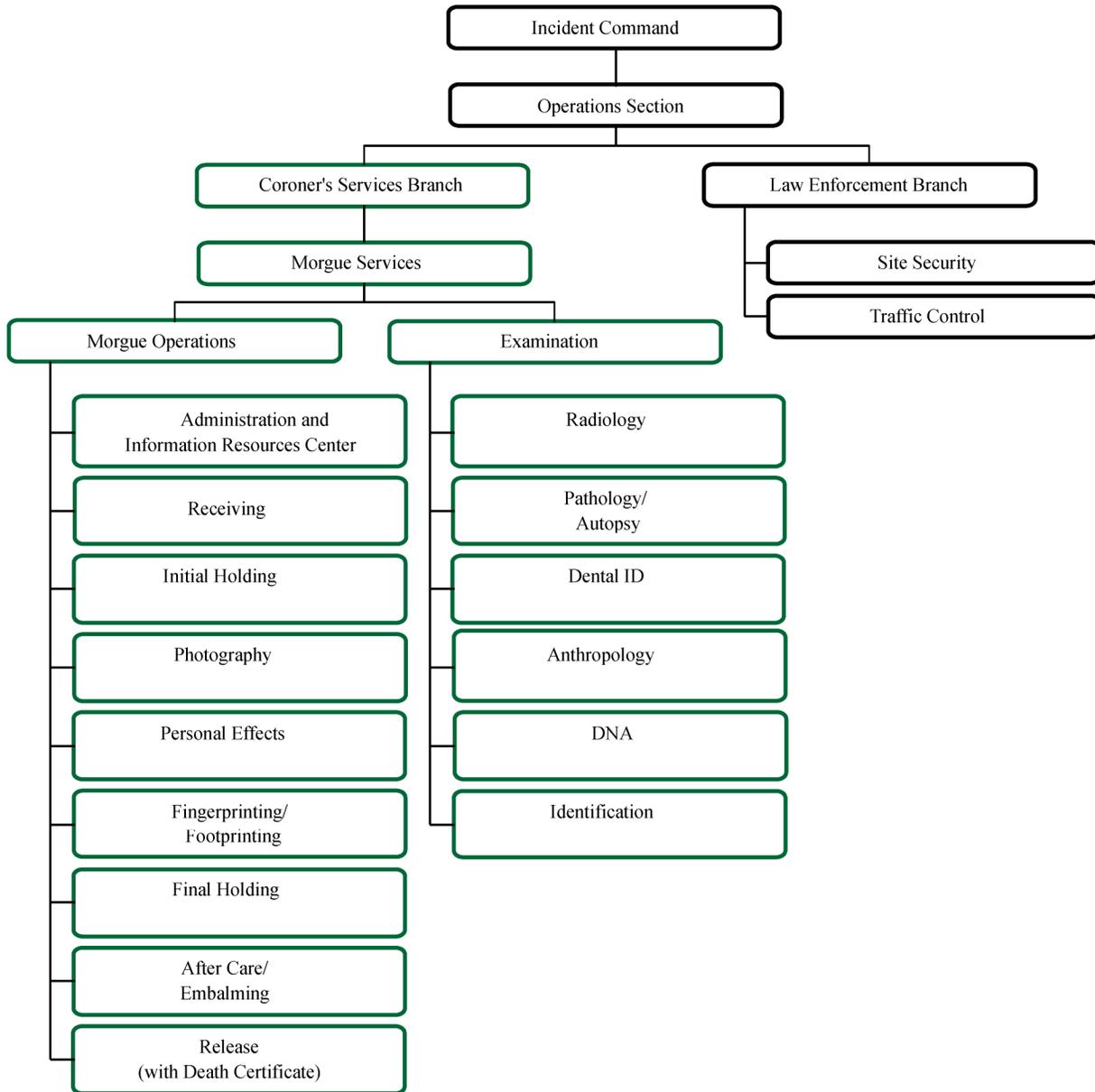
The Medical Examiner/Coroner is in charge of morgue services in a mass fatality.

### Step 3: How are morgue services organized?



An example of an organization for mass fatality Morgue Services is presented below.

Example of Field Organization for Mass Fatality Morgue Services



- Identify staff requirements and alert staff. Request staff assistance (Logistics for local staff; and/or Coroner Mutual Aid, including CalDIT, DMORT, etc.) as needed.
- To ensure worker safety, plan to comply with safety plan and have health provisions in place (includes PPE and ensuring that appropriate immunizations for all staff—Tetanus, Hepatitis B—are up to date).
- Assign Morgue Operations Group Officer in Charge (OIC), and Examination Group OIC.
- Assign team leaders and/or supervisors for each morgue station/function.
- Assign an Information Resource Center team leader to set up procedures and oversee the Information Resource Center (IRC).
- Assign an incident morgue registrar to set up a system and procedures for records management.
- Establish procedures/protocols for morgue operations stations/functions that build on

procedures presented in this toolkit for each station/function and are appropriate to the nature of the incident.

- Assign data entry operators and data analysts. If computers and access to CME or VIP are not available for all stations and WIN ID at Dental Station, morgue records will be maintained on paper and entered into CME or VIP and WIN ID afterwards in the IRC.
- Arrange for daily back-up of all electronic files.
- Ensure that all photographers have signed the *Release of Copyright* form.
- Ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191 and additional local laws that protect privacy of morgue information and records.
- Maintain Personnel Log (daily attendance and time worked).

## Equipment and Supplies

- Keep an inventory of and track all equipment and supplies—donated, loaned and purchased items.
- Arrange for refrigerated (35-38° F) trucks with ramps to allow access and egress to transport human remains (a 40 foot truck/trailer can hold ~22 bodies/pouched remains).
- Secure personal protective clothing (PPE) for personnel that is appropriate for the incident.
- Arrange for communications (telephones, cell phones, radios, fax, and paging systems). Local cell operators may designate a specific reserved air wave.
- Determine number of computers needed and arrange for computers with software (e.g., CME and/or VIP, WIN ID, supplies, tracking, etc.).
  - Note, if CME or VIP is accessible, computers will be needed at *all* stations.
  - WIN ID is set up in the Dental Station (minimum 1 computer for postmortem and 2 computers for comparison).
- Arrange for adequate number of required forms:
  - Personnel log that includes name, agency, Social Security Number, and in and out time.
  - Postmortem forms. Hard copies of forms are necessary even if mass fatality

- software, such as DMORT's VIP, is used.
- Antemortem forms (a copy even though antemortem data collection takes place outside of the morgue).
- Arrange for office equipment and supplies (e.g., copiers, faxes, typewriters, log books, etc.).

### **Preparation for Morgue Examination Functions**

- Prepare to use the human remains tracking system that was initiated from the onset of the incident and is being used at the Incident Site.
- Prepare station processing plans and procedures/protocols, building on guidelines presented in this toolkit for each station.
  - Procedures/protocols will reflect the nature of the incident, number and condition of the decedents, weather conditions, and complexity of search and recovery.
- Determine policies/procedures regarding photography and cell phone use in the incident morgue.
- Arrange for staff support (rest areas, toilet facilities, showers, food and beverages, mental health services, place to secure staff possessions while working, etc.).
- Make arrangements for laboratory analysis (toxicology, histology, DNA, etc.).
  - The Armed Forces DNA Identification Laboratory (AFDIL) may be a resource for assistance with the DNA Station and/or with DNA analysis.
- Determine if embalming will be required at the incident morgue.

### **Select agency/company (most likely a contractor) that specializes in the processing of personal effects for the processing of personal effects.**

### **Incident Morgue Preparation**

If a temporary incident site morgue is needed:

- ME/C requests assistance with incident morgue setup through Coroner Mutual Aid (e.g., request DMORT Disaster Portable Morgue Unit).
- ME/C determines layout/workflow for the temporary incident morgue considering the physical condition of the victims, the number of victims, and the number of personnel needed to perform morgue functions. The layout will have stations for all operational areas:
  - Administration (morgue management and administration).
  - Information Resource Center (electronic comparisons of antemortem and postmortem records).
  - Receiving (unprocessed remains storage, chain of custody implementation, and radiograph of remains container).
  - Screening/Triage Station (sort remains, personal effects, and evidence; select remains having potential for ID based on incident guidelines and probative value; and determine path—short or long—for examination and identification).
  - Admitting Station (numbering, Disaster Victim Packet (DVP), and tracker

- assigned).
- Documentation Station (photography and personal effects).
  - Print Station (finger, palm and foot).
  - Radiology/X-ray Station (radiology).
  - Dental Station (dental identification).
  - Pathology Station (complete or partial autopsies).
  - Anthropology/Morphology Station.
  - DNA Recovery Station.
  - Processed Remains Storage (in separate area of receiving station).
  - Identification Team Station (identification confirmation and death certificates).
  - Embalming Station (if it is determined that it is needed).
  - Release of Human Remains Station (may be same area as the receiving station).
  - Area for rest and emotional, spiritual, and medical support, storage of personal

belongings, briefings, restrooms and showers, and area(s) for storing, donning, doffing, and disposal of PPE.

For management purposes, the morgue services division is divided into two groups—morgue operations and examination.

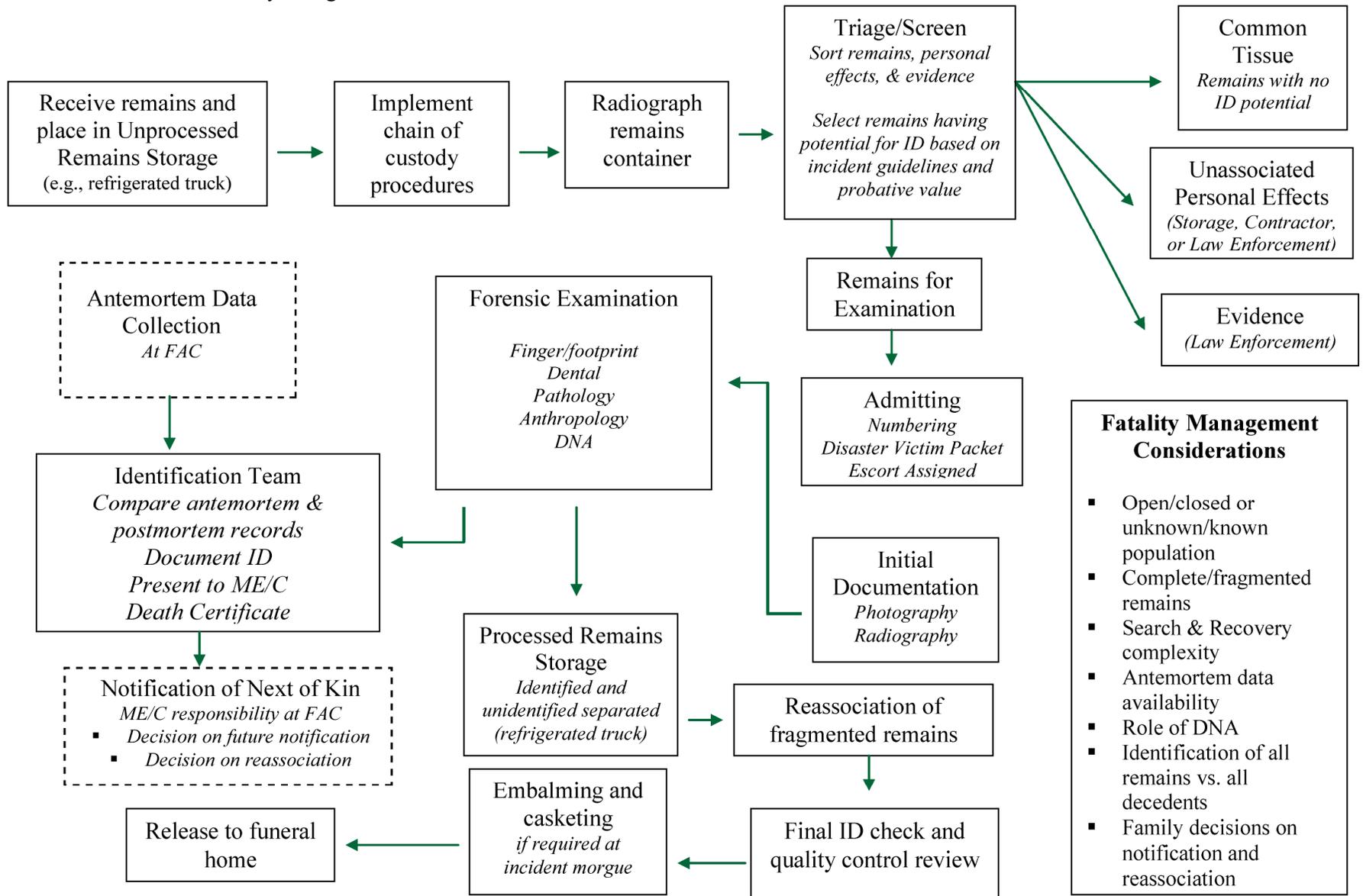
Morgue Operations includes Administration, the Information Resource Center, Receiving Station, Screening/Triage Station, Admitting Station, Documentation Station, Print Station, Final Holding, Release or Human Remains, and After care Station.

The Morgue Examination Group includes stations for radiology, dental identification, pathology, anthropology/morphology, DNA retrieval, and identification confirmation meetings.

## **Mass Fatality Morgue Services Flow Chart**

The following page presents a flow chart of mass fatality morgue services.

### Mass Fatality Morgue Services Flow Chart



## **Guidelines for the Morgue Operations Group**

The Morgue Operations Officer in Charge (OIC) oversees the operational functions and personnel. The OIC obtains necessary supplies and equipment related to morgue operations duties by interacting with Morgue Services Logistics and maintains communication with other divisions/groups.

Morgue Operations includes Administration, the Information Resource Center, Receiving Station, Screening/Triage Station, Admitting Station, Documentation Station, Print Station, Final Holding, Release or Human Remains, and After care Station.

### **All Morgue Operations Staff**

Prior to the commencement of morgue operations and at the beginning of each shift a briefing will be conducted. The briefing will include but not be limited to:

- Orientation and/or updates.
- Safety procedures.
- Necessity for security and confidentiality of all records and data.
- Workflow/procedural issues.

### **Administration Station**

Administration is a critical area of the morgue. It houses the Morgue Services Officer in Charge, Logistics Officer (and team), and personnel/volunteer management staff.

- Manage/Oversee all morgue operations.
- Manage personnel, supplies and equipment.
- Enter data into appropriate electronic incident management tool system.
- Maintain all documentation of labor time and purchases needed for reimbursement:
  - Daily attendance rosters and time worked logs.
  - Mission number assignment from the Emergency Operations Center.
  - Tracking of all supplies and equipment requested, loaned and received.
- Report staffing, supplies, and equipment needs to EOC Logistics and/or the ME/C if Mutual Aid resources are needed.
- Maintain adequate supplies of:
  - General morgue forms.
  - Disaster Victim Packets (DVP).
  - Embalming forms (if required).
  - Death certificates.
  - Release Forms.

## Information Resource Center

The Information Resource Center is the central repository for collection, recording, and storage of antemortem and postmortem information. The IRC procedures include a record library, antemortem records tracking procedures, database management system, and management of mass fatality incident victim records.

All records and data must be kept secure and confidential because they are protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, and additional applicable local laws.

No information will be released to any person(s) or agencies without proper authorization from the ME/C.

At the conclusion of the incident, all records and data collected become the property of the local ME/C.

DMORT's Victim Identification Program (VIP) software can be used to assist in managing the information, if the local ME/C does not have a system in place. Personnel trained in the information system(s) being used are required to handle data management. If a DMORT Disaster Portable Morgue Unit (DPMU) and VIP software are used, network support and troubleshooting for the VIP data system is the responsibility of the DPMU team.

- Staff include IRC Team Leader and staff familiar with software to enter data into electronic systems and for antemortem and postmortem data matching.
- Establish IRC procedures and protocols.
- Assure security of information systems and records.
- Establish procedures for data entry, for matching antemortem and postmortem files, and for quality assurance.
- Receive electronic antemortem data from Family Assistance Center.
- Enter antemortem data that is received as hard copy into selected electronic system.
- Enter postmortem data into appropriate electronic system (if not already done at morgue stations):
  - Once entered in the computer, an internal case number will be generated. Unique number(s) generated earlier, will be cross-referenced on the narrative section on the face page of the report.
- Review antemortem and postmortem files/records to identify possible matches using search and comparison functions.
- Appropriate forensic specialist reviews possible/presumptive identifications and completes *Identification Summary Report* for Identification Team.
- Establish back-up protocols for computer files (e.g., backup twice a day), using standard computer backup system used by ME/C Office/DMORT.

## Records Library

- Assign Registrar to manage the records library and staff to file and manage hard copies of records.
- Establish procedures for postmortem and antemortem records management.
  - Four major file categories:
    - Unidentified remains case files in morgue case number order.
    - Missing person reports case files (antemortem data collection interviews) in last name alphabetical order.
    - Identified remains (the ME determines which master number to use and merges all related materials into one file).
    - Court issued presumptive death certificates and related documents (if applicable).
- Manage records and perform file quality assurance.
- Notify appropriate station(s) if any relevant antemortem information becomes available for a decedent.
- Do not release any records without approval of the ME/C.
- Only shred confidential documents that are no longer needed (e.g., duplicates) after review and authorization by the IRC Team Leader and/or ME/C.

## Receiving Station

### *Receiving*

Receiving is where the decedents (in body bags) are delivered from the Incident Site. All incoming body bags and property bags are documented.

- Establish procedures/protocols for Receiving Station.
- Receive and review *Transportation Log* and accompanying remains.
- Log-in documentation accompanying human remains (date, time, and tag number/numbering from the scene).
- Place in initial holding, a temporary holding morgue or refrigerated vehicle being used for temporary holding.
- Implement chain of custody procedures.

### *Radiograph*

All body bags are radiographed to facilitate safe handling of collected remains.

- Establish procedures/protocols for radiographing body bags.
- Radiograph entire, unopened remains container (do not open bag) and label radiograph with the field number assigned by the Search and Recovery Team.
- Pathologist or anthropologist (with augmentation from other appropriate staff, e.g., bomb technician, law enforcement evidence technician, etc.) reads radiograph.

- Use radiographs to assess the contents of the bag so that more effective sorting can be completed at triage and any associated hazardous materials (knives, guns, bomb parts, etc.) collected with the remains can be safely managed.

### Screening/Triage Station

Screening/triaging is performed per incident-based guidelines to separate remains, personal effects, evidence and debris delivered from the incident site in the body bag. The examination path remains will take is also determined.

- Establish procedures/protocols for Screening/Triage Station.
- Open bags delivered from scene.
- Using radiographs of bags taken prior to screening/triage, separate diagnostic human tissue from material evidence, debris and personal effects.
  - Photograph prior to disturbing clothing, property, foreign objects.
- Personal effects are not removed from human remains if removal will damage or compromise remains.
- Complete anatomic charting.
- If deemed necessary, apply appropriate protection to oral, facial, skeletal or other structures to insure integrity of those structures.
- Document and describe any personal effects or evidence that is removed.
- Route potential evidence to law enforcement using chain of custody forms.
- Route unassociated personal effects using chain of custody forms to selected team/private company (most likely a contractor that specializes in the processing of personal effects) selected by ME/C.
- Log bag number and other information into *Triage Log*.
- Evaluate remains.
- Determine path for examination/identification based on protocol:
  - Long path—continue through all subsequent stations.
  - Short path—Photography, Radiology, Anthropology and DNA Retrieval Stations only.
- Bag human tissue/remains having potential for ID based on incident guidelines and probative value (remains with highest likelihood for identification).
  - Attach a Disaster Victim Packet (DVP) with *Tracking Form* attached on front of packet.
- Note the stations where the specimen should be routed on the DVP Tracking Form.
- Store tissue that does not have potential for ID and unassociated personal effects as determined based on the incident.
- If personal effects or dangerous material items (e.g., bomb fragments) could not be removed without possible damage, notify the ME/C and leave effects associated with tissue.
  - Mark the DVP to alert future stations.
- Screening/Triage scribe signs and dates the DVP.
- Route to Admitting.

If remains are determined, at any station, to be unrelated, they will be separated and returned to Screening/Triage for assessment.

### **Admitting Station**

The Admitting Station is where remains and personal effects morgue reference numbers (MRN) are added, Disaster Victim Packets are numbered, and trackers are assigned.

The tracker will accompany the remains—staying with them at all times—until examination/identification is complete, ensure the security of the case file, and ensure that proper documentation is complete, signed, and attached at each station.

Religious and cultural customs concerning the handling of remains will be considered and adhered to if they do not impact the examination of remains. The ME/C will make the final determination on how religious and cultural practices are addressed.

- Establish procedures/protocols for Admitting Station.
- Admit remains with associated personal effects (per protocol).
- Enter information in *Morgue Admission Log*.
- Number remains and associated personal effects using the a simple ascending numbering system that is referenced with the incident site number.
  - Each body or fragment thereof is assigned a separate MRN.
    - If the morgue electronic system is used at this time, the software’s morgue reference number can be used for each body or fragment thereof and be cross referenced with the incident site number.
  - If a bar code or radio frequency tagging (RFID) system is used to track bodies and fragments through the morgue stations, a number and bar code will be assigned and the Admitting Station will print corresponding sheets of bar code stickers to be included in the DVP. As the body proceeds through the stations, the tracker will be responsible for attaching a unique bar code to that body and to all x-rays and papers generated through the process.
- Assign a body tracker (one per body bag with associated personal effects), who will remain with the assigned case while the case is processed in the morgue.
- Transfer DVP with *Tracking Form* attached on front of packet and chain of custody form to the assigned tracker.
- Direct tracker to Documentation Station.

### **Documentation Station**

The Documentation Station is where remains and personal effects are documented. All remains and/or fragments and personal effects are photographed.

- Establish procedures/protocols for Documentation Station.
- Photograph remains and personal effects following ME/C Office policy regarding the

photography of human remains:

- photograph prior to disturbing clothing, property, foreign objects,
- proper documentation in photo, and
- use of scale in photo, etc.
- For complete bodies, take standard autopsy-type photographs (anatomical position).
- Where possible, take full-face photographs.
- Ensure entire remain is present in the photograph.
- Enter information in *Photography Log*.
- Personal effects:
  - Follow standard operating procedures for handling personal effects.
  - Tag and log all effects.
  - Document personal effects by completing *VIP DMORT Program Clothing Inventory and Jewelry Inventory*.
- Ensure that all documentation is complete (hard copies of digital photographs, if possible) and placed in the case file.
- Give DVP with Documentation Station and chain of custody forms completed and *Tracking Form* checked and signed to the tracker.
- Direct tracker to next station.
- Send digital files to Information Resource Center for inclusion in VIP.

### **Print Station**

The Print Station is where finger/foot/palm printing of remains or body parts is performed.

- Establish procedures/protocols for Print Station.
- Enter information in *Print Station Log*.
- Print all remains with finger, palm, and/or foot.
- Fingers or hands are removed only at the discretion of the ME/C Pathologist. If removed, place in a properly identified container and place them back with the body after processing.
- Complete *VIP DMORT Program Fingerprinting* and place in the DVP.
- Sign and date *Tracking Form*.
- Give tracker DVP with completed *VIP DMORT Program Fingerprinting* and *Tracking Form* checked and signed.
- Direct tracker to next station.

### **Final Holding Station**

(Located at/near Receiving Station)

Final holding is the refrigerated area where remains that have been processed are held until release. All human remains (identified, unidentified, and common tissue) will be stored with dignity.

*In keeping with tradition established 9/11 at the World Trade Center, consider having all remains in morgue blessed by clergy every day.*

The holding areas for processed victims and for common tissue will be separate from that for remains that have not been processed and from where specimens (e.g., for DNA, histology, and toxicology) are stored while awaiting transfer to the lab for analysis.

- Establish procedures/protocols for Final Holding Station.
- Tracker returns the remains to the Receiving Area.
- Maintain a Movement Log Sheet
  - Number of body bags comprising the decedent's remains,
  - Date and time in or out of storage,
  - Name and signature of tracker,
  - Name and signature of storage worker releasing or accepting body bag(s), and,
  - If more than one refrigerator is used, record which unit the decedent's body bag(s) are stored in.
- Direct the remains to be transferred to the appropriate, secure, designated "processed" refrigerated area where its return is documented.
- The refrigerated area must be fully staffed with Receivers and Security.
- Maintain chain of custody.
- The tracker takes the DVP to the IRC for filing.
- Hold remains until victim can be released for final disposition.
- At direction of ME/C Office based on the decision of the Coroner's Services Branch Director, document and store unidentified body parts as "common tissue." Subsequent disposition will be the responsibility of the ME/C Office in consultation with victim/family groups and consistent with laws and resources.

Toxicology, Histology and DNA Specimens To Be Analyzed:

- Special storage sites will be designated for DNA, histology and toxicology specimens.
- Hold specimens until they are picked-up by authorized person for processing.

### **Release of Human Remains for Final Disposition Station** (Located at/near Receiving Station)

This is where identified decedents and their personal effects are released to next of kin or a person authorized by next of kin. Release functions include, preparation, final identification review, and funeral home contact. Preparation of human remains may include reassociation and/or aftercare (embalming and casketing). All human remains will be prepared with professionalism and transported to authorized funeral home/crematory with consideration.

#### ***Preparation for Release***

- Establish procedures/protocols for Release Station.
- Prepare remains for release.
- If remains are fragmented and the next of kin has requested that they be reassociated:
  - Reassociate remains of one decedent at a time.
  - Remove all of a decedent's remains from storage to area designated for reassociation.

- Use appropriate documentation (Identification Summary Report, DNA laboratory results, VIP forms, postmortem photographs) to select the appropriate numbered remains for the decedent.
- Examine to ensure that the physical characteristics are identical to those on associated documentation.
- After review, place all remains associated with the decedent in the appropriate container (e.g., casket, transfer case, body bag, etc.).
- Return associated remains to storage or send to embalming (if requested by next of kin and done at the incident morgue).
- If remains are to be released, send to Final Identification Review before release.

### ***Final Identification Review***

- Establish procedures for Final Identification Review.
- When remains are ready to be released, the Identification Team Leader and forensic specialists involved in the identification will:
  - Conduct a final review of the methods of identification.
  - Physically examine the remains to ensure that the remains match the biological attributes of the deceased (based on the antemortem information).
  - Ensure that the numbers associated with each remain are accounted for.
  - Sign and date the form indicating that the remains have been reviewed for final identification and place it in the DVP.
- If next of kin/legal authority authorized after care and it is provided at the incident morgue, route to the After Care Station.

### ***Contact with Funeral Home***

- Establish procedures/protocols for contacting funeral homes and crematoriums.
- Liaison with funeral homes and crematoriums to coordinate pickup or the shipping of remains.
  - When ME/C notifies next of kin, gather the following information:
    - Name of funeral home or crematorium.
    - Contact person at funeral home.
    - Location (city, state, zip code).
    - Telephone and fax number.
  - If funeral home/crematorium is not local, get information on the best airport or train station to which decedent should be shipped.
  - Inform the funeral home/crematorium of the schedule once the transportation arrangements have been made.

### ***Final Release***

- Establish procedures/protocols for Final Release.
- Keep a log of remains/bodies that are cleared for release and those on hold.
- Check/assure that remains/bodies are prepared for release as authorized by next of kin.
- Complete Release of Human Remains form and Release of Personal Effects form.

- Release human remains and associated personal effects that are not deemed evidence to authorized person/funeral home according to the standard operating procedure of the ME/C Office once the final identification review has been completed.
  - Separate personal effects from remains, inventory, and get signature of the family’s contracted funeral home/authorized person.
  - Implement chain of custody.
- Maintain a *Release Log* to document the overall release process.
- When decedents are transported from the morgue as part of incident morgue services:
  - Obtain the required burial-transit-cremation permit and other documentation required by the receiving funeral home and provide a copy to the IRC.
  - Place documentation in envelope that is securely affixed to the head end of the outside container.
  - If released with the remains, personal effects will be released on a chain of custody form and the receiving funeral home shall inventory and sign for all items received.
  - Hearses and other appropriate vehicles will be used for transport.
  - Maintain a log reflecting the date, time, transfer vehicle identification, transfer personnel identification and destination.
  - Instruct drivers to travel directly to the destination and directly back to the morgue without any stops except at a designated staging area or to refuel.

### After Care Station



If after care is provided at the incident morgue, it will include embalming and casketing. As part of your jurisdiction’s planning process, you will need to determine:

- The circumstances under which after care will be provided at the incident morgue.
- The circumstances under which it will be discontinued when it is provided.

In general, this function is only carried out at the incident morgue if conditions are such that human remains cannot be preserved adequately for morgue examination or if funeral homes and crematories are so overwhelmed that final disposition cannot be carried out within a reasonable timeframe. Otherwise, the next of kin or legal authority can contact a funeral home to perform this function or authorize cremation as the final means of disposition.

It is important for mortuary representatives to participate in this decision since providing after care could mean a loss of business for them. It may also be helpful to involve Vital Records since the After Care Station will need to apply for and manage final disposition permits—which is normally handled by the mortuary—if after care is provided.

## ***Embalming***

Thorough disinfection, preparation, and minor reconstructive surgery procedures are accomplished on each body or part of body when authorized by the appropriate next of kin or legal authority.

The volume of remains, morgue flow and number of shifts will determine the staffing level of embalmers.

- Establish disaster-specific guidelines/procedures/protocols for embalming.
- Enter victim information in *Embalming Station Log*.
- Review next of kin or legal authority approval for embalming (must be in writing).
- Assign two licensed embalmers (with knowledge of postmortem reconstructive surgery) to assess remains according to the potential for viewing by next of kin and any other aspects that may impact embalming.
- Use embalming and minor reconstructive surgery techniques to enhance the possibility of “viewability” of the deceased.
- Complete *External Preparation/Embalming Case Report* and *Embalming Classification of Human Remains* and place in the DVP.

## ***Casketing***

When casketing is provided, human remains will be placed in a casket, dressed when appropriate, and relocated to the incident morgue shipping point, located at Receiving.

- Establish procedures/protocols for casketing.
- Maintain log identifying receipt of remains for casketing and the date and time the casket is relocated to the morgue shipping holding area (most likely, at or near the Receiving Station).
- Dress decedents with supplied clothing.
- Place decedent in plastic pouch, if advisable.
- Place decedent in casket and/or other supplied container (Ziegler type cases, shipping boxes, air trays, etc.), using acceptable blocking material to prevent shifting in transit.
  - No personal effects, except burial clothing, should be in the casket or container.
- Place decedent’s name on the outside of the casket/container.
- Ensure that the person who is supervising the shipping holding area signs the appropriate form and that the signed form is inserted into the DVP.

## ***Cremation***

- Establish procedures/protocols for handling cremations.
- Authorization to release the decedent or remains to a specific crematory or funeral home must be signed by next of kin or legal authority.
- Upon request of the next of kin, the decedent or remains may be embalmed and then shipped to the authorized funeral home or crematorium for cremation.

- Any necessary ME/C cremation authorization will be secured and released with the decedent remains.

## Guidelines for the Examination Group

The Examination Group Officer in Charge monitors progress of specialists in the Examination Group, channels information to the Morgue Operations Group and the Coroner's Services Branch at the Emergency Operations Center, and ensures that documentation received is assigned to appropriate specialist.

The Morgue Examination Group includes stations for radiology, dental identification, pathology, anthropology/morphology, DNA retrieval, and identification confirmation meetings.

It is the responsibility of the Examination Group to maintain strict confidentiality of all documentation.

### All Morgue Operations Staff

Prior to the commencement of examination and at the beginning of each shift a briefing will be conducted. The briefing will include but not be limited to:

- Orientation and/or updates.
- Safety procedures.
- Necessity for security and confidentiality of all records and data.
- Workflow/procedural issues.

### Radiology Station

The Radiology Station conducts radiographic examinations to provide postmortem radiographs for comparison with antemortem clinical radiographs and to detect evidence. The radiologist also assists in the interpretation of radiographs.

This station should be established in an area of the morgue that is secluded from other processing stations and have portable lead protective walls. The radiology team leader will monitor radiation safety issues such as shielding; monitor radiation dosage of team members via dosimeters; and assign dosimeters to other morgue personnel, as appropriate, considering location and shielding of the x-ray unit.

- Establish procedures/protocols for the Radiology Station.
- Enter information in *Radiology Station Log*.
- Take full body x-rays, if possible.
  - Whenever possible, the remains should be positioned so that standard and conventional views are obtained for ease of comparison with antemortem films.

- When dealing with fragmented remains, this may require the assistance of an anthropologist or pathologist.
  - Take complete radiographs of the abdomen and chest region.
  - Include a clear view of the sinuses in Anterior Position and lateral radiographs.
  - Take radiographs of the extremities as needed.
  - Take dental x-rays, if not part of the Dental Station.
  - Maintain log of all films.
  - Mark each radiograph with the corresponding morgue reference number.
  - Review films for adequate exposure and proper labeling.
  - Conduct additional radiographs as requested by forensic specialists.
  - Provide a written description of the points of similarity leading to identification to the Identification Team for review.
  - Call-in bomb technician or other specialist, if needed.
  - Ensure and document that a qualified forensic specialist has read each radiograph. Complete *VIP DMORT Program Radiology* form and place in the DVP.
  - Sign and date *Tracking Form*.
  - Give tracker DVP with completed *VIP DMORT Program Radiology* and *Tracking Form* checked and signed.
  - Direct tracker to next station.

The Radiology Station may also:

- Assist other forensic specialists (pathologists, anthropologists, and odontologists) with the comparison of antemortem and postmortem radiographs.

### **Dental Identification Station**

Dental identification operations are divided into three sections—the Postmortem Section, Antemortem Section, and the Comparison Section.

The Dental Postmortem Section performs the dental autopsy, including postmortem dental radiography and photography, and records the results in WinID or in a standardized format compatible with WinID. Documentation in the postmortem record includes photographs, radiographs, and charting of all dental structures and restorations.

The Antemortem Section is responsible for transcribing all available clinical information onto an antemortem record. This section, working closely with the Family Assistance Center, assists with the procurement of the clinical dental record or any other pertinent dental identification information. The *CalDIT Request for Clinical Information Form* can be used to assist law enforcement agencies with obtaining complete dental records. Documentation for the Antemortem Section includes radiographs, written record of treatment, and charting of all dental structures and restorations.

The Comparison Section compares antemortem and postmortem dental records for the purpose of identification. If all dental information is immediately entered into WIN ID correctly and transferred, the comparison can be done digitally.

## ***Postmortem Section***

The Postmortem Section performs the dental autopsy.

- Establish procedures/protocols for Postmortem Section.
- Enter information in *Dental Station Log*.
- Clean remains.
- Craniofacial Dissection. Any facial or dental dissection required for complete and accurate dental examination must be approved in advance by the ME/C. No craniofacial dissection will be performed if adequate information can be obtained without dissection.
  - If removed, the jaw is to be placed in a properly identified container and returned to the remains after processing.
- Visual Examination and Charting: Chart all dental structures and restorations. The universal dental numbering system (1-32 with the upper right 3<sup>rd</sup> molar as #1, upper central incisors as #8 and #9, upper left 3<sup>rd</sup> molar as #17 and lower right 3<sup>rd</sup> molar as #32) is usually preferred. The FDI numbering system can also be considered.
  - Record directly into WinID, if possible. Otherwise record onto standard forms and transfer to appropriate area for data entry.
- Radiographic Examination: A complete radiographic survey of the available craniofacial remains should be recorded using digital intraoral sensors. Extraoral radiography may be employed when available and practical if it assists identification.
- Dental Models: Impressions for dental models may be made if they will assist in identification of a decedent. Standard dental impression materials should be used following manufacturer instructions.
- Add digital radiographic files (e.g., Dexis) and digital photographs of impressions to decedent's WinID file.
- Transfer completed Win ID file to Comparison Section.
- Sign and date *Tracking Form*.
- Give tracker DVP with *Tracking Form* checked and signed.
- Direct Tracker to next station.

## ***Antemortem Section***

This section procures, analyzes, and consolidates dental information into a single, standardized, comprehensive antemortem dental record.

- Establish procedures/protocols for the Antemortem Section.
- Assist in procurement of dental records at the Family Assistance Center, via telephone, or visits to dental offices.
- Transcribe dental information from dental records into standard format using WinID nomenclature.
- Record antemortem dental information into WinID.
- Scan non-digital image information (radiographs and photographs) and enter into WinID graphics file.
- Enter digital image information into WinID graphics file.

## ***Comparison Section***

This section compares antemortem and postmortem dental information. Comparisons resulting in positive identifications are reported to the Identification Team.

- Establish procedures/protocols for the Comparison Section.
- Dental Comparison team members must be familiar with WinID, including advanced search and comparison functions.
- To facilitate the comparison process and minimize errors, teams will work in pairs, when possible,.
- Positive dental identification recommendations are agreed upon by two qualified individuals (one of whom is Board Certified by the American Board of Forensic Odontology) and confirmed by the Dental Team Leader before submission to the Identification Team.

## **Pathology Station**

The Pathology Station is where complete or partial autopsies are performed. The decision to do a complete or partial autopsy resides with the local jurisdiction's ME/C (responsible for death certification). Some reasons for complete autopsies include: homicides, terrorism, indeterminate manner of death, flight crews (in which the same pathologist autopsies all members), unidentified human remains, and upon federal request.

- Establish procedures/protocols for the Pathology Station.
- Enter information in *Pathology Station Log*.
- Review radiographs.
- Document general physical characteristics.
- Document specific scars, tattoos, and other unique identifying features.
- Document injuries and trauma.
- Document and recover, when appropriate, internally implanted medical devices for identification.
- Document and recover evidence, if present.
- Collect and label appropriate toxicology and histology samples.
- Conduct a complete autopsy, if indicated.
- Document findings on the *VIP DMORT Program Pathology*.
- Sign and date *Tracking Form*.
- Give tracker DVP with completed *VIP DMORT Program Pathology* and *Tracking Form* checked and signed.
- Direct tracker to next station.
- Send properly labeled histology and toxicology specimens to the Final Holding Stations for transport to a lab for analysis.

## Anthropology/Morphology Station

The Anthropology/Morphology Station provides comprehensive forensic anthropological documentation of human remains. It is where fragmented, incomplete, charred, and commingled remains are examined to determine a biological profile.

- Establish procedures/protocols for the Anthropology/Morphology Station.
- Log in remains in the *Anthropology Station Log*.
- Complete a standardized forensic anthropology report form.
- Evaluate and document the condition of the remains.
- Separate obviously commingled remains and return the remains to the admitting section for subsequent processing in the morgue.
- If the remains are fragmented, describe the anatomical structure(s) present.
- Provide a biological profile of the decedent or remains, including:
  - Sex,
  - Age at death,
  - Ancestry,
  - Forensic stature,
  - Antemortem trauma or pathology,
  - Anomalies and idiosyncratic variation including surgical hardware and prosthetic devices, and
  - Perimortem trauma.
- Document, remove and save non-human and/or non-biological materials for proper disposal.
- Follow Anthropology Specimen Cleaning Protocol if it is necessary to remove the tissue from bone features used for analysis of age, sex, or pathology in order to observe subtle features.
- Review x-rays.
- Review Pathology and Dental forms for consistency (bone, side, biological parameters, etc.).
  - If there is a discrepancy, the team consults with other team(s) to reach consensus on assessment.
- If a bone section or other specimen is retained, place it in a properly identified container and return to the remains after processing.
- Document (*VIP/DMORT Anthropology*) and place in the case file.
- Sign and date *Tracking Form*.
- Give tracker DVP with completed *VIP/DMORT Anthropology* and *Tracking Form* checked and signed.
- Direct tracker to next station.

The forensic anthropologist may also assist with:

- Obtaining DNA samples from bone.
- Taking radiographs (to ensure proper alignment of specimen).
- Interpreting trauma in consultation with the pathologist.
- Obtaining and isolating dental evidence in consultation with the odontologists.

- Interpreting and comparing antemortem and postmortem records and radiographs.
- Assisting the pathologists and odontologists in establishing identity via antemortem-postmortem radiographic comparison.
- Examining identified remains prior to release to confirm that the biological evidence used for identification matches the biological parameters of the remains.

## DNA Station

The DNA Station is where DNA is retrieved to assist with identification when other means of identification of remains are inadequate. If a separate DNA station is not set up, DNA retrieval is done at the Pathology Station.

DNA analysis is expensive and its funding must be addressed. FEMA provides funding for the DNA identification effort if the incident meets its criteria for a disaster. However, confirming that funding for DNA analysis has been secured and contracts with appropriate laboratories and analysts are in place is important.

*In the Hurricane Katrina (August 2005) response, DNA work did not begin until late December when federal funding was secured and appropriate contracts granted.*

Specimens will come to DNA Station last.

Prior to collecting specimens, DNA specimen collection criteria and guidelines must be developed. AFDIL policies and procedures for mass fatality incident DNA collection can serve as a guide.

- Establish procedures/protocols for the DNA Station.
- Check to see if *Victim Tracking Form* indicates that the victim has been processed at all stations directed by the Screening Station. If a station has been skipped, return remains and file to that station for processing prior to admitting.
- Admit and enter information in *DNA Station Log*.
- Pre-label DNA collection tube(s).
- Take DNA sample(s)—whole blood, tissue, bone, teeth, or hair—as directed by protocol.
- Place DNA specimen in specimen tube that has been pre-labeled, by hand. The numbers should appear on the tube itself and on the lid.
- Give the specimen tube to the computer operator to:
  - Enter the MRN of the specimen, the type of material, and the exact nature of the specimen.
  - Generate two labels:
    - The first label is placed on the tube on the opposite side of the handwritten numbers, as close to the lid as possible.
    - The second label is placed on the plastic evidence bag.
  - Insert the labeled tube into the labeled bag.

- Heat-seal the bag and place it into a cooler or a -20° freezer until it is released to lab for analysis.
  - Once a specimen is frozen, it should remain frozen.
  - Complete *VIP/DMORT Program AFIP/DNA Specimen* and place in the DVP.
- Sign and date *Tracking Form*.
- Give tracker DVP with completed *VIP/DMORT Program AFIP/DNA Specimen* and *Tracking Form* checked and signed.
- Direct tracker to Final Holding.
- Route DNA samples to lab that will analyze the DNA with chain of custody documented.

### Identification Station

This is a designated meeting area where possible identifications that have been determined as remains have been examined are reviewed and confirmed. The Identification Team, chaired by a pathologist, consists of representatives from pathology, anthropology, odontology, radiology, prints, DNA, and the ME/C Office.

Once identity is confirmed by the Identification Team, the information is presented to the ME/C, who will review and, if approved, issue a death certificate.

- Establish procedures/protocols for the Identification Team.
  - Convene Identification Team at the end of each working day.
  - Review all proposed identifications (based on examination and review of antemortem and postmortem records).
    - Possible identification methods include:
      - Prints,
      - Dental,
      - Medical radiography,
      - Distinctive physical characteristics,
      - Serial numbers on permanently installed devices,
      - DNA, and
      - Visual in some cases (personal effects do not constitute positive ID, but with other factors, may be considered).
  - For confirmed identifications, team members sign the *ID Summary Report* indicating concurrence for the identification.
  - Present signed *ID Summary Report* to ME/C for approval/signature.
  - Original report goes to IRC and copy of report to ME/C.
  - Prepare a standard death certificate according to normal ME/C Office procedures for identified remains.
- 
- Transfer positive identifications to Family Assistance Center Death Notification Team. The ME/C Office is responsible for all death notification procedures.
    - Determine next of kin wishes, including decision of future notification and

decision on reassociation.

- Release names of decedents to the EOC and JIC *after* next of kin have been notified.
- Give instructions to Final Holding Stations in accordance with next of kin wishes for preparation for release of identified human remains and associated personal effects that are not deemed to be evidence.

When no human remains are recovered, or scientific efforts for identification prove insufficient, the ME/C will file a single verified petition with the superior court to judicially establish the fact, time, and place of death for individuals who die in a mass fatality incident. By California law, a hearing will be set no later than 15 days from the date the petition was filed.

If remains are later located and identified for an individual where a court ordered delayed certificate was prepared, a new standard death certificate is *not* prepared. Each decedent must have only one death certificate. However, the court ordered delayed certificate may be amended to reflect the disposition of human remains. Requests to replace a court-ordered certificate with a standard certificate are referred to the office of vital records.

## **Guidelines for the Long-Term Examination Center/Sifting Site**

The Long-Term Examination Center Sifting Site may be needed when there is extensive property destruction with the commingling of human remains and limited operations need to continue after the temporary incident morgue closes and/or to provide additional working space for law enforcement and Hazmat/bomb technicians.

Often times, the emergency has officially been declared over and the incident site, temporary incident morgue, and Family Assistance Center are closed.

It is the responsibility of the ME/C Office to assure proper support and operation of the site as long as it is required.

Functions at the incident morgue that will be continued at the long-term examination center/sifting site will be determined by the ME/C prior to incident morgue demobilization.

## Morgue Services Logistics

Morgue Services logistics requirements include:

- Staffing.
- Communications and information systems.
- Equipment and supplies.
- Facility requirements.



You will have to make decisions in your planning process to complete your logistics planning. The information below can be modified for your jurisdiction. You will then need to complete the column for alternate sources to include resources that are available in your jurisdiction. The exact number of resources required will depend on the nature of the incident and can only be determined at the time of the incident.

### Procedures for Managing Logistics/Support Requirements

The Morgue Services Logistics Officer will identify ME/C incident site service and support needs and will work closely with Emergency Operations Center Logistics to procure and allocate service and support needs. The Logistics Officer will also work closely with morgue leadership to track and maintain required documentation for supplies, equipment, and personnel.

### Step 5: Describe staffing requirements.

Morgue staffing consists of medical, forensic and mortuary professionals. This guide's goal is to present staffing requirements as teams. The number of teams needed to effectively respond to the incident will be determined based on the incident.

### Guidelines for Finding Additional Morgue Services Staffing

Team members need to have the expertise required for specific functions.

- Request CA Coroner Mutual Aid, State-to-State Mutual Aid (Emergency Management Assistance Compact (EMAC), and/or DMORT, if needed. Requests are made to California's Region II Coroner Mutual Aid Coordinator by the ME/C Office in accordance with the State of California Coroners Mutual Aid Plan.
  - CA Coroner Mutual Aid can provide:
    - Morgue staff from other CA jurisdictions and from other states through EMAC.

- California Dental Identification Team (CalDIT).
- DMORT can provide:
  - All standard forensic and morgue operations staffing involving the
    - handling of remains.
    - management of data pertaining to the decedents.
    - cause and manner of death determinations.
    - embalming and release of remains.
    - production of identification reports.

Mutual Aid and DMORT requests need to be coordinated with the Emergency Operations Center. EOC Logistics will track requests, deploy Mutual Aid/DMORT personnel once they arrive, and provide housing and food for Coroner Mutual Aid and DMORT staff.

- Request local alternate staff through EOC Logistics.

Morgue required staff and possible alternate staff are presented in the table below. A team for each station is identified. The ME/C will determine the number of teams needed (and fill in the column on the left) based on the size and complexity of the incident.

Some alternate staff have been filled in. Continue to fill in alternate staff that are appropriate for your jurisdiction.

<b>Incident Morgue Staffing Requirements</b>		
<b># of Staff Requested</b>	<b>Required Staff</b>	<b>Alternate Staff</b>
	<b>Administration &amp; Information Resources Center</b>	Mutual Aid, DMORT
	Morgue Services OIC	
	Morgue Operations Group OIC	
	Examination Group OIC	
	Morgue Logistics Officer	
	Logistics Team	
	Communications clerks	
	Security—24 hours	Law Enforcement
	Information Resources Team Leader	
	Data entry clerks (trained in morgue software)	
	Data analysts (trained in morgue software)	
	Information systems specialist for electronic file backup	

<b>Incident Morgue Staffing Requirements</b>		
<b># of Staff Requested</b>	<b>Required Staff</b>	<b>Alternate Staff</b>
	Communications clerks	
	Registrar	
	File Clerks	
	<b>Receiving Station Team</b>	Mutual Aid, DMORT
	Receiving Station Team Leader & Members	
	<b><i>Receiving Team</i></b>	
	Receiving Supervisor	
	Storage Workers	
	<b><i>Radiograph Team</i></b>	Mutual Aid, DMORT
	Radiograph Supervisor	
	X-ray Technician	
	Pathologist or anthropologist (to read radiographs)	
	<b>Final Holding Team</b>	Mutual Aid, DMORT
	Final Holding Supervisor	
	Storage Workers	
	Clergy to bless remains daily	
	<b>After Care Team (if required)</b>	Local Funeral Homes, CA Funeral Directors Association, Mutual Aid, DMORT
	After Care Team Leader	
	Embalming Team Leader	
	2 licensed embalmers with postmortem reconstructive surgery experience	
	Casketing Team Leader & Members	
	Cremation Team Leader & Members	
	<b>Release of Human Remains Team</b>	Mutual Aid, DMORT
	Release Supervisor	
	Release Team	
	Identification Team Leader/forensic specialists involved in identification (for Final Identification Review)	
	Drivers (to transport released human remains from	

<b>Incident Morgue Staffing Requirements</b>		
<b># of Staff Requested</b>	<b>Required Staff</b>	<b>Alternate Staff</b>
	morgue to designated destination)	
	<b>Admitting Station Team</b>	Mutual Aid, DMORT
	Admitting Supervisor	
	Admitting clerks	
	Tracker Supervisor	
	10 Trackers	Law enforcement officers & ME/C approved volunteers from funeral homes
	<b>Screening/Triage Station Team</b>	Mutual Aid, DMORT
	Screening/Triage Team Leader	
	Pathologist	
	Anthropologist	
	Odontologist	
	ME/C Coroner Investigator	
	Evidence Technician	
	Bomb Tech or other specialist as indicated	
	Scribe	
	Photographer	
	Photography Assistant	
	<b>Documentation Station Team</b>	Mutual Aid, DMORT
	Documentation Team Leader	
	Photographer	
	Photography Assistant	
	Personal Effects Technician	
	Photography Runner	
	<b>Print Station</b>	Mutual Aid, DMORT
	Print Station Team Leader	Sheriff's Office, FBI Disaster Squad, Local Law Enforcement
	Print Specialist	
	<b>Radiology Station Team</b>	Mutual Aid, DMORT
	Radiology Team Leader	
	Radiologist	
	X-ray Technologist	

<b>Incident Morgue Staffing Requirements</b>		
<b># of Staff Requested</b>	<b>Required Staff</b>	<b>Alternate Staff</b>
	Scribe	
	<b>Dental Station Team</b>	CalDIT, Mutual Aid, DMORT, Department of Defense Office of the Armed Forces Medical Examiner
	Dental Team Leader	
	Postmortem Team Leader	
	2 Odontologists	
	2 Dental Assistants	
	Photographer	
	Evidence technician	
	Scribe	
	Evidence Technician	
	Antemortem Team Leader (at FAC)	
	2 Forensic Dentists (at FAC)	
	Comparison Team Leader	
	2 Forensic Dentists	
	<b>Pathology Station Team</b>	Mutual Aid, DMORT, Department of Defense Office of the Armed Forces Medical Examiner
	Pathology Team Leader	
	Forensic pathologist	
	Autopsy technician (1 per pathologist)	
	Scribe (1 per pathologist)	
	Evidence technician	
	Bomb tech or other specialist (available when needed)	
	Forensic Photographer (available when needed)	
	Lab technician	
	Pathology Runner	
	<b>Anthropology Station Team</b>	Mutual Aid, DMORT
	Anthropology Team Leader (Forensic Anthropologist)	

<b>Incident Morgue Staffing Requirements</b>		
<b># of Staff Requested</b>	<b>Required Staff</b>	<b>Alternate Staff</b>
	Forensic Anthropologist	
	Anthropology Assistant (to serve as scribe)	
	Evidence technician	
	Photographer	
	Radiographer	
	Forensic pathologist	
	Anthropology Runner	
	<b>DNA Station Team</b>	Armed Forces DNA Identification Laboratory (AFDIL) Department of Justice Bureau of Forensic Services Section DNA Analysis Mutual Aid & DMORT for specimen collection only
	DNA Station Team Leader	
	Autopsy Technician	
	Lab technician	
	DNA Runner	
	<b>Identification Station Team</b>	Mutual Aid, DMORT
	Identification Team Leader	
	Team is composed of staff from morgue stations (pathology, anthropology, odontology, radiology, prints, DNA, & ME/C Office)	
	ME/C (for review and approval)	
	Death Certificate	

<b>Long-Term Examination Center/Sifting Center Staffing Requirements</b>	
<b>Required Staff</b>	<b>Alternate Staff</b>
Officer in Charge	Mutual Aid, DMORT
Logistics Officer	Mutual Aid, DMORT
Teams from incident morgue as determined by ME/C	Mutual Aid, DMORT

<b>Long-Term Examination Center/Sifting Center Staffing Requirements</b>	
<b>Required Staff</b>	<b>Alternate Staff</b>
Additional resources determined by incident	
Security—24 hours	Law Enforcement
Workers capable of assisting with significant physical labor demands	Public Works

Support services—mental health, spiritual care, and medical services/first aid—will be needed at the incident morgue. Responding to a mass fatality can create traumatic stress. The support staff will assess behavioral health reactions in morgue services personnel and provide emotional and spiritual support, Psychological First Aid\*, and medical care when needed.

\*The literature suggests that psychological debriefing may have adverse effects on some disaster survivors and first responders. As a result, many disaster response organizations have chosen to utilize Psychological First Aid (PFA) as the supportive intervention of choice for responders in the early aftermath of disaster.

## **Step 6: Describe communication and information system requirements.**

Morgue Services will need communications and information systems.

### **Guidelines for Determining Communications and Information Systems Requirements**

- Develop a strategy for establishing lines of communication and managing information flow and for meeting information system needs.
- Consult with ME/C to determine mass fatality software that will be used (e.g., DMORT VIP, WIN ID, and/or local ME/C Office software). Note: See *Mass Fatality Information Systems* section of this toolkit.
- Secure redundant communications systems (interoperable with other systems being used at the site—especially radios) and information systems equipment.
- Train personnel in equipment use as needed.
- Implement safeguards and regulate access to information to ensure integrity of sensitive victim information.
- Have alternate backup systems in case there are problems with main communication lines, Web-based or area networks, electronic database systems or if these systems are not available.

## Planning Considerations

- Establish key points of contact and phone lists of staff and of responding organizations and agencies.
- Identify the communications needs of morgue personnel.
- Identify the methods of communication that will be used and how they will be integrated into morgue functions.
- Identify redundant communications systems to meet the needs of personnel.
- Determine what information is essential to support the operation.
- Establish an information management system that provides standard and centralized processes and procedures for collecting, processing, retrieving, controlling, and reporting information.
- Identify information systems that will be used in addition to mass fatality software specified by ME/C.
- Identify critical information for after action reports, records preservation, and historical documentation of the operations.
- Produce diagrams and signage to communicate important information and manage traffic flow.

### **Step 7: Describe equipment and supply requirements.**

Morgue equipment and supplies can be accessed within the jurisdiction and through California Coroner Mutual Aid, the Emergency Management Assistance Compact (EMAC), and DMORT.

If the number of decedents can be handled by the jurisdiction's morgue, EOC Logistics will be very involved in securing needed equipment and supplies.

If the number of decedents is too great for the jurisdiction's morgue to handle, it is likely the a Disaster Portable Morgue Unit (DPMU), which includes equipment and supplies (over 10,000 individual items), will be requested by the ME/C and EOC Logistics role will be to manage receipt, delivery and setup of equipment/supplies (with the DPMU core team).

## **Guidelines for Morgue Services Equipment and Supplies**

The Morgue Logistics Officer manages morgue services equipment and supplies.

- Requests for additional supplies are made to EOC Logistics.
- Requests for California Coroner Mutual Aid and DMORT supplies/equipment are made to California's Region II Coroner Mutual Aid Coordinator by the ME/C in accordance with the State of California Coroners Mutual Aid Plan.

DMORT's Disaster Portable Morgue Unit (DPMU) is a packaged system containing all forensic equipment, instrumentation, support equipment, and administrative supplies required to operate an incident morgue facility under field conditions or support an existing morgue facility. The DPMU carries computers and related equipment to support the Family Assistance Center and Information Resource Center in the management of postmortem and antemortem information.

Three fully equipped DPMUs are maintained. They are located in Moffett Field, CA, Ft. Worth TX, and Frederick, MD. DPMUs are deployed rapidly, along with logistical specialists to establish and manage the DPMU. A DPMU can be requested even if DMORT staffing assistance is not needed (e.g., staffing needs can be met through Coroner Mutual Aid).

To ensure safety, DPMU pallets must be off-loaded and opened as directed by the DPMU team.

The basic floor plan of the incident morgue will incorporate the ME/C's proposed layout for the morgue stations. The setup, normally under the direction of the DPMU team with the assistance of the ME/C Office and Regional DMORT members, will be done in accordance with established DPMU procedures.

- Mutual Aid and DMORT requests need to be coordinated with the Emergency Operations Center. Once requested EOC Logistics follows-up to track, manage receipt, delivery and setup of supplies and equipment.

A table of equipment and supplies is not included here. It is recommended that you use your jurisdiction's ME/C Office supplies list since the required supplies are the supplies typically used in a morgue. An advantage of using your jurisdiction's supplies list is that it provides purchasing information (e.g., description, manufacturer/vendor, catalogue number, unit of measure, and price).

### **Long-Term Examination Center/Sifting Site**

Supplies and equipment needed for the long-term examination center/sifting site will be based on the ME/C decision regarding morgue stations that will operate at this site, which will be based on the incident and will be determined at that time, and other requirements based on the incident.

### **Step 8: Describe facility requirements.**

The site requirements for an incident site morgue and for a long-term examination/sifting site are specified below.

## Incident Morgue Site Requirements

The incident morgue facility must meet certain requirements for size, layout, and support infrastructure and provide adequate parking for morgue staff. Administrative offices are necessary and may require the use of portable buildings established on site.

The following site suggestions are based on DMORT experience.

- Airplane hangars and abandoned warehouses have served well as incident morgues.
- Consideration should be given to the possible stigma that may be attached to a temporary morgue. Facilities such as school gymnasiums, public auditoriums, churches, or similar facilities that will be used by the general public after the disaster are not recommended.
- The selected facility should not have adjacent occupied office or work space.
- Facility is available for the time frame necessary.
- If a building is not available, a large banquet style tent or prefabricated building—with arrangements for sufficient flooring, HVAC, electrical, and water requirements—built on site may be used. A portable tent unit with adequate flooring, heating and air conditioning may be available through contract.
  - Modular tents with sealed floors may be better suited for incidents with contaminated remains.

## Security Considerations

- Secure entrance(s) to general area.
- Secure entrances into facility with uniformed guards.
- Security for entire site.
- Removed from public view. May require screening.
- Removed from the Family Assistance Center in a “need to know” location.

DMORT’s Disaster Portable Morgue Units (DPMU) site requirements are presented below for guidance.

## DPMU Site Requirements

### *Structure Type*

- Hard, weather tight roofed structure.
- Separate accessible office space for Information Resource Center and for administrative needs/personnel.
- Space for staff support and rest. Supporting and maintaining the readiness and optimal capabilities of the morgue’s most valued resource—its staff and volunteers is critical to an effective response.
- DPMU re-supply and staging area minimum of 5,000 square feet.
- Non-porous floors, preferably concrete. Floors need to be capable of being decontaminated (hardwood and tile floors are porous and not usable).

- Heat or air conditioning (depending on season).
- Ventilation.

### *Size*

- Adequate space for examination, administrative, and rest areas.
- Minimal size of 10,000-12,000 square feet.
- More square footage may be necessary for casket storage or other mission-specific needs.

### *Accessibility*

- Tractor trailer accessible.
- 10-foot by 10-foot door (ground level or loading dock access).
- Parking areas for staff and trucks.

### *Electrical*

- Electrical equipment utilizes standard household current (110-120 volts).
- Power obtained from accessible on site distribution panel (200-amp draw).
- Electrical connections to distribution panels made by local licensed electricians.
- If no house power available the incident morgue will need 125K generator and a separate 70K generator for Admin and Information Resources Center.
- Small 7K diesel generators are carried in DMORT's DPMU cache for temporary power of specific equipment.

### *Water*

- Hot and cold water or single source of cold water with standard hose bib connection.
  - Water hoses, hot water heaters, sinks, and connectors in the DPMU.
- Restrooms.
- Showers.

### *Communications Access*

- Existing telephone lines for multiple telephone/fax capabilities.
- Expansion of telephone lines may occur as the mission dictates.
- Broadband Internet connectivity.
- If additional telephone lines are needed, only authorized personnel will complete any expansion or connections.

### *Sanitation/Drainage*

- Pre-existing rest rooms within the facility are preferable.
- Gray water will be disposed of utilizing existing drainage.
- Biological hazardous waste, liquid or dry, produced as a result of morgue operations, will be disposed of according to local/state requirements. Bulk disposal tanks may be needed.

### *Human Remains Storage Considerations*

- Ideal temperature for storing and preserving human remains is between 34-37° F.
- If trucks are used:

- *40 foot trailer can hold 22 pouched remains.* If shelving is installed at 3-3 1/2 feet off the floor and does not go above waist level, the number can be doubled and transporter back injuries avoided.
- *Avoid stacking remains on top of each other* to prevent distortion of features and to allow easier moving.
- Ensure:
  - Company names/logos are covered up.
  - Interior of the trailer is metal for later decontamination.
- Ramps are required.
- Contract includes fueling, truck drivers and refrigeration maintenance.
- If cooled room is used:
  - Store remains on floor (do not stack), or
  - Store on tables.

### **Special Equipment Needs**

- All terrain forklift capable of lifting ten to fifteen thousand pounds, with six-foot forks, or fork extensions to safely off-load the DPMU pallets.
- A smaller forklift, capable of lifting two to four thousand pounds, is needed to move heavy equipment within the morgue during setup.

### **Miscellaneous Requirements**

- Consider the placement of refrigerated trailers for morgue personnel access.
- The number of decedents dictates the number of refrigerated trailers needed.
- Separate refrigerated trailers need to be designated for the separation of processed from unprocessed remains.

Exact placement of the morgue within the facility is determined by electrical source location, water source location, morgue accessibility by personnel, placement of refrigerated trailers, the morgue flow plan, and security concerns. The ME/C will work with the Regional DMORT Commander and the DPMU Team Commander to determine morgue placement within the facility.

Once the placement is determined, the DPMU Team will oversee all aspects of the setup in accordance with DMORT procedures. This includes staging, floor preparation, basic layout (respecting ME/C Office specified workflow/layout), electrical and water distribution systems, drainage and liquid waste disposal, equipment dispersal, work station setup, accountable property, staged DPMU pallets, and inventory and re-supply.

### **Long-Term Examination/Sifting Site Requirements**

Many of the requirements for the incident morgue will also be requirements for the long-term examination center/sifting site. If the incident requires a long-term examination center/sifting site, the ME/C Office will determine requirements at that time based on the incident.

## ***Associated Tools and Resources***

### **Job Responsibility Checklists**

The job responsibility checklists in this toolkit present a general summary of actions. It should be understood that:

- Some required actions may not be listed, but must be identified and assumed by the appropriate position.
- Some actions may be the primary responsibility of a particular position, but may require assistance and coordination from other position(s).
- The actions are listed in a general chronological order, but deviation may be required to meet incident objectives.

The Common Responsibilities Job Checklist presents general actions that pertain to ALL personnel of the Coroner's Services Branch. In addition to instructions listed in their respective job responsibility checklists, all personnel are responsible for the Common Responsibilities. The Common Responsibilities Job Checklist is only included with the *Command and Control* section of this toolkit.

The following job responsibility checklists are attached.

- Morgue Services Officer in Charge.
- Morgue Logistics Officer.

Responsibilities of the:

- Morgue Operations Group OIC.
- Examination Group OIC.
- Receiving Specialist.
- Tracker.
- Photography Specialist.
- Print ID Specialist.
- Release Specialist.

are available in the California Governor's Office of Emergency Services Law Enforcement Branch's *Coroner Mutual Aid, California Coroner Operations Guide* at:  
<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. Then click on Coroner's Mutual Aid.

## Forms

*Transportation Log*  
*VIP/DMORT Program Tracking Form*  
*Chain of Custody*  
*VIP/DMORT Program Clothing Inventory*  
*VIP/DMORT Program Jewelry Inventory*  
*VIP/DMORT Program Fingerprinting*  
*Release of Human Remains*  
*External Preparation/Embalming Case Report*  
*Embalming Classification of Human Remains*  
*VIP/DMORT Program Radiology*  
*VIP/DMORT Program Pathology*  
*VIP/DMORT Anthropology*  
*VIP/DMORT Program AFIP/DNA Specimen*  
*VIP/DMORT Personal Information Questionnaire*

Additional Forms can be found in the National Association of Medical Examiners Mass Fatality Plan. It is available at: [www.dmort.org](http://www.dmort.org). to find it, click on ‘Forms.’

## Resources

*Mass Fatality Plan* by the National Association of Medical Examiners has a mass fatality resource list (pages 15-18). It is available at:  
<http://www.dmort.org/FilesforDownload/NAMEMFIplan.pdf>.

# Family Assistance

In the immediate aftermath of a mass fatality, families and friends will frantically seek assistance. They will gravitate to where they believe they will find their loved one or where they believe they will find information about them. That translates to the incident site and to local hospitals (thinking their loved ones are injured and have been transported to the nearest hospital). This is why a center or centers to provide family assistance immediately is so important.

The Medical Examiner/Coroner Office needs to be prepared to mobilize the appropriate resources to open a family assistance center in addition to managing the incident. Opening a family assistance center immediately and starting with basic services is critical to meeting families' needs and to demonstrating to the public that there is some semblance of order, despite the disaster circumstances.

Hospitals will also need to be prepared to mobilize resources to assist families. If there are large numbers of missing people, even larger numbers of family members will arrive looking for loved ones and for information.

Providing family assistance that meets family needs in a mass fatality is a challenging job. Following a large-scale event, family assistance typically involves a range of services provided by local, state, and federal agencies as well as nonprofits and private organizations. All services need to be victim sensitive and easily accessible. An effective family assistance center is a multi-agency effort that requires leadership, collaboration, commitment, flexibility, and organization. The challenges increase as family assistance staff work with families from many countries and cultures for family assistance must be provided in a way that is sensitive to cultural and language differences.

Family assistance is one of the most sensitive operations in mass fatality response. It is important for local organizations to be involved in community planning and to understand their role in providing mass fatality family assistance.

## Planning considerations



As you plan for mass fatality family assistance in your community, consider the many contingencies that could impact effective response and what has been learned from previous mass fatalities.

- *Anticipate eight to 10 family members per potential victim requesting assistance.* For purposes of family assistance, family should be defined broadly and include the many individuals that consider themselves to be the victim's 'family,' even when the law does not formally recognize the relationship. Any time family is used in this

*The Pentagon Family Assistance Center found that families of critically injured survivors had many similar needs for services as those families whose loved ones died.*

document, it includes all friends and loved ones that have identified themselves as ‘family’ to the victim.

- Recognize the importance of understanding the full range of people who have been impacted by the incident who will need assistance—families of survivors, families and individuals living in the area impacted by the incident, coworkers of victims, and families of missing persons.
- Be prepared to adjust planning based on the nature of the incident itself, in particular, the length of time recovery and identification will take.
- Plan from the perspective of the bereaved. It is important to realize that the families seeking assistance may remember how they were dealt with after the disaster for years to come.

Careful planning and the pre-disaster relationships that you form will enable you to activate family assistance quickly and are the key to successful family assistance.

*The Hurricane Katrina response changed from identification of human remains to identification of human remains and missing persons location to handle the 13,197 missing person’s reports. Missing persons had to be located to meet families’ needs for information and to focus the identification of remains. In addition, due to mass evacuation, there was also a need to locate family members to obtain DNA samples and information needed to assist with identification of remains.*

## **Overview of Section**

The information in this section of the guide provides the foundation of a conceptual model for providing joint family assistance at a Family Assistance Center (FAC). This section includes:

- The purpose and guiding principles of family assistance.
- The functions and key expectations for providing family assistance.
- An example of an organization for family assistance.
- Identification of who is responsible for family assistance and guidelines for FAC leadership and administration.
- Core family assistance services with guidelines.
- Identification of additional services that will likely be required for a large-scale mass fatality.
- Logistics (staffing, communications and information systems, equipment and supplies, and facility requirements).

The information provided will allow for variations and scalability based on the nature, size and complexity of the mass fatality.

Experience informs the guidance in this section. Family assistance provided in response to Hurricane Katrina, the September 11, 2001 acts of terrorism, the Oklahoma City bombing, and

other mass fatality responses provide a good foundation for developing plans for future family assistance. Key resources used to develop this guidance include:

- *California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan*, The State of California Governor's Office of Emergency Services, September 2007.  
(<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. And, then clicking on Coroners Mutual Aid)
- *Federal Family Assistance Plan for Aviation Disasters*, National Transportation Safety Board, 2000  
([www.nts.gov/Publicatn/2000/SPC0001\\_toc.htm](http://www.nts.gov/Publicatn/2000/SPC0001_toc.htm)).
- *Oklahoma City—Seven Years Later: Lessons for Other Communities*, Oklahoma City National Memorial Institute for the Prevention of Terrorism, 2002.  
(<http://www.terrorisminfo.mipt.org/okc7toc.asp>)
- *Providing Relief to Families After a Mass Fatality: Roles of the Medical Examiner's Office and the Family Assistance Center*, U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime Bulletin, November 2002  
([http://www.ojp.usdoj.gov/ovc/publications/bulletins/prmf\\_11\\_2001/welcome.html](http://www.ojp.usdoj.gov/ovc/publications/bulletins/prmf_11_2001/welcome.html)).
- *Response to the Terrorist Attack on the Pentagon: Pentagon Family Assistance Center (PFAC)*
  - *After Action Report*;
  - *Appendix A, PFAC Management Component Source Documents*;
  - *Appendix B, PFAC Administrative Component Source Documents*; and
  - *Appendix C, PFAC Operations Component Source Documents*, Department of Defense, 2003  
(<http://www.defenselink.mil/mapcentral/actionrpt.html>).
- *Reuniting the Families of Katrina and Rita: Final Report of the Louisiana Family Assistance Center*, Louisiana Department of Health and Hospitals, 2006  
(<http://www.dhh.louisiana.gov/offices/publications/pubs-303/Full%20Report.pdf>).

The highlights and lessons learned from previous experience that are incorporated in this guidance will assist you in developing your family assistance plan.

An additional resource that is available is *Family Reception Center Exercise Guidelines, Disaster Mental Health: A Critical Response Instructor's Guide*, University of Rochester, 2006. For this guide, contact Jack Herrmann, Senior Advisor Public Health Preparedness for the National Association of County & City Health Officials at [jherrmann@naccho.org](mailto:jherrmann@naccho.org).

## Key Assumptions

The following are the key assumptions underlying family assistance:

- Expect eight to 10 family members/loved ones for each potential victim.
- Family members have high expectations regarding:
  - The identification of the deceased,
  - The return of loved ones to them, and

- Ongoing information and updates.
- Family members will begin to come to the incident site almost immediately. The family assistance center—with at least basic services—needs to be open and operating within 24 hours at most.
- FAC operations may be long-term.
- Responding to a mass fatality incident can be overwhelming, leading to traumatic stress. *Support for responders is essential to monitoring and minimizing the impact.*

## Proposed Approach



Since most jurisdictions are fortunate in that they have never experienced a mass fatality and had to provide mass fatality family assistance, preparing a family assistance plan requires research. This toolkit does that work for you. Lessons learned from recent major mass fatalities in the United States have been incorporated.

This section of the toolkit provides the conceptual framework for establishing a joint family assistance center. The approach used in it is a single family assistance center that opens as soon as possible with basic services—a place to gather and get information, emotional support, and food and beverages—and services added as they become available. Your jurisdiction may prefer to plan for an initial reception center or centers and open its family assistance center in another location at a later time. Or your jurisdiction may decide to plan for multiple family assistance centers. The choice is yours. Whatever you decide, the information below will be helpful.



The key stakeholders for this section are the local jurisdiction ME/C Office, the agency/organization that the ME/C Office has designated to manage and coordinate family assistance in the event of a mass fatality, key agencies that will provide services, and EOC Logistics. It is important for local organizations and local chapters of the American Red Cross and Salvation Army to be involved in community planning and to understand their role in providing mass fatality family assistance.

A mass fatality family assistance plan is a plan in and of itself. Once you've completed it, it can be included in your mass fatality plan or be a separate plan that is maintained by the agency/organization that will be coordinating family assistance per agreement with the ME/C Office. If it is a separate plan, include the ME/C responsibilities at the FAC and reference to the family assistance plan in the mass fatality plan.

**Note:** An effective response to victims' families is dependent upon prior planning and stakeholder coordination. Understanding the needs of family members, clarifying the roles of responders, leveraging resources, building trust among agencies, and developing a plan with a sound conceptual framework will allow a jurisdiction to focus its planning in the aftermath of a mass fatality incident on the unique aspects of the incident that impact family assistance—facilitating a more rapid and effective response.

## ***Developing Your Family Assistance Plan***

### **Step 1: What is the purpose of family assistance?**



The **Purpose** of family assistance is to provide victims' families with a secure and controlled area:

- To provide a private place for families to grieve.
- To protect families from the media and curiosity seekers.
- To facilitate information exchange between the ME/C Office and families so that families are kept informed and the ME/C Office can obtain information needed to assist in identifying the victims.
- To address family needs (responding quickly and accurately to questions, concerns, and needs—psychological, spiritual, medical and logistical).
- To provide death notifications and facilitate the processing of death certificates and the release of human remains for final disposition.

Effective family assistance emphasizes compassion while imposing structure on a chaotic situation.

The following guiding principles, developed by the Pentagon Family Assistance Center, are appropriate to all mass fatality family assistance.

#### **Family Assistance Guiding Principles:**

- Maintain a single focus—supporting the families.
- Convey this single focus in all communications and actions, both internally and externally.
- Deliver only unequivocal, accurate information to families with honesty and empathy—although painful, the truth is always most supportive to the families.
- Guide family member expectations from the beginning of the operation.
- Accommodate families' requests—group or individual situations—to the maximum extent possible and recognize that some requests cannot be met.
- Remain flexible, allowing room to adapt and evolve to meet new requirements and family needs.
- Provide every opportunity for family members to make decisions to regain control of their lives.

## Step 2: What are the key functions and family assistance expectations in a mass fatality?



The following are the key family assistance functions with the agency/organization responsible identified.

Family Assistance Functions	
Functions	Agency/Organization
Family briefings	ME/C Office
Collection of antemortem data for identification of human remains	ME/C Office
Death notification to next of kin.	ME/C Office
Management/coordination of all family assistance operations, including all involved organizations and personnel	Agency/organization with which ME/C Office develops an agreement to provide family assistance management (e.g., Social Services Agency/Human Services Agency, Public Health, or American Red Cross)
<p>Family support services:</p> <ul style="list-style-type: none"> <li>▪ Call center,</li> <li>▪ Reception and information desk,</li> <li>▪ Spiritual care,</li> <li>▪ Mental health services,</li> <li>▪ First aid/medication,</li> <li>▪ Translation/interpreter services,</li> <li>▪ Child care, and</li> <li>▪ Food services/mass care.</li> <li>▪ Web Search/Lead Investigation Center (if the mass fatality involves large numbers of missing persons).</li> <li>▪ A wide range of additional services that are based on the incident. These may include: lodging, clothing, transportation, financial assistance, financial services, legal services, crime victims services, etc.</li> </ul>	<p>A wide array of agencies, organizations, and volunteers that work collaboratively under the direction of the agency in charge of family assistance, for example:</p> <p>Department of Mental Health, Alcohol and Drugs, and/or Behavioral Health.</p> <p>American Red Cross.</p> <p>Salvation Army</p> <p>Faith-based organizations and churches.</p> <p>Nonprofit organizations.</p> <p>Local volunteer agencies.</p>

**Recommendation:** Begin to define roles and responsibilities in the planning process. Develop memorandums of agreement/intent with agencies and organizations that will play a major role in the family assistance center. It will better enable your jurisdiction to move quickly and efficiently in the event of a mass fatality. In the memorandums, include agreements to share information with other agencies in the FAC—it is crucial effectively serving families.

## Start-Up Expectations

Preparations to open the FAC need to be efficient and fast. Plan for resources and services as they are needed consistent with operational periods.

The FAC should open as soon as possible. The most critical services needed immediately are:

- A safe, secure place for victims' family members to gather and grieve.
- Accurate information.
- Food for family members and staff.
- A call center/hotline.

Emotional support services (chaplain services and mental health services), basic first aid, and translation/interpreter services (based on impacted population) are also critical services to mobilize quickly.

The sooner additional services are provided, the better.

*The following are examples of startup times and length of service for FACs from recent U.S. mass fatalities.*

- *The Oklahoma bombing (169 deaths): FAC opened within 3 hours and stayed open for 16 days, until the last body was recovered.*
- *The 9/11/2001 Pentagon attack (182 deaths): FAC call center was open by 3 p.m. September 11 and the FAC opened with 50 volunteers by 7 a.m. the next morning. It operated 24/7 from September 12 through October 12, 2001.*
- *The 9/11/2001 World Trade Center attack (approximately 2,800 deaths): FAC was opened at its first location on 9/12, moved to a second location the afternoon of 9/12, and moved to its third location on 9/15. When lines of concerned family members stretched eight blocks in four directions, a new fourth site, Pier 94, was prepared. The FAC was open for approximately 460 days with Pier 94, the final site, closing December 2002.*
- *Hurricane Katrina hit Louisiana on August 29, 2005 (approximately 1,460 deaths—910 deaths processed through DMORT morgues—and 13,197 missing persons reports): FAC opened September 7, 2005 and stayed open for 342 days, closing August 14, 2006.*

An *FAC Priority Action Checklist for Startup* is included in the tools for this toolkit section.

## **Expectations for Hours of Operations**

*For most mass fatalities, expect the FAC to operate 24 hours/seven days a week in the beginning. While some services will be needed during all open hours, many of the direct services can be provided between 8 a.m. and 5 to 9 p.m.*

## **Expectations Regarding Changing Needs**

Experience providing family assistance after a mass fatality indicates that *the needs of families will change over time*. Anticipate this and plan accordingly. Flexibility is a key principle in providing family assistance.

*The following phases illustrate the changing needs of families as family assistance evolves and are based on Pentagon FAC experience.*

**Phase 1.** *This is the full FAC operation.*

*Stage 1—families will be seeking basic information about their loved one and be seeking basic emotional support.*

*Stage 2—families will be seeking specific information about the disposition of remains, about benefits and entitlements, and will be seeking to bond as a group with other families.*

*Stage 3—families will be seeking a wide range of services. Legal assistance will become important.*

*Stage 4—families will begin to move on with the next phase of their lives.*

**Phase 2.** *This is a scaled down version of the FAC. It may:*

- *Maintain a master locator list of all victim families.*
- *Provide a walk-in center for families with information and referral and mental health counseling.*
- *Provide death notifications—information on continued positive identification of human remains.*
- *Provide a toll-free number for information and referral, legal assistance, counseling, and referral to community agencies for housing and financial aid. This could be the call center in its next stage of evolution to meet family needs.*
- *Provide a family assistance center resource guide for families to assist them in their transition to longer-term assistance in their communities with information on relevant resources, information about relevant Web sites, and information about financial grants, points of contact for donations, and other benefits.*
- *Provide a process for donation acceptance, transfer and referrals.*

**Phase 3.** *This is the long-term response, with resources directed toward easing the long-term emotional, psychological and financial impact on families. Phase 3 may include the following:*

- *A letter to all families notifying them that Phase 2 activities are closing and providing information to further transition to community-based resources.*

- *A secure, interactive Web site for families to provide a single source of useful information, including resources, foundations, donations, plans for a memorial (interactive so families can make recommendations and suggestions for the memorial and provide feedback on needs), and links to other related sites. The site will need to be regularly updated and modified to serve the changing needs of families.*
- *Information on family support groups. Pentagon FAC feedback indicated that families benefited from group support meetings. Publicize organizations that come forward to provide professional assistance in coordinating family support groups in the subsequent months and years.*

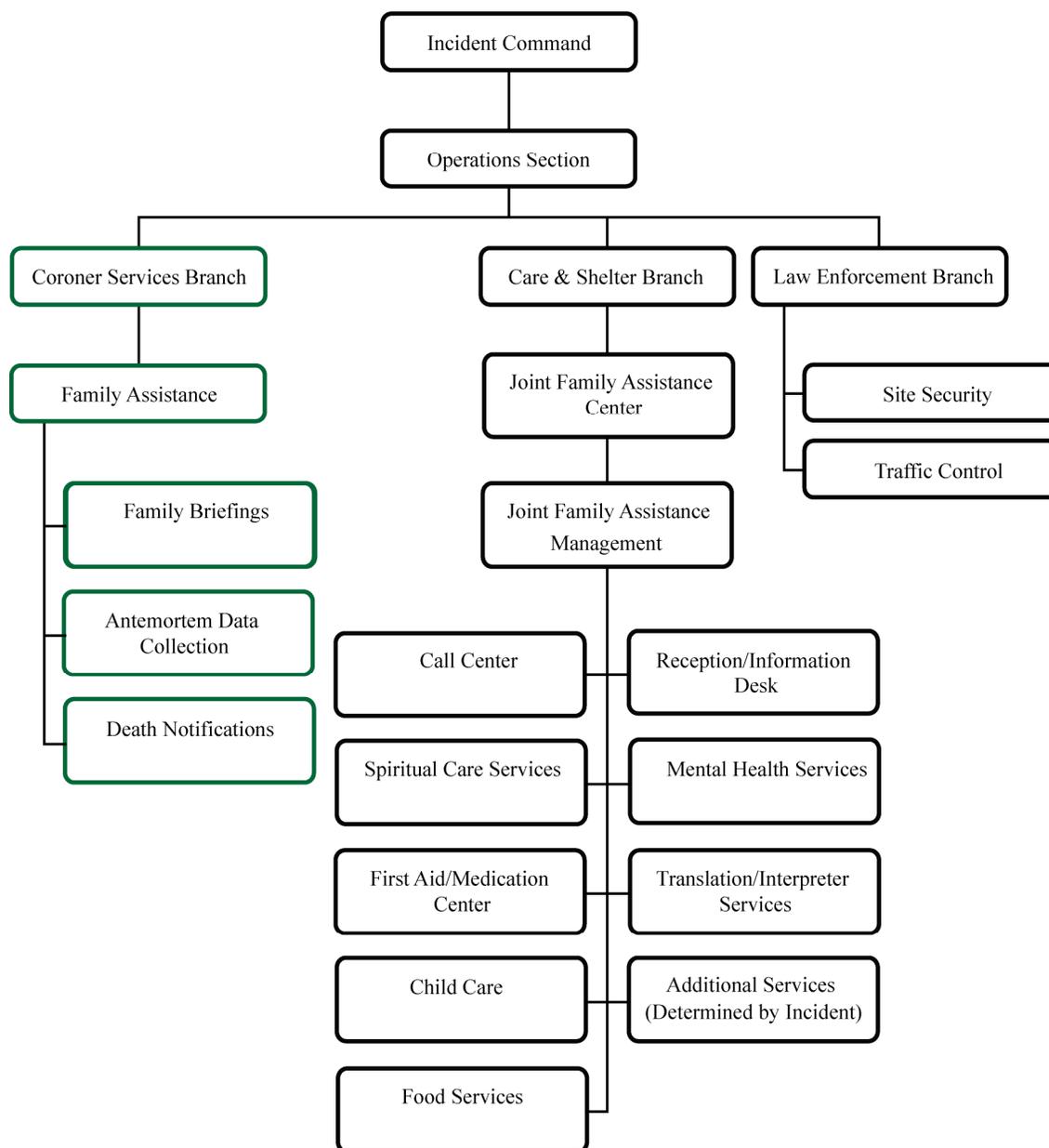
Even after the FAC closes, families will have long-term needs for continued resources and services. Educate families on the normalcy of this need and encourage them to access resources. Resources, provided by a wide array of public and private agencies, may include: emergency assistance; shelter; transportation; financial assistance, including grants and special funds; legal rights and pro bono services; mental health and crisis counseling as well as special services aimed at helping children cope with grief; educational support; and information and referral. Publicize the multitude of resources that are available.

### **Step 3: How will family assistance center be organized?**



An example of an organization for family assistance operations in one center is presented below. In this example, Joint Family Assistance (separate from the ME/C Office Family Assistance responsibilities) is presented as if the designated agency for this role is a government agency in the ME/C Office’s jurisdiction. In this example, the jurisdiction’s social service agency is the agency the ME/C Office has designated to manage and coordinate family assistance.

Example of Field Organization for Mass Fatality Joint Family Assistance Center (FAC)



## Step 4: Who is responsible for family assistance?

The ME/C Office is responsible for family assistance for all mass fatality incidents. The only exceptions are commercial airline and some transportation accidents. The Federal Family Assistance Act of 1996 requires the National Transportation Safety Board and individual air carriers to take actions to address the needs of families of passengers involved in aircraft accidents.

Due to the demands on the ME/C Office—human remains recovery, morgue services, and some family assistance services—the ME/C Office will typically designate a lead organization to manage and coordinate joint family assistance and work with that organization to ensure that family assistance is provided. A typical organization for this designated role is the jurisdiction’s social services or human services agency, public health department, or the American Red Cross.



Designate the agency/organization that the ME/C Office will work with to provide joint family assistance in your plan. Having one agency that will lead the coordinated response will help reduce the chaos that families will be experiencing.



Guidelines for:

- JFAC Management and
- Administration (Information Systems and Communications Support, Personnel and Interagency Coordination and Management, and Administrative Support) follow.

## Joint Family Assistance Center Management

The purpose of Joint Family Assistance Center (JFAC) Management is to provide an organizational structure:

- To plan, execute, coordinate, and monitor family assistance response operations maximizing the utilization of all available resources.
- To coordinate and manage the numerous organizations and personnel involved in providing family assistance and ensure communication and information sharing to enable a successful emergency response.

The JFAC Management Team will include the JFAC Officer in Charge (OIC), Deputy OIC, the ME/C Family Assistance OIC, Administration Officer, and representatives of organizations providing services (e.g., Social Services Agency, Mental Health Department, DMORT, American Red Cross, nonprofit organizations, State Department, Department of Justice, etc.). Team Leaders, representing their service areas, will also participate as needed.

Plan to have the management team meet daily to discuss and resolve issues in a timely manner—focusing on keeping the best interests of families at heart. It is recommended that the Logistics Officer, Personnel and Interagency Coordination Manager, and the Information and Communications Systems Manager, and, in some cases, the caterer be present for all JFAC Management Team meetings.

The goal is to create a simple, flat, decentralized organizational structure that will allow the management team to focus on major issues that affect families while Team Leaders manage more routine support activities within their respective service areas. Plan to empower Team Leaders to use their professional expertise to do their jobs—doing the necessary research and coordination to execute team management decisions.

### **Leadership Staff Recommendations**

The JFAC Officer in Charge will coordinate all family assistance services and attend/participate in family briefings. The seniority of the officer in charge and the deputy officer in charge must be appropriate for the scope and mission of the JFAC. They should be mature individuals and possess exceptional leadership, management and communication skills. The officer in charge, in particular, should have significant positional authority and be recognized by those internal and external to the JFAC.

The ME/C Family Assistance Officer in Charge will serve as a member of the JFAC Management Team, lead family briefings, and oversee antemortem data collection and death notifications.

*When designating leadership and management staff for the family assistance center, aim for a core staff that is assigned to support the mission for the duration. This ensures that institutional continuity and trust from family members are maintained throughout the operation.*

The formation of strong, cohesive teams—the management team and service teams—is important and a challenge with the diverse backgrounds needed for family assistance staff. Patience is necessary in establishing new staff teams under crisis conditions.

### **Management Guidelines**

- **Oversee/coordinate FAC operations—all organizational, staffing, facility, and operational requirements.**
  - Establish a command structure to manage the FAC.
  - Appoint a Logistics Officer. The FAC Logistics Officer will be responsible for working with EOC Logistics on the acquisition, storage, issue, and accountability of all supplies, equipment, facilities, personnel and services necessary to support the family assistance operation.
  - Convene daily management team meetings.
  - Ensure development of FAC safety, security and transportation plans.
- **Develop FAC mission and objectives.**

- Establish consistent policies and procedures/guidelines on FAC roles, responsibilities and requirements early in the process.
  - Communicate this information in writing to the management team, team leaders and all staff and volunteers involved in the operation.

While the different agencies/organizations represent complementary tasks and duties, it is important to recognize that all agencies will bring their own assumptions, priorities, needs and interests to the FAC. A clear command structure, mission, and objectives will facilitate development of a team approach. This is imperative to the success of a joint operation.

- Oversee enforcement of FAC safety, transportation and security plans.
- Monitor human remains recovery operations and morgue operations. Continuous and open communication is necessary in order to provide families and officials with current and timely information on the progress of the operation at the incident site and the morgue.
  - Discuss DNA testing with the Morgue Services Officer in Charge so that family assistance staff and volunteers understand under what conditions DNA testing will be used, to what extent it will be used, from whom the Medical Examiner would like test samples collected, and who will pay for testing of samples.
  - Discuss how personal effects will be handled with the Morgue Services Officer in Charge so that family assistance staff and volunteers understand and are able to inform family and loved ones.
- Manage work schedules to allow key staff some respite from the high demands of the mission. Experience indicates that over time, some staff and volunteers will emerge as a secondary victim group.
- Maintain and update daily plan.
- Plan for future operations.
- Monitor ongoing family assistance activities (*FAC Daily Status Update*) and track mission activities of each organization involved in the FAC.

*Managing donations became a significant operation for the Pentagon Family Assistance Center in the first week of operations. This role may be primarily managed by EOC Logistics or a separate agency; however, expect the FAC to carry some responsibility in this area.*

- *Develop a well-defined policy and guidelines that allow flexibility for handling various types of donations (monetary and non-monetary).*
- *Maintain inventory and distribute donated items to family members. There may be a need to administer funds and services for several years, which will need to be transitioned to another organization when the FAC closes.*
- *Develop a database to a system to track the donor's name, address, the type of donation, the value of the donation, and the disposition of the donation.*

- Provide input for the daily family briefings.
- Maintain a daily journal of organizational activities and responses.
- Consult with EOC Logistics regarding the handling of donations.
- Develop a transition plan for when the FAC closes to provide longer-term support to the families.
- Complete JFAC After Action Report.

## FAC Administration

The purpose of administration is to support the operation of the FAC by 1) information systems and communications management; 2) personnel and interagency coordination; and 3) general administration/support services. Post Incident Activities are included at the end of the Administration section to facilitate post-FAC planning.

### Information Systems and Communications Guidelines

Purpose: To set up, manage, and provide technical support for FAC information and communications systems.

#### Information Systems

- Establish needs for, procure (working with EOC Logistics), allocate and track all necessary information systems equipment and supplies to support the FAC (computers and software programs, etc.).
  - Oversee distribution, installation, maintenance and recovery of computer equipment.
- Create a centralized database management system to reduce duplication of effort, minimize the potential for errors, and improve response time in retrieving essential information. This will include:
  - System for collecting victim antemortem information.
    - With capacity to communicate with the Morgue Information Resources Center.

See *Mass Fatality Information Systems* section of this toolkit.
  - System for recording services provided to family members by service team members.
  - System to maintain accurate records of staff hours.
  - System to maintain accurate accounting for:
    - Supplies and equipment.
    - Food.
    - Donations.
- Provide technical support (computer and software installation and services, maintenance,

*The Hurricane Katrina response used ArcGIS software to create a series of Web-based maps to provide a visual representation of the geographical distribution of the missing, the found, and the confirmed deceased by last known location as well as of recovered remains for the entire region.*

telecommunication lines, Internet/e-mail access, and development of database programs).

- Create and manage Web sites, e.g., for families to access and/or for the public to access information on the recovery effort (coordinate with the Joint Information Center).

### ***Communications Systems***

- Establish needs for, procure (working with EOC Logistics), allocate and track all necessary communications supplies and equipment to support the FAC (2-way radios, cellular phones and service, telephones and service, public address systems, fax machines, etc.).
  - Oversee distribution; installation; maintenance; and recovery of communications equipment.
- Test all communications equipment.
- Develop and activate a communications equipment accountability system.
- Provide technical advice on:
  - Adequacy of communications systems.
  - Geographical limitations.
  - Equipment capabilities.
  - Amount and types of equipment available.
  - Potential problems with equipment.

### **Personnel/Interagency Coordination and Management Guidelines**

Purpose: To manage and coordinate FAC staffing and personnel resource requirements, emphasizing interagency cooperation and sharing of information.

#### ***Management/Coordination***

- Identify staffing requirements in consultation with Team Leaders and communicate needs to JFAC Management Team and EOC Logistics/Staff and Volunteer Processing Center.
- Serve as the central focal point for coordination and sharing of information among participating organizations.
  - Conduct daily coordination meetings with all Team Leaders to review daily activities, resolve problem areas, synchronize future family assistance activities, and report on/discuss perceptions/status of family members and loved ones.
  - Brief all family assistance staff and volunteers at the beginning of each shift.
    - Provide updates relevant to all staff.
      - Team Leaders will brief their teams at the beginning of each shift on information specific to their teams (e.g. new procedures).
    - Repeat information in daily e-mails to staff/volunteers.
  - Maintain message boards and post messages for staff and volunteers working at the FAC.
- Assure ongoing emotional support for workers during the operation by monitoring morale and maintaining a proactive, coordinated effort.
  - Provide briefings and Psychological First Aid:

- at the end of each shift and
- at the conclusion of the operation.
- Make mental health and spiritual care staff available in the staff dining area for informal discussions/support.
- Make additional Psychological First Aid and other mental health support available as needed.

*Encourage/mandate participation.* Make a concerted effort to prevent staff and volunteers from becoming a secondary victim group.

### ***Scheduling and Tracking***

- Maintain master schedule.
- Aim to formalize schedule a week in advance.
  - Coordinate schedules with Team Leaders.
  - Plan for busy times—before and after daily briefings, site visits, etc.
  - Manage work times to allow some respite.
  - Aim to cover 2-week work periods.
  - Contact staff and volunteers to verify availability prior to finalizing and distributing the schedule.
- Distribute schedule.
  - Make daily adjustments as volunteers reschedule or FAC staffing requirements change.
- Develop and maintain:
  - staff/volunteer rosters,
  - organizational and staffing charts,
  - JFAC Management and Team Leader contact information/telephone numbers,
  - Staff/volunteer contact information/telephone numbers, and
  - Daily updated list of all organizations and agency service providers located in the FAC.

### ***Orientation and Training***

All staff and volunteers at the FAC will participate in orientation and training.

When staff/volunteers check-in at FAC:

- Check ID badges against day's schedule and have staff and volunteers sign the *FAC Daily Staff Registration*.
  - Issue color-coded name tag badges to distinguish assignments/functions, if ID badge was not issued at Staff and Volunteer Processing Center.

Provide orientation for new staff/volunteers:

- Information on meals, parking, sign-in/check-out procedures, and behavioral Dos and DON'Ts.
  - How to provide sympathetic help, protect confidentiality of family information, the most effective support techniques, and warnings NOT to talk to media other

- than to take questions and refer to immediate supervisor, who will refer media requests to the Joint Information Center.
- Provide a tour of the FAC.

Team leaders will be responsible for ensuring that each team member participates in team training specific to the team as needed to fulfill position duties.

### **Administration/Support Services Guidelines**

Purpose: To manage FAC administrative, resource, and information requirements.

- Manage routine office functions and emerging FAC requirements.
- Compile, generate and maintain correspondence, reports, statistical information, and logs, including the *FAC Daily Status Update*.
- Document FAC operations.
- Monitor and oversee data entry and control activities.
- Monitor broadcast and print news coverage of events to anticipate impact of information on families and center operations.
- Monitor and ensure that all sensitive material is handled or disposed of properly.
- Provide logistical support:
  - Manage resource requirements, maintain inventories of donated, purchased, and leased equipment and supplies, and work with EOC Logistics to manage distribution of donated items to families.
  - Employ an accounting system to accurately record cost data in specific cost categories and track personnel for later reimbursement, including but not limited to:
    - Mission number assigned by the Emergency Operations Center.
    - Daily attendance rosters and time worked logs.
    - Tracking of all supplies and equipment requested, loaned, received, and used.
  - Establish procedures for determining funding sources and processes.
  - Manage and monitor food services (work with caterer and/or provide meal tickets, e.g., to use in hotel dining area if FAC is located in a hotel).
  - Manage and monitor parking passes, transportation, etc.
  - Manage and monitor janitorial services.
- Manage information:
  - Provide responses to calls and requests or provide an appropriate hand off to the primary organization responsible for the issue.
  - Work with graphics staff and the Joint Information Center to:
    - Maintain message boards and post messages for family members.
    - Update/maintain locations and telephone numbers of participating organizations and service providers, team leaders, and key mass fatality response personnel.
    - Create a fact sheet with information on all services provided for families and for all staff/volunteers so that everyone is informed and able to provide accurate information to families.

- Prepare input for the incident family Web site.
- Maintain information on status and location of injured victims.
- Prepare finished copy for informational materials for families, memory board for family briefing room, professional signs, etc.
- Provide information releases to the Joint Information Center regarding the types of support that have been brought in to assist family members and loved ones.
- Provide Department of State necessary information of foreign decedents to facilitate interaction with appropriate foreign government embassies.
- Provide routine administrative/clerical support.
- Coordinate a possible visit to the incident site with the Human Remains Recovery Officer in Charge and any other events that may be scheduled for family members and loved ones.
  - Manage transportation.
  - Coordinate participation of mental health counselors and chaplains to accompany families on buses.
  - Coordinate participation of medical personnel at site.
- Request and collect information for After Action Report using recommended format from staff/volunteers and all agencies and organizations that participate in the FAC.

## Post Incident Activities

The agency/organization responsible for these activities will be determined during planning for FAC closure. Post Incident Activities will most likely be handled by the ME/C Office.

- Arrange for a memorial service.
- Maintain contact with family members and loved ones to keep them informed about the progress of the investigation (if the incident is the result of a crime/terrorist act) and continue to meet their future needs.
  - Inform families prior to the factual report being made public and tell them whom to contact to request a copy of the report.
  - Coordinate with the Department of Justice in arranging meetings with family members to explain their rights under the victims of crime legislation.
- Consult with families about the selection of the burial site for common tissue, the type of service, and the memorial marker. Typically, common tissue is interred during a memorial service to which the victims' families are invited.
- Consult with family members about any monument, including inscriptions, that is planned to commemorate the incident.
- Consider planning a memorial service one year after the incident.

*Four and a half years after the Oklahoma City bombing, the common tissue was buried on the grounds of the Oklahoma State Capitol in a nondenominational memorial service.*

## Step 5: What are the guidelines for core family assistance services?



The core family assistance services or functions are:

- Family Briefings.
- Antemortem Data Collection to assist in identifying victims.
- Death Notifications.
- Call Center/Hotline.
- Reception and Information Desk.
- Spiritual Care Services.
- Mental Health Services.
- Medical/First Aid Services.
- Translation/Interpreter Services.
- Child care .
- Food Services.

A brief description with guidelines for these functions appear below.

A wide range of additional family support services based on the nature of the mass fatality incident will also be required. Information on the core services is followed by:

- Additional support requests made by families at the Pentagon FAC (as examples that could be replicated for a local incident).
- Additional family support services often provided at the FAC.

### Family Briefings

Families will have a strong need to receive a continuous flow of information and to understand what happened to their loved ones.

Family briefings are convened to meet this need. Their purpose is:

- To provide information to all families (at the FAC and not at the FAC) on the progress of recovery efforts, identification of victims, the investigation, and other areas of concern.

In general:

- *Always provide information to families before releasing it to the general media.*
- Maintain contact with families once it is established regardless of whether additional information is available.

- Bring in subject matter experts as needed. And, plan to have rescue workers (selected via the Joint Information Center) and officials visit the families so that they can thank the workers for their efforts and support. When this occurs will depend on the nature of the incident.

The ME/C Family Assistance OIC or a designated representative will lead family briefings with the JFAC OIC present to answer questions about FAC services. If possible, have the same person provide all family briefings so that this person can become the recognized authority.

### **Information of Interest to Families**

Families will have many questions and concerns as they assimilate and accept information about the deaths of their loved ones. The *Family Concerns and Religions/Cultural Considerations* section of this toolkit contains detailed information on family member concerns and advice on sensitively addressing these concerns that is based on ME/C Office experience in managing mass fatalities. In general, emphasizing respect for family members and a systematic approach can have a calming effect on those in attendance.

### **Family Briefing Guidelines**

- Establish procedures for family briefings.
  - When guests are invited to present to families on topics of interest, orient/brief them on the family briefing procedures.
- Prepare family briefing room:
  - Setup a conference call bridge in the room where briefings will be held and provide a toll free number to connect to the bridge to families so that families who are not on site can listen to the briefing.
- Arrange for translators as needed.
- Prepare a schedule for daily family briefings (minimum two per day, e.g., one in the morning at 9:30 and one in the afternoon at 3:30; however, more frequent information sessions may often be held).
- Post the schedule in the FAC. Inform families that they may attend as often as they like and may bring as many people as they like.
- Consider preparing an informational letter for all families in the beginning that addresses key concerns, such as, identification methods, disposition options, issuance of death certificates, and matters related to unidentified remains.
- Collect information from the incident site, the morgue, the FAC, and the Joint Information Center (JIC) for briefings and consult with the JIC as needed to ensure that families are informed first and for consistency in messages to families and to the public.
  - Note: If the incident is the result of a crime, the ME/C must sensitively convey information to families during recovery that is consistent with the information provided to the prosecution.
- Prepare briefings.
- Convene families and friends at FAC for scheduled briefings.
  - Briefings are important even if there is no new information to report.
- Provide information relating to victims and progress of the response effort to families.

- Emphasize that the FAC is the best source of current and accurate information for families at each briefing.
- Present information in terms family members can understand.
- Repeat information frequently during the briefing to accommodate families at various levels of receptiveness in the grieving process.
- Plan for question and answer sessions after each briefing (may last up to 2 hours). If a question cannot be answered, get the answer by the next briefing.
- The JFAC Officer in Charge should attend all briefings and make him/herself available after each briefing to meet with families one-on-one at a designated area in the family briefing room, spending as much time as needed to address their concerns.
- Provide copies of transcripts of daily briefing notes (translated as needed), resource and services information, and other pertinent handouts for pick-up in the family briefing room to help families keep track of the difficult and overwhelming information they are receiving.  
In the aftermath of a mass fatality, families are often in shock and may not be able to accurately recall what was said to them. Not having the correct information can be very distressing at the time of the event and later.
- Participate in daily JFAC Management meetings to review daily activities, resolve problem areas, and synchronize future family support activities.

## **Antemortem Data Collection**

The purpose of antemortem data collection is to collect vital information to assist in positive identification of the victims. Antemortem data may include a victim's physical, clothing and jewelry descriptions, unique characteristics (like tattoos, scars and birthmarks), dental records, medical records, and fingerprint records.

DNA reference samples are collected when conventional means of identification are exhausted or may be inadequate. Family reference samples and personal effects of the victim containing biological material may provide the only method by which victim remains can be identified.

ME/C or ME/C designated personnel will collect antemortem data. They will meet with family members in private areas within the family assistance center or contact them by phone to collect antemortem information. Families may also call the call center and be referred to a member of the antemortem data collection team for an interview.

All interviewers should be personnel specially trained in dealing with grieving individuals. It is helpful to have experienced DNA professionals available to help establish credibility in the DNA identification process.

## Antemortem Data Collection Guidelines

- Establish antemortem data collection procedures.
    - Process for setting up family interviews.
    - Documentation—an antemortem data acquisition and entry plan.  
Determine if interviewers will enter the antemortem data into a database or if data entry clerks will transcribe the data from an interview form into a database that will be used for comparisons with postmortem data.
      - Consider using the DMORT questionnaire, the *VIP Personal Information Questionnaire*. It is a universal questionnaire designed to expedite antemortem data collection.
        - Add local jurisdiction death certificate information to the questionnaire so that families do not have to provide this in another interview at the funeral home.
- Note: Directions for filling-in the *VIP Personal Information Questionnaire* are available at:  
<http://www.dmort.org/forms/Forms%20Manual-VI-DMORT.doc>.
- For multicultural populations:
    - Ensure proper formatting of first and last names and correct spelling of similar sounding names.
    - Note information about the family’s religious or spiritual beliefs, including practices and rituals, daily prayer times, important dates, beliefs about autopsy, and other information that may be relevant to the rescue, recovery and disposition of their loved ones. Leaders of religious or spiritual communities can also provide guidance.  
Demonstrating sensitivity to cultural beliefs and practices of the victims’ families in a mass fatality—even when needs cannot be met—is important to effective response.
  - Identify an address for receipt of all antemortem records (e.g., the ME/C Office).
    - Be prepared to add changing and new information to each person’s file as it is collected from family members, friends, dentists and doctors after the initial interview.
    - Maintain logs of the files, of all incoming data/samples, and of all forwarding data/samples.  
Accountability for forwarding and receiving records is essential.
    - Be prepared for some family members to not want to provide antemortem information or supply DNA for kinship matches because they view doing so as a sign that they have given up hope.
  - Orient/brief Antemortem Data Collection Team on the information they need to collect from families (forms, procedures, etc.) and their role as a representative of the ME/C Office.
  - Coordinate operations with the Morgue Information Resource Center and the Morgue Records Supervisor.

- Schedule interviews with families. Allow 2 hours for each interview with a 30 minute period between interviews.
- Conduct interviews in rooms that are private and quiet.
- Reassure families that all information will remain confidential.
- Collect antemortem data using ME/C approved form. Once form is completed, antemortem information is given to the ME/C, the Morgue Information Resource Center, and any other appropriate agencies approved by the ME/C.
  - Dissuade families from acquiring or carrying the victim's medical or dental records to the JFAC.
    - Ask family members to sign release forms to allow for the release of the missing person's dental and medical records.
  - Call dentist and physician offices to request *original* dental records, x-rays, and medical records.
    - Follow-up call by sending an authorization fax that includes the HIPAA Exemption for Medical Examiners and Coroners, CFR 164.512(g), to verify and confirm the request for the victim's medical/dental record and request timely delivery of records.
  - Monitor the status of incoming dental records, x-rays, and medical records to insure that all records are original and have been received.
    - Inform families when antemortem data and samples have been received.
    - Have victim records in foreign languages translated as needed.
  - Follow-up on requests that have not been received.
- Arrange for collection of DNA samples.
  - Establish DNA collection procedures to ensure proper collection procedures, prevent cross contamination, and ensure the best possible specimens are collected for subsequent laboratory testing.
  - Provide families with a copy of Appendix G, *Identifying Victims Using DNA: A Guide for Families*, in the National Institute of Justice's *Lessons Learned From 9/11: DNA Identification in Mass Fatality Incidents*, September 2006. The family guide is available in English and Spanish and how to access it is included later in this section under *Associated Tools and Resources*.
  - Answer family members' questions regarding collection of DNA samples. Explain the differences between Forensic DNA and Kinship DNA analysis.
  - Maintain an open, honest and sensitive approach to questions surrounding lineage when requesting samples for Kinship DNA analysis.
  - If buccal swabs are used, assist family members in collecting the samples.
  - If blood samples are used, arrange for family members to meet with staff who will be collecting blood samples. Allow families to go to their family physician to collect their blood sample, if they prefer to do so.
- If family members do not visit the FAC, interviews can be conducted over the telephone following the same procedures.
- For families that do not come to the FAC, DNA samples can be arranged through the ME/C and local law enforcement agencies. Send letters and consent forms to families that do not visit the FAC. If necessary, make arrangements to collect samples from anywhere in the world. When families are sending DNA samples, it is important that

they are aware of complex mailing procedures for specimens and that not all companies provide this service.

- If telephone contact is made before a family arrives at the FAC, follow a scripted checklist to request location and information on the following:
  - Physician
  - Dentist
  - Hospital
  - Fingerprints
  - Photographs
  - Military service records
  - Essential vital statistics.
- Arrange for collection samples to be sent to the DNA laboratory that the ME/C Office has approved at the end of each day.
- Get daily status reports from the DNA lab.
- Once the form for antemortem data collection has been completed and copied/printed at the FAC, direct it to the Information Resource Center at the Morgue for review and analysis. This may also be done electronically.
- Maintain chain of custody of records via sign-in and sign-out logs.
- Keep copies of forms at the FAC for reference. When the FAC is closed, the forms will be maintained by the ME/C Office or destroyed.

## Death Notifications

The purpose of death notification is to notify next of kin/family members when their loved one has been positively identified.

- Once notified, the release of the remains between the family, the morgue and the selected funeral home is coordinated.

The death notification process facilitates the return of remains and allows families to grieve, memorialize their loved ones, settle estates, and resolve legal issues.

Death notification is the responsibility of the local ME/C Office. A Death Notification Team is preferred for notifications and may include a representative of the ME/C Office, a crisis counselor, and/or clergy.

## Death Notification Guidelines

- Establish death notification procedures.
  - Notify family members of a loved one's death in person, if at all possible. Notification can take place at the FAC or at a location of the family's choice, such as their home. If the family's selected location is too far for the local ME/C Office to go to, enlist the assistance of local law enforcement for that area.

- A team rather than an individual is preferred for notification. It is better to err on the side of having support persons present in case needed than to need them and not have them present.
- Brief Death Notification Team members on death notification procedures and their role as a representative of the ME/C Office.
- Identify the Death Notification Team that will notify the family of a loved one's death. In cases where local law enforcement in another area is making the notification, encourage them to bring a local mental health professional or member of the clergy.
- When assistance is needed to find next of kin, notify appropriate authorities.
  - If the victim lived out-of-state, the State Office of Emergency Services may assist by contacting the law enforcement agency where next of kin lives.
  - If the victim is from another country, the Agency for International Development, Office of Foreign Disaster Assistance may assist in contacting a deceased foreigner's family through the appropriate embassy.
- Prepare a fact sheet for each family with relevant information:
  - Explain how identification was determined.
  - Explain process for release of remains.
  - Include:
    - FAC number to call for services and/or referrals.
    - ME/C Office contact person and phone number for further questions and information on how and when the ME's report will become available, if they are interested.
- Assemble the Death Notification Team and ensure that all members are thoroughly briefed—before meeting with the family—on the information that will be given to the family so that they can answer as many questions as possible.
- Notify next of kin when an identification has been made and the Death Notification Team is ready to meet with them.
- In cases of fragmentation or commingling of remains, counsel families on the available options for disposition of any subsequently identified remains:
  - Notification each time additional remains are identified.
  - Notification at the end of the identification process.
  - Return of the currently identified remains to the family now for final disposition.
  - Return of all remains at the end of the identification process.

Note: If DNA analysis is the method used to conduct identifications of fragmented/commingled remains, the physical reassociation of all remains may take place several weeks or months after the incident.

  - Consider other requirements the family may have if they do not impact overall identification efforts.
  - Counsel families on the likelihood of common tissue.

Note: Due to the length of time required to complete the scientific identification of the tissue and/or the time required to investigate and complete legal proceedings if the incident is the result of a crime, inform families that internment of common tissue will not occur soon.
- Document the family's decision. Complete a *Release Authorization* and place it in the victim's file.
- Ask family members and loved ones if they desire crisis assistance or someone to talk to.

If family members are undecided or say no, give them the family assistance call center number to use if they change their mind in the future.

- Give families copies of the fact sheet prepared for the notification and of the *Release Authorization* with their decision on disposition of any subsequently identified remains documented.
- Coordinate the release of the remains between the family, the morgue and the selected funeral home.
- Provide the FAC Officer in Charge (and JIC) with names of victims and their next of kin, relationship to victim, and next of kin addresses and telephone numbers after the death notification. The antemortem questionnaire is a good source for this information.

## Call Center/Hotline

The call center is an important communications link to victims’ families. It manages all calls coming into the family assistance center via a dedicated toll-free telephone number. It is set up as soon as possible after notification of a mass fatality incident.

The purpose of the call center is:

- To provide a critical communications link to victims’ families and to families requesting information on missing persons.
- To act as a primary contact point for all incoming calls to the FAC.

Since most mass fatality events will also have survivors, plan to organize the call center so that it can meet the needs of family and loved ones of both decedents and survivors in the beginning. Each call received should trigger an organized and compassionate process to help find the missing and to help identify the victims.

It is recommended that the setup of the call center be coordinated with the Joint Information Center.

Plan to operate the call center 24/7, with most staffing during the day.

The call center’s communication link can be solely phones or phones and e-mail. If e-mail is included, e-mail protocols will need to be developed and staff will be needed to respond to e-mails.

*The Pentagon FAC had 15 phones with headphones. It received over 5,000 calls, averaging 170 calls per day. They noticed that types of calls changed over the evolution of the operations. In the beginning the calls had a tone of urgency from close family members and friends seeking information on loved ones. In the second week distant relatives and friends began to call. As victims are identified and the call center number had been increasingly publicized, callers began offering to volunteer and wanted to make donations. In the last two weeks of the operations, calls were overwhelmingly focused on a few key areas that included the memorial service, family briefing times, and FAC services.*

## Call Center Training Manual

A resource for developing the call center staff resource information and training manual is the *Pentagon Family Assistance Center Information and Training Manual*. The manual contains an Introduction; Pentagon Family Assistance Center (PFAC) Call Center Operation (purpose, primary functions, and PFAC services and providers); Crisis Intervention Training Basics (emotional reactions to crisis, hints for helping, and talking about death); Ground Rules for Staff; Confidentiality; Media Requests; Values Clarification; Taking Care of Yourself; Volunteer Information; Call Record and Family Member Contact Information; Questions and Concerns; and Call Center Forms and Additional Information. It is included later in this tool under *Associated Tools and Resources*.

## Resource Information Binder for Call Center Phone Operators at Each Phone Station

A resource information binder is recommended at each phone station with:

- Call center staff resource information and training manual.
- Family assistance center information:
  - points of contact phone numbers
  - scripts for frequently asked questions\*
  - daily family briefing updates
  - lists of injured, unaccounted for, and casualties
  - press releases
  - services that are available at the family assistance center
  - local area lodging information
  - transportation information.
- donation information.
- volunteer information (refer to Staff and Volunteer Processing Center).
- a bomb threat checklist (if deemed appropriate).

\* The scripts for frequently asked questions need to be updated daily to reflect current questions and concerns of family members from family briefings and Joint Information Center public communications.

## Call Center Guidelines

- Establish call center procedures:
  - Respect, consideration, and sensitivity for all callers.
  - Confidentiality.
  - Based on caller:
    - Family members:
      - referral to Antemortem Data Collection Team for collecting sensitive victim and family information,
      - referral to DNA personnel (Antemortem Data Collection Team) to provide guidance on questions such as whether it would be helpful for a certain family member to provide a kinship DNA sample, and



The purpose of the reception and information desk is to welcome and check-in families and visitors to the FAC to ensure FAC security, assess immediate needs of family members, and assist families in accessing services.

The reception and information desk plays an important role in taking care of families by monitoring their visits, assessing their needs, and by reporting to leadership on how families are responding to services at the FAC. This feedback allows the FAC to be proactive and flexible.

Be prepared to:

- Meet families as they arrive.
- Assist when necessary in coordinating activities to meet families' needs.
- Provide liaison between the family and the agencies involved as needed.
- Control who gains access to the FAC. Each family member should receive a photo identification badge to allow access to secured areas and maintain the privacy of all families.

The Reception and Information Desk Team includes staff working at the desk and escorts. Staff and escorts should receive an orientation briefing that includes training on:

- Awareness of and responding to family grief.
- Importance of confidentiality.
- Continual support of families while in the FAC.
- List of services available at the FAC.
- Tour of the FAC.

### **Reception and Information Desk Guidelines**

- Establish reception and information desk procedures:
  - FAC is only for families and loved ones of anticipated victims and pre-approved guests. Media, curiosity seekers, etc., are not welcome.
  - Consider establishing an order for family members to register and visit various agencies (based on family needs) to ensure that families get the assistance they need.
- Welcome families when they arrive. Escorts may meet families at the entrance and accompany them to the reception and information desk if it is not at the FAC entrance.
- Check-in families, ensuring that they are treated with respect, consideration and sensitivity. Allow people to move through the process at their own pace:
  - Ask them to sign the *FAC Daily Sign In Log*.
  - Gather locator information on primary and secondary next of kin and who will be visiting the FAC on the *FAC Family/Friend Registration Form*. Thoroughly explain the process and purpose of requesting this personal information prior to asking questions.
    - Forward this information to administration, the call center, and the antemortem data collection team for further processing and reporting.
  - Provide each family member/friend with a photo ID badge for identification with a same day pass. The photo ID badge should be a different color from staff

badges so that family members and staff can be quickly distinguished. On subsequent visits, check IDs and issue same day passes.

- Assess emergency and non-emergency needs of family member(s).
- Offer information on available services and connect families with the appropriate on-site service providers.
- Give directions for signing in on future visits and for signing out.
- Assign an escort to each family who can take them to a designated area where they will be more comfortable and can be located if necessary or to requested service provider.
  - Escorts can inform families of available services, provide written information that has been developed, provide the schedule for family briefings, assist families in navigating FAC services, and help them with any need that arises during their stay at the FAC.

*Expect families visiting the FAC for the first time to use the escorts extensively and to rely less on them during subsequent visits.*
- Provide information and referral services.
- When families leave the FAC, ask them to check-out and confirm that the FAC has their address and phone number so that they can be contacted with additional information, including notification of a loved one's death.

## Spiritual Care Services

The purpose of spiritual care services is to:

- Provide interdenominational pastoral counseling and spiritual care for people of all faiths who request it.
  - Being accessible to the families, friends, and co-workers of victims and to the FAC staff and volunteers during all FAC hours, particularly during large group meetings and events.
- Conduct religious services and provide worship opportunities.
- Provide emotional support/crisis intervention and assist mental health staff as needed.
- Serve as a member of the Death Notification Teams.

*At the Pentagon FAC chaplains were at the FAC the day it opened. They were located at the main entrance point (near the reception/information desk and mental health services), which made their services highly visible. More than 58 chaplains and 22 assistants provided spiritual care with nine to 16 per shift. More than 4,800 contacts were made, of which about 3,800 included family members and friends and about 1,000 were FAC staff and volunteers.*

## Spiritual Care Guidelines

- Establish the procedures for spiritual care services.
  - Emphasize reaching across faith group boundaries and not proselytizing. In coordination with mental health counselors, protect family members from being confronted by unwelcome forms of spiritual intrusion.

- Be available throughout the FAC to keep a watchful eye on the emotional reactions of those around them. Guide family members to a private room where they can talk about their loss and pray as needed.
- At a minimum, maintain records of the number of contacts and the assistance provided to document FAC activities and manage staffing requirements.
- Orient team to procedures.
- Monitor the information received at family briefings, particularly the numbers of positive identifications and of missing victims.
- Choose strategic positions throughout the family briefing room during briefings to reach out to any family experiencing grief or trauma.
- Assist with antemortem interviews and death notifications as needed.
- Assist with callers to the call center as needed.
- Walk around the FAC, visiting and talking to people and monitoring how families and how FAC staff and volunteers are holding up over time.
- Share meals with families to provide support.
- Make counseling in private rooms available.
- Arrange suitable inter-faith memorial service in the days following the incident. Offer single-denominational services at the FAC on Sundays.
- Make materials available to help those who are grieving and to positively reinforce the pastoral contacts with family members.
- Work with mental health staff in providing emotional support for FAC staff and volunteers.
- Work closely with the mental health services staff to maximize assets and minimize functional overlap.
- Attend all special events (e.g., visits to the incident site) to monitor family reactions during activities and provide support.

## Mental Health Services

The purpose of mental health services is to:

- Assist family members and FAC staff and volunteers in understanding and managing the full range of grief reactions.
  - Being accessible to families and staff and volunteers during all FAC hours, particularly during large group meetings and events.
- Provide Psychological First Aid, crisis intervention, mediation, and management of ‘at risk’ family members, including child and adolescent counseling.
- Provide referrals, as requested, to mental health professionals and support groups that are in the family member’s local area.
- Provide Psychological First Aid and grief process educational materials for the FAC.

**Mental health services goals** are to provide services based on the most current best practices:

For families:

- To help families grieve and stabilize as they prepare to move on to the next phase of their lives.

The sooner educational information and counseling staff are available, the more likely family members will become aware of issues and seek assistance.

For staff and volunteers:

- To help staff and volunteers cope with the common stress symptoms that result from working in mass fatality response and prevent/mitigate traumatic stress and its symptoms—physical illness and disease, mental and psychological disorders, and relationship problems.

## Mental Health Services Approach

Psychological First Aid\* is the recommended mental health strategy in the immediate aftermath of the disaster. This focus can last for several weeks for large-scale incidents.

*\* The literature suggests that psychological debriefing may have adverse effects on some disaster survivors and first responders. As a result, many disaster response organizations have chosen to utilize PFA as the supportive intervention of choice for responders in the early aftermath of disaster. It is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and foster short and long-term adaptive functioning.*

An additional approach to consider has been developed by the Palo Alto Medical Reserve Corps—a three-stage treatment alternative to Critical Incident Stress Debriefing. Its three phases are: Phase I—psychological first aid, Phase II—intermediate support/anxiety control, and Phase III—continued support/control or support/control plus prolonged exposure. All three phases are empirically derived therapeutic interventions for acute stress reactions following mass casualty trauma.

Resources for Psychological First Aid and the Palo Alto Medical Reserve Corps model are presented later in this document under *Associated Tools and Resources*.

## Mental Health Services Staffing

*It is important to maintain an appropriate mix of professionals—social workers; marriage, family and child therapists; psychologists, psychiatrists, and grief counselors—on duty. Aim to develop a core team for continuity.*

The Mental Health Services Team will participate in orientation/training in Psychological First Aid (PFA). For long-term FAC operation, Team members may also participate in orientation/training for evidence based interventions developed by the Palo Alto Medical Reserve Corps to assist families.

*At the Pentagon FAC there were an average of 20 counselors and two administrative assistants on each shift. Each counselor averaged 23 in-person and six telephone contacts a day. An estimated 18,000 contacts were made during the first month. Counselors were located at the main entrance point (near the reception desk and spiritual care services), which made their services highly visible.*

*In response to the 2001 World Trade Center attack, American Red Cross*

## Mental Health Services Guidelines

- Establish mental health/emotional support services procedures.
  - Use of Psychological First Aid.
  - Availability throughout the FAC.
  - Recordkeeping. At a minimum maintain records of the number of contacts and the assistance provided to document FAC activities and manage staffing requirements.
  - Confidentiality and privacy protection.
  - Medication. Disaster Psychiatry Outreach is a resource for information on the disorders victims are likely to develop, medications appropriate to dispense on site, and crisis interventions.
- Orient team to procedures and to local resources.
  - Make referral lists available to all staff.
  - Consider using the generic title of ‘counselor’ for all mental health staff to help lessen the avoidance some people have toward the term mental health.
- Walk around the FAC, visiting and talking to people and monitoring how families and how FAC staff and volunteers are holding up over time. Serve as mental health eyes and ears throughout the FAC.
- Guide family members to private rooms for counseling—re: spectrum of normal grief reactions, crisis intervention, mediation, management of ‘at-risk family members, child/adolescent counseling, family counseling, consultation services, and referrals for longer-term follow-up counseling as needed.
- Provide mental health services/consultation in child care center as needed.
- Make PFA handouts for survivors and educational materials on the grief process, how to answer children’s questions about the tragedy, etc., available for distribution throughout the FAC.
- Monitor the information received at family briefings, particularly the numbers of positive identifications.
- Assist with antemortem interviews and death notifications as needed.
- Provide behavioral health assessments and appropriate interventions for callers to the call center as needed.
- Attend all special events (e.g., incident site visits) to monitor behavioral health reactions during activities.
- *Provide mental health services for the FAC staff and volunteers* and direct staff and volunteers to additional counseling resources as needed.

This is a significant role for the team. A crisis situation is an intense experience for those involved in the response effort—physically, emotionally and psychologically. Research shows that the closer an individual works with traumatized victims, the more likely he or she will experience secondary trauma. Emotional and spiritual support can help minimize the vicarious trauma impact on personnel who are directly supporting victims.
- Work closely with the chaplains to maximize assets and minimize functional overlap.
- Provide consultation to FAC leadership and leaders of other teams.

## First Aid/Medication

The medical aid station's purpose is to:

- Provide immediate emergency medical evaluation and stabilizing care to family members and FAC staff and volunteers.
- Serve as a liaison with medical service providers in the event of a medical emergency.
- Assist family members by providing general support and comfort.

The staff will consist of doctors, nurses, and technicians and is ideally stationed near mental health and spiritual care services.

*The FAC medical area for the Oklahoma City bombing had eight beds and was staffed by registered nurses, paramedics and doctors.*

### First Aid/Medication Guidelines

- Establish first aid/medication procedures.
  - Including access to pharmaceuticals.
- Position throughout the facility during family briefings and other events when large numbers of families are gathered for activities.
- Provide first aid/medication as needed.
- Arrange for transport to hospital as needed.

## Translation and Interpretation Services

The purpose of translation and interpretation services is to:

- provide translation and interpretation services in individual and family meetings and during family briefings and
- to translate FAC materials and antemortem records as needed.

### Translation/Interpretation Services Guidelines

- Establish translation and interpretation services guidelines and procedures.
- Be available to all families and all agencies and staff/volunteers during all hours of operation.  
Assist with translation for:
  - Services for families.
  - Written materials that are available for families.
  - Translation of dental and medical records from other countries.

*At the 9/11 New York City Pier 94 FAC, 35-75 volunteer translators worked 8-12 hours shifts and were kept busy all of time.*

## Child Care

The purpose of child care is to provide a safe and secure environment for FAC families' children during main FAC operating hours. The primary goal is to establish a friendly and healthy setting for short-term care while providing some respite for parents as they deal with a very difficult, challenging situation.

Services include:

- Providing activities and caring support for children.
- Providing structure, comfort and acknowledgement to minimize the impact of traumatic stress and to meet children's unique needs.
- Providing information and referral for families who need more extensive child care after FAC hours.

*The Pentagon FAC cared for 140 different children, aged 2 months to 21 years (including youth with special needs) from 66 families. On average, the staff cared for 21 children per day.*

*Operating hours were:*

*8:00 a.m. to 8:00 p.m. daily (in initial phase)*

*8:00 a.m. to 5:00 p.m. daily (later when the intensity of the operation decreases).*

*Hours were adjusted for special events.*

It is recommended that only licensed child care providers be used to provide these services.

### Child Care Center Guidelines

- Establish child care center procedures.
  - Whether or not parents/guardians must be on site at FAC when their children are in child care.
  - How security will be ensured, e.g., take a Polaroid photo of each child and his/her parent when the child is brought to child care. Check the photo and/or identification prior to releasing child.
  - Evacuation plan.
- Make sure room(s) is child safe based on the state's recommendations for child care operations.
- Set up the room(s) daily:
  - Organize play areas with toys accessible to children.
  - Set up bathroom and diaper changing areas.
  - Arrange for snacks, juice, and meals.
  - If a television is available, only use it for tapes and DVDs—not for general TV programs to avoid news broadcasts.
- Orient new staff:
  - Review safety standards.
  - Review hygiene standards for diapering and toileting.
  - Review sign-in and sign-out procedures.
  - Provide information available on dealing with children's grief/disaster response, number to call if help is needed, evacuation plan, etc.
- Brief staff at the beginning of each shift.

- Sign-in (parent/guardian's name, child's name and age, time in).
  - Get any special instructions from parents, such as food allergies, medication, approximate time of return and planned location(s) in the building in case parents must be notified if their child is experiencing distress and since they have primary responsibility for evacuating their child(ren) in case of emergency.
- Engage children in age-appropriate activities/provide care.
- Coordinate/monitor special needs of children and coordinate activities to meet those needs (art therapy, trained therapy dogs, child psychiatrists, social workers, etc.).
- Communicate with parents/guardians to pass on appropriate information on activities and issues.
- Sign-out (parent/guardian check Polaroid photo of parent and child/show identification as needed, signs name and time out).
- Daily closing procedures:
  - Ensure that all children have been accounted for.
  - Prepare a daily shift report.
  - Disinfect toys—especially those that children put in their mouths. Place in a sink or tub and spray with bleach solution, rinse, and air dry.
  - Organize room and leave any special instructions for opening—sweeping, replacement of towels, etc.
  - Return key to the FAC Officer in Charge.

## **Food Service**

Food for families and for staff is required. The purpose of food services is to provide three high quality meals daily and make snacks and drinks available during all hours of operation.

### **Guidelines for Food Services for Families and Staff**

- Arrange for two dining areas—one for families and staff and one for staff only (for when staff want private time/time to regroup).
- Provide food (catered, made on premises, food vouchers for the hotel restaurant if the FAC is in a hotel).
  - Three high quality meals daily.
  - Beverages and snacks during all FAC hours of operation.
- Spiritual Care counselors and mental health counselors should be available throughout the hours of operation in both dining rooms and in snack/beverage areas.

## **Support Ideas and Activities Families Will Appreciate**

At the Pentagon Family Assistance Center (PFAC), families identified the following things as valued support in addition to the many available services:

- Memorial Table.
- America’s Heroes Board.
- Pentagon (Incident) Site Visits.
- Families Connecting with Other Families.
- Pentagon Remnant Vials.

These supportive measures can easily be modified for replication during other mass fatality incidents.

<b><i>Examples of PFAC Support Ideas and Activities Families Appreciated</i></b>
<p><b><i>Memorial Table</i></b></p> <p><i>The memorial table lined one side of the family briefing room. It provided space for families to place mementos, photos, and letters honoring their loved ones. The memorial table became a powerful and emotional area where family members, visitors, staff, and volunteers solemnly and reverently read the touching letters and viewed the photos of victims.</i></p>
<p><b><i>Heroes Board</i></b></p> <p><i>The graphics specialists produced a special board that was displayed at the front of the family briefing room. The display was lined with laminated photographs and biographies of the victims that had been published in The Washington Post. New biographies were added daily as they were printed in the paper. The biographies provided a more personal description of the victims than a standard obituary. The American Heroes Board became a place where families, staff, and volunteers would frequently gather to read about the lives of those who had perished.</i></p>
<p><b><i>Incident Site Diagrams and Charts</i></b></p> <p><i>A number of family members had a need to know where their loved one was in the Pentagon or in the aircraft at the time of the attack and how the attack site was changing over time. In response, graphics specialists developed graphic displays of the affected Pentagon offices and seating diagrams of Flight 77. To a number of families, seeing where their loved one was at the time of the attack helped them better understand and process what happened. As the recovery process progressed, families were kept updated on the status of the operation and diagrams were used to show the progress of the efforts at the attack site. These charts and diagrams proved to be a powerful way to communicate information to families.</i></p>
<p><b><i>Incident Site Visits</i></b></p> <p><i>Family members asked to view the site where their loved ones died. This was originally discouraged, but when it became clear how important this was to the families, necessary arrangements were made for visits. FAC staff conducted the first site visit, which occurred the weekend after the attack. Family members were escorted to the site on buses. A mental health counselor and chaplain were assigned to each bus. Medical personnel and therapy dog teams were on-site to provide additional support. The</i></p>

***Examples of PFAC Support Ideas and Activities Families Appreciated***

*viewing site was 100 yards from the actual attack site, since recovery work was still being done. FAC staff arranged for a table at the site where families could leave flowers (provided by the FAC) and other mementos of their loved one. A viewing platform was erected for families to see the site from an elevated position. Families were also briefed on the attack, using diagrams and charts to explain what happened. Families were allowed to stay at the site as long as they wished. Blankets were provided as days got colder. Several more visits were arranged. The final set of visits allowed families to get closer to the attack site since the recovery phase had been completed. Going to the actual location where loved ones died proved to be a significant part of the grieving process.*

***Families Connecting with Other Families***

*Families were very interested in meeting colleagues of loved ones and wanted to connect with others families experiencing a similar loss. Locations in the family briefing room were designated for families to gather and meet. This provided interested families with opportunities to share information, develop relationships, and form support groups.*

***Incident Remnant Vials***

*Many family members requested remnants from the attack site. Remnants were obtained, placed in vials and put in small wooden boxes (designed specifically for this purpose, they were produced and donated by a wood carver). The FAC managed distribution to ensure that every family received one. FAC staff stressed that the vials contained rubble from the site, free of human remains and toxic materials, and were not to be considered as the partial remains of loved ones. To the families, the vials were reminders of where their loved ones had perished.*

***Special Support Activities***

*On September 24, a large number of families attended a special Kennedy Center concert hosted by the First Lady. The concert was a special tribute to those who were lost or missing, family members, and survivors. Although family members did not request this, this event and others like it provided a brief reprieve for families.*

***Memorial Service and Support***

*One month after the event, a memorial service was held. It appeared to serve as an important milestone in the families' grieving process. After the memorial service, many families began returning to work, reconnecting to their communities, and resuming their lives.*

*Some families preferred not to go to the Pentagon for the service. To meet their needs a live satellite dish was positioned to broadcast the event via satellite to the family briefing room so family members, staff, volunteers, and hotel personnel could watch the event. The decision to have a dedicated satellite dish allowed the FAC staff sufficient time to coordinate the logistics for the transmission and avoid the risk of*

### ***Examples of PFAC Support Ideas and Activities Families Appreciated***

*complications that could result from a last minute link-up with a public broadcast network.*

*Children at the child care center who were eight years old or older and had their parent's/guardian's permission, were brought to the family briefing room to view the service. Professional staff were on hand to support any issues the children or family members had. The FAC staff also made arrangements to provide all families with a video tape of the memorial service.*

### **Additional FAC Services**

Following a large-scale event, family assistance typically involves a range of services provided by local, state, and federal agencies as well as nonprofit and private organizations. The additional family assistance center services needed will depend on the nature of the incident and on the victim population. Examples of these services—in alphabetical order—include:

- Benefits Counseling and Assistance.
- Financial Assistance.
- Financial Planning.
- Laundry Services.
- Legal Assistance.
- Physical Health Services.
- Salvation Army Services.
- Therapy Dogs International Services.
- US Department of Justice Office of Victims of Crime and State Victim Assistance and Compensation Program.
- US Department of State Services.
- US Department of Veterans Affairs Services.
- US Federal Bureau of Investigation Victim Witness Assistance Program.
- US Federal Emergency management Agency Services.
- US Social Security Administration Benefits Assistance.
- Web Search/Lead Investigation Center to manage large numbers of missing persons that are not presumed dead.

If the victim population includes members of the armed services or government employees, there are many services available that can be accessed for victim families. If the victim population is predominantly comprised of employees of a large corporation, it is also likely that the impacted corporation will be actively involved in the family assistance center.

The many additional services that provide on-site services at the FAC will need to:

- Appoint a Team Leader.
- Establish procedures for operation.
- Maintain data on the numbers of families/family members served.

Each of these additional service categories is described in a table in the *Logistics* section under *FAC Required Staffing*.

## FAC Logistics

The FAC logistics requirements are extensive. This section outlines the general requirements for:

- Staffing
- Communications and information systems
- Equipment and supplies
- Facility requirements.



You will have to make decisions in your planning process to complete your logistics planning. The information below can be modified for your jurisdiction. You will need to complete columns for alternate sources/resources to include resources that are available in your jurisdiction and contact information. The exact number of resources required will depend on the nature of the incident and can only be determined at the time of the incident.



### Procedures For Managing Logistics/Support Requirements

The FAC Logistics Officer will identify FAC service and support needs and will work closely with Emergency Operations Center Logistics and the Staff and Volunteer Processing Center to procure and allocate service and support needs. The FAC Logistics Officer will also work closely with FAC administrative staff to track and maintain required documentation for supplies, equipment and personnel.

### Step 6: Describe staffing requirements.

A core staff from the FAC managing agency and from the local ME/C Office will be important to ensuring continuity for families. Involving additional agencies with experience in providing family assistance for mass fatalities is strongly recommended. The remainder of the FAC staff will be a largely volunteer staff from multiple agencies and organizations.

### Guidelines for Staffing the FAC

Information on agencies with expertise in mass fatality family assistance is followed by FAC lead organization and tables for staffing requirements and for additional services/resources.

## Agencies with Expertise in Mass Fatality Family Assistance

Examples of agencies that have experience in managing a family assistance center include the American Red Cross and the DMORT Family Assistance Center Team.

### *American Red Cross*

American Red Cross (ARC) involvement is activated by contacting the local Red Cross chapter. Local chapter paid and volunteer staff provide the initial response in the form of a Disaster Action Team (DAT). In larger incidents, the DAT may conduct an initial assessment and alert the chapter of the need for a Disaster Relief Operation (DRO). If the disaster is deemed to be beyond local capacity, the local chapter will contact the Red Cross state lead chapter for assistance. If the state lead chapter determines that an incident requires resources beyond the Red Cross resources of the entire state, the state lead unit requests assistance from the Red Cross National Disaster Operations Center (DOC), which will then bring to bear Red Cross resources from across the nation.

The American Red Cross Disaster Services functions and activities that may be available as part of a mass fatality response include:

- Assistance in setting up the FAC and in escorting family members to the site.
- Administration— coordinate and ensure appropriate performance of the Red Cross functions, including effective communication with other agencies, ARC headquarters, daily activity reports, staffing, equipment and supply requests.
- Immediate Emergency Assistance To Families—provide money for travel and transportation, food, clothing, shelter, and funeral costs.
- Hotline to provide immediate access to national and community-based resources, ranging from grief counseling to how to answer questions from children related to the tragedy.
- Disaster Mental Health Services—provide mental health services to families and staff at the FAC.
- Spiritual Care—provide spiritual care services and reach across faith group boundaries without proselytizing. Work in coordination with mental health counselors to protect family members from being confronted by unwelcome forms of spiritual intrusion. Provide supportive spiritual care through empathic listening, demonstrating an understanding of persons in spiritual and emotional distress.
- Child care—ensure that children at the FAC are provided a safe and secure environment to play while their families are at the FAC. Provide structure, comfort, and acknowledgement to meet the unique needs of children immediately following a disaster and to minimize the impact of traumatic stress.
- Interpretation and Translation Services—staff the FAC and be available to clients, agencies and personnel during the hours of operation.
- Supervision and management of staff and family dining areas.
- Provide food for staff and volunteers.
- Public Affairs—provide appropriate information to the media outside the FAC and work with mental health services to prepare family members who wish to address the media.

- Logistics—support the physical management of ARC activity at the FAC and act as a liaison with the FAC Logistics Officer and/or facility landlord to address facility requirements and daily supply needs.
- Coordination of therapy dogs.
- Family Gift Program, a cash grant program to assist with living expenses for up to one year while long-term recovery issues are being addressed.

### ***DMORT Family Assistance Center Team***

DMORT assistance is accessed in California through the California Coroner Mutual Aid process. The DMORT Family Assistance Center Team (FACT), working under the local ME/C, can:

- Provide guidance in setting up the FAC.
- Collect antemortem data, including the collection of DNA reference samples.
- Provide information to next of kin.
- Assist the ME/C with death notifications.

The expertise of organizations such as the American Red Cross and the DMORT FACT will improve response time in activating a joint family assistance center, minimize management and training issues, and enhance operational capability.

### **FAC Local Organization**

To the extent possible, staffing and training requirements should be planned in advance to avoid confusion. Government and nonprofit organizations are ideally the primary providers of FAC services. Some commercial businesses may also become involved.

It is recommended that service providing organizations and commercial businesses be carefully screened and approved by the appropriate legal policy and general counsel officials prior to being integrated into the operation.

### **Family Assistance Center Staffing Requirements**

A family assistance staff table and a table for additional FAC services are provided to assist your planning.

The family assistance staff table presents the beginning of the process to identify the types of personnel and the alternate staff/potential resources for these staff positions. Continue to fill-in the Alternate Staff/Resources column based on what is appropriate for your jurisdiction.

The quantity or number of staff needed will be determined at the time of the incident, based on its complexity and the estimated number of potential victims.

When determining the number of staff required, *plan for eight to 10 family members/loved ones for each missing or deceased disaster victim.*

<b>Family Assistance Staff</b>		
<b>Staff</b>	<b>Quantity</b>	<b>Alternate Staff/Resources</b>
<b>JFAC Management Staff</b>		
FAC Officer in Charge		Agency in Charge
Deputy Officer in Charge		Agency in Charge
Family Assistance ME/C Officer in Charge		Local ME/C Office
FAC Logistics Officer		
Logistics Team		
Administration Officer		
Legal Advisor (to research and resolve complex legal issues raised by staff and families)		
<b>FAC Administration/Finance Team</b>		
Administration Manager		
Shift Supervisor		
Finance Staff		
Runners		
Administrative/Clerical Staff		
Data Entry Staff		
Graphics Specialists		
Personnel/Interagency Coordination Manager		
Shift supervisor		
2-3 phone/receptionists		
Trainers		
Information & Communications Systems Technical Support Manager		
Tech Support Staff		
<b>Family Briefings Team</b>		
Team Leader		Local ME/C Office, DMORT FACT
Coroner Investigators		
Admin Support Staff		
<b>Antemortem Data Collection Team</b>		
Team Leader		
Shift Supervisors		
Coroner Investigators		DMORT FACT, law enforcement

<b>Family Assistance Staff</b>		
<b>Staff</b>	<b>Quantity</b>	<b>Alternate Staff/Resources</b>
		agents, funeral service personnel
DNA Specialists/Genetic Counselors		
Clinical Staff for blood draws (DNA collection)		
Data Entry Clerks		
<b>Death Notification Team</b>		
Team Leader		
Coroner Investigators		Experienced death investigators, funeral directors
Admin/Support Staff		
<b>Call Center Team</b>		
Team Leader/Lead Supervisor		Local hotline staff, Red Cross
Shift Supervisors		
Phone Operators		
Data Entry Staff		
<b>Reception &amp; Information Desk Team</b>		
Team Leader		
Shift Supervisors		
Intake Specialists		
Escorts (may be helpful if they have counseling training)		Red Cross, Salvation Army
<b>Spiritual Care Team</b>		
Team Leader		Public Safety Chaplains, Faith-based Disaster Relief Services (e.g., Lutheran, Baptist, Methodist, Muslim, Assembly of God, etc.), Tzu Chi Foundation, local Council of Churches, local churches
Shift Supervisors		
Chaplains		
Chaplain Assistants		
<b>Mental Health Services Team</b>		
Team Leader		Mental Health Department and approved contractors, Drug and
Shift Supervisors		
Mental Health Professionals		Alcohol Department and approved contractors, National Association of Social Workers, State Association of
Administrative Assistants		

<b>Family Assistance Staff</b>		
<b>Staff</b>	<b>Quantity</b>	<b>Alternate Staff/Resources</b>
		Marriage and Family Therapists, State Psychological Association, Disaster Psychiatry Outreach, American Red Cross Disaster Mental Health Services
<b>First Aid/Medication Team</b>		
Team Leader		Jurisdiction Health & Hospital Agency, Public Health Department,
Doctors		Medical Volunteers for Disaster Response, Occupational Health & Safety Agency, Federal Disaster Medical Assistance Teams, State Disaster Medical Assistance Teams, American Red Cross
Nurses		
Paramedics		
<b>Translation/Interpretation Services Team</b>		
Team Leader		Local CBOs serving non-English speaking populations, Social Services Agency, local Consulate and Embassy representatives, US Department of State
Translators/Interpreters		
<b>Child Care Team</b>		
Team Leader/Lead Supervisor		Church of the Brethren (MOU with Red Cross), Save the Children, Local Recreation Department
2 Staff caregivers (minimum)		
Use standard staff/child ratios		
<b>Food Services Team</b>		
Team Leader		Red Cross, Salvation Army, & Jurisdiction's Department of Corrections, State Restaurant Association
Assistants		
<b>Additional Services Teams</b>		
To be determined		Determined based on required teams

This table does not include the American Red Cross or DMORT FACT, which were described at the beginning of the staff section and included in the required staff table above.

<b>Additional FAC Services</b>	
<b>Additional FAC Service Categories</b>	<b>FAC Resources—Agencies &amp; Contact Information</b>
<p><b><i>Benefits Counseling and Assistance</i></b></p> <ul style="list-style-type: none"> <li>▪ Assists with death claim benefits, victims’ unpaid compensation, Workers’ Compensation Program employee injury and death claims, death gratuities, and medical, disability and/or life insurance benefits, settlements, and claims.</li> <li>▪ Coordinates the wide range of servicing organizations to facilitate how to access all available financial benefits to which families may be eligible and the processing of payments to families.</li> </ul>	
<p><b><i>Financial Assistance Services</i></b></p> <ul style="list-style-type: none"> <li>▪ Assists families with donations, cash assistance, food stamps, and other benefits as needed.</li> </ul>	
<p><b><i>Financial Planning Services</i></b></p> <ul style="list-style-type: none"> <li>▪ Advises on banking issues, payment of bills, and budget and cash flow management.</li> <li>▪ Advises on organization of family finances.</li> <li>▪ Advises on savings options and stocks versus bonds or certificates of deposit for short-term resources.</li> <li>▪ Advises on analysis of future investments.</li> <li>▪ Advises on annuities and insurance policy information.</li> <li>▪ Advises on working with other professionals, such as accountants, attorneys and insurance professionals.</li> </ul>	
<p><b><i>Laundry Services</i></b></p> <ul style="list-style-type: none"> <li>▪ Washers and dryers for facility needs. May also be needed for families.</li> <li>▪ Laundry service.</li> </ul>	
<p><b><i>Legal Assistance</i></b></p> <ul style="list-style-type: none"> <li>▪ Meets with each family to ascertain relevant facts concerning legal issues and provides consultation on issues such as: <ul style="list-style-type: none"> <li>○ Securing victim’s automobile(s), housing and personal</li> </ul> </li> </ul>	

<b>Additional FAC Services</b>	
<b>Additional FAC Service Categories</b>	<b>FAC Resources—Agencies &amp; Contact Information</b>
<ul style="list-style-type: none"> <li>effects;</li> <li>○ Accessing victim’s single-holder bank and brokerage accounts;</li> <li>○ Creditor matters;</li> <li>○ Identity theft;</li> <li>○ Child custody;</li> <li>○ Media relations;</li> <li>○ Estate administration; and</li> <li>○ Probate issues.</li> <li>▪ Advises on how to respond to and evaluate solicitations for representation in possible mass casualty tort claims.</li> </ul>	
<p><b><i>Physical Health Services</i></b></p> <ul style="list-style-type: none"> <li>▪ Massage.</li> <li>▪ Chiropractic treatment.</li> </ul>	
<p><b><i>Salvation Army Services</i></b></p> <ul style="list-style-type: none"> <li>▪ Has disaster response teams. Typical focus is on aiding emergency response workers.</li> <li>▪ Provides grief counseling at FAC.</li> <li>▪ Willing to assist in the FAC in any way needed, e.g., warmly greeting families and attending to their needs.</li> </ul>	
<p><b><i>Therapy Dogs International Services</i></b></p> <ul style="list-style-type: none"> <li>▪ Specially trained therapy dogs and qualified handlers to support the FAC mission.</li> <li>▪ The dog teams help comfort families and provide companionship during FAC visits. <ul style="list-style-type: none"> <li>○ Dogs are available for petting and hugging, providing unconditional acceptance and affection. <ul style="list-style-type: none"> <li>▪ They provide a great deal of comfort to the children in the child care center.</li> </ul> </li> <li>○ Handlers assist FAC by defusing the stress so that all can enjoy a few moments of focusing on matters other than those associated with the tragedy.</li> </ul> </li> </ul>	

<b>Additional FAC Services</b>	
<b>Additional FAC Service Categories</b>	<b>FAC Resources—Agencies &amp; Contact Information</b>
<p><b><i>US Department of Justice Office of Victims of Crime and State Victim Assistance and Compensation Programs</i></b> (if the mass fatality is related to a criminal act)</p> <ul style="list-style-type: none"> <li>▪ Provides a representative to the family assistance management team to coordinate with other members on DOJ-related issues.</li> <li>▪ Provides information to victims’ family members, on-site and off-site, as required under the Victims of Crime Act of 1984, the Victim and Witness Protection Act of 1982 as amended, other relevant statutes, and the 1995 Attorney General Guidelines for Victim Assistance.</li> <li>▪ Assists the FAC with additional trained and experienced crisis counselors through the Office for Victims of Crimes Community Response Program.</li> <li>▪ Provides updates to victims’ family members on the progress of the criminal investigation.</li> </ul>	
<p><b><i>US Department of State Services</i></b></p> <ul style="list-style-type: none"> <li>▪ Official notification of foreign governments that have citizens involved in the mass fatality.</li> <li>▪ Assistance with notifying and obtaining antemortem information from families of victims living in other countries.</li> <li>▪ Maintenance of daily contact with foreign families that do not travel to the United States.</li> <li>▪ Assistance with entry into the United States and to extend or grant visas for families of foreign victims.</li> <li>▪ Assistance in the effort to provide the ME/C with the necessary information on foreign victims to complete death certificates.</li> <li>▪ Facilitation of necessary consulate and customs services for the return of remains and personal effects to the victim’s country.</li> </ul>	
<p><b><i>US Department of Veterans Affairs</i></b></p> <ul style="list-style-type: none"> <li>▪ Claims Processing.</li> <li>▪ Toll-Free Telephone Service.</li> <li>▪ Web Page.</li> </ul>	

<b>Additional FAC Services</b>	
<b>Additional FAC Service Categories</b>	<b>FAC Resources—Agencies &amp; Contact Information</b>
<p><b><i>US Federal Bureau of Investigation Victim Witness Assistance Program</i></b> (if the mass fatality is related to a criminal act)</p> <ul style="list-style-type: none"> <li>▪ Notifies victims of their rights as a Federal crime victim.</li> <li>▪ Provides information on the FBI’s criminal investigation through a victim notification system, if the victim chooses to be notified.</li> </ul>	
<p><b><i>US Federal Emergency Management Agency Services</i></b></p> <ul style="list-style-type: none"> <li>▪ Helps families apply for assistance through other agencies.</li> <li>▪ Offers limited assistance in the areas of crisis counseling, mortgage and rental assistance, and unpaid funeral expenses.</li> <li>▪ Helps with financial assistance to cover lost wages, loss of support, and uncovered or uninsured medical treatment.</li> </ul>	
<p><b><i>US Social Security Administration Benefits Assistance</i></b></p> <ul style="list-style-type: none"> <li>▪ Provides families with information on eligibility requirements for benefits. <ul style="list-style-type: none"> <li>○ Survivor benefits for an eligible widow or widower age 60 or older, 50 or older if disabled, and any age if caring for a child under the age of 16.</li> <li>○ Survivor benefits for children under age 16 or unmarried and under age 19, but still in high school.</li> <li>○ Survivor benefits for disabled adult children.</li> <li>○ Survivor benefits for parents, if the worker was the primary means of support.</li> <li>○ A special one-time payment of \$255 to the worker’s surviving spouse or minor children.</li> </ul> </li> <li>▪ Helps families file claims for earned Social Security, disability benefits , and disbursed death benefits without a death certificate.</li> </ul>	
<p><b><i>Web Search/Lead Investigation Center</i></b></p> <p>A Web Search/Lead Investigation Center will be needed if the mass fatality involves large numbers of missing persons who are not presumed injured or dead (e.g., Hurricane Katrina). The purpose of the Web Search/Lead Investigation Center is:</p>	

<b>Additional FAC Services</b>	
<b>Additional FAC Service Categories</b>	<b>FAC Resources—Agencies &amp; Contact Information</b>
<ul style="list-style-type: none"> <li>▪ To perform searches for missing persons using numerous resources—mounting sophisticated Internet searches, making calls, and doing mailings. Finding missing persons who are alive allows the ME/C to focus the human remains identification process on those who are truly missing.</li> <li>▪ To follow the wishes of the individual found concerning reunification with family and notifications made to family or friends.</li> <li>▪ To assist in locating relatives for DNA samples and for information essential to making positive identifications of human remains.</li> </ul> <p>If a Web Search/Lead Investigation Center is required, involve stakeholder agencies as early as possible. This includes the State Police, National Center for Missing and Exploited Children, and the National Center for Missing Adults. They have the greatest expertise in finding missing persons and have access to databases that are not accessible by the public. These are also the agencies to which this function will be transitioned when the FAC closes.</p>	

## Step 7: Describe communication and information systems requirements.

The FAC will need communications and information systems.

### Guidelines for Determining Communications and Information Systems Requirements

The Information Systems and Communications Guidelines under Administration earlier in this section will assist in determining information systems and communications systems requirements.

The FAC will need communication and information systems. Plan to:

- Develop a comprehensive strategy for establishing lines of communication and managing information flow and for meeting information systems needs.
- Consult with ME/C to determine mass fatality software that will be used (e.g., DMORT VIP, WIN ID, and/or local ME/C Office software) to collect antemortem data.  
Note: See *Mass Fatality Information Systems* section of this toolkit.
- Train personnel in use of equipment and software as needed.
- Implement safeguards and regulate access to information to ensure integrity of sensitive victim and victim family data.
- Have alternate backup systems in case there are problems with main communication lines, Web-based or area networks, electronic database systems, etc., or they are not available.

#### Planning considerations:

- Establish key points of contact and phone lists of staff and of responding organizations and agencies.
- Identify the methods of communication to be used and how they will be integrated into management and service delivery functions.
- Assess the necessary capabilities for contracting telephone system services (dedicated toll-free lines with branching capability), including publicizing phone numbers.
  - For call center phones, seek telephone contract service that includes the capacity to roll calls over and expand telephone lines during peak hours. Request telephone company monitoring of the number of incoming calls, quantity of calls answered, number of calls not answered, the length of time of calls, and the total number of calls per hours. This is important to managing staffing requirements, assess training needs, and identifying technical problems with equipment and making appropriate adjustments to call center operations.
- Identify communication needs of families:
  - Computer with Internet/e-mail access.
  - Calling cards and/or banks of free long distance telephones.
  - Cellular telephones.

- Determine what information is essential to support the operation.
- Establish an information management system that provides standard and centralized processes and procedures for collecting, processing, retrieving, controlling, and reporting information.
- Identify existing information management systems and technologies within the agency/organization or those used in crisis response organizations.  
Note: selection of software for antemortem data collection is the ME/C decision.
- Establish a comprehensive victim assistance program database for tracking contact information, services available and services delivered. (For example, New York City’s family assistance center used a network, Web-based approach for managing all their computer systems so that family services and interactions were recorded in one centralized database.)
- Implement safeguards and regulate access to information to ensure integrity of sensitive victim and victim family data.
- Develop pre-formatted templates for forms and databases.
- Identify critical information for after action reports, records preservation, and historical documentation of the operation.
- Produce diagrams, displays and signage to communicate important information and manage traffic flow.

## **Step 8: Describe equipment and supply requirements.**

The equipment and supply requirements for family assistance are not normally part of ME/C Office inventory.

### **Guidelines for FAC Equipment and Supplies**

The DMORT Disaster Portable Morgue Unit (DPMU) is a packaged system that contains computers and related equipment to support the family assistance center management of antemortem information.

The following table is a Family Assistance Center Equipment/Materials List. Complete the Sources column by filling in sources that are appropriate for your jurisdiction. You can also determine a baseline quantity as part of your planning. Then, in the event of a mass fatality, refine the numbers based on the nature of the incident and the potential number of victims and missing persons.

See *Mass Fatality Information Systems* section of this toolkit for information re: antemortem data collection requirements.

Plan to add to the supplies and equipment list based on FAC Team Leader input.

<b>Family Assistance Center (FAC) Equipment/Materials List</b>			
✓	Item	Quantity	Source
	Bulletin board(s)		
	Burn bags and shredders		
	Cell phones (with chargers)		
	Chairs/tables		
	Child Care Center (first aid kit; toys, cribs, cots, linens, blankets, pillows & furniture to enhance children's comfort and sense of safety; diaper changing supplies)		
	Computers (PCs/laptops) at each team station and for families		
	Computer connectivity (e-mail, internet, modems, etc.)		
	Copy (high speed) machine(s)		
	Crates, boxes for files		
	DNA Collection Materials		
	Fax machines		
	Flashlights and batteries		
	General comfort item packages		
	Maps (local area, facility diagrams, etc.)		
	Microphone, podium & audiovisual (Family Briefing Room)		
	Nametags/badges		
	Office supplies (paper, binders, steno pads, log books, print cartridges, pencils, etc.)		
	Pagers		
	Parking passes		
	Pertinent Instructions/Directives/Forms		
	Radio (portable)		
	Signs		
	Snacks, beverages, meal passes		
	Telephone lines into the FAC (including toll-free) and head phones		
	Telephone lines, public		
	Telephone books, directories (local)		
	Transportation vehicles		
	Trash bags		
	Trash receptacles		
	TV/Cable connections (Management, Call Center, Family Area)		
	TV/VCR combination (Child Care Center, Family Briefing Room)		

## Step 9: Describe facility requirements.

The family assistance center is the site where family members and friends of potential disaster victims will gather to receive information about the recovery process, provide information about their missing loved ones, receive death notifications, and receive services to meet their needs.

### Guidelines for an FAC Facility

It is imperative to open a center as soon as possible (less than 24 hours) with basic family reception services. It may be easier to select a site that will meet all family assistance needs in the long-term rather than begin with a smaller reception center and then move to an established family assistance center. However, how family assistance is managed will depend on the incident, extent of pre-planning, the resources at hand, and your jurisdiction's decisions regarding how family assistance will be provided.

*As a rule of thumb, anticipate eight to 10 family members per potential victim.*

There will be more options for a family assistance center for smaller mass fatalities. Site selection for a large-scale mass fatality may be more difficult. Consider pre-identifying potential facilities in different geographical areas in your jurisdiction. A jurisdiction may also want to consider some form of memorandum of understanding or contract that could be activated in the event of a mass fatality.

Possible locations for a family assistance center are a hotel, convention center, college, or community center. In rural areas, tents may be used. A neutral, nonreligious site is preferred because some families may be uncomfortable coming to a religious structure.

A professional logistics/events company can be called in to set up the FAC.

*New York City's Pier 94 facility (9/11/2001 World Trade Center incident) was set up by a professional logistics/events management company in the style of a "pole and drape" trade show. Pier 94 had ~40,000 square feet. Two additional piers that were adjacent to the FAC were used for various government temporary office sites.*

### Site Selection Considerations

The type of mass fatality incident and the number of fatalities and persons needing assistance will affect site selection. Location and functional capability are important when determining the site.

### ***Incident Characteristics***

There may be specifics of the incident that will determine site selection that will only be recognized at the time of the incident.

### ***Availability—Immediate and Long-Term***

Immediate, with flexible, long-term availability is needed.

### ***Location in Relation to the Incident Site and the Morgue***

Close enough to the site to allow the ME/C and others to travel easily between the incident site, morgue and FAC, but far enough from the site that families are not continually exposed to the scene and to prevent sensory input (sights, sounds, and smells).

### ***Adequate Size to Meet the Needs of Anticipated Number of Families***

The FAC facility size should not be underestimated. Enough floor space is needed to conduct the many FAC functions. Sufficient space for expanding the operation as family needs evolve is required. Remember, anticipate eight to 10 family members per potential victim. And then add staff.

### ***Accessibility***

Easily accessible for victims' families and friends and for staff and volunteers or plan to provide transportation.

### ***Needs of the Participating Agencies***

Different service teams may have different needs regarding their space. The Team Leaders will need to communicate with the FAC Logistics Officer regarding specific team needs for furniture, equipment and supplies.

### ***Need for Overnight Facilities***

If the incident is not a local event, access to overnight facilities will be critical.

### ***Need for Transportation Services***

If location is difficult to access by public transportation and/or there are parking limitations, transportation services will be necessary.

## **Security Requirements**

FAC security will need to be arranged. Access to the FAC must be controlled so that families and friends of the victims have privacy and are not overwhelmed by the press, photographers, and the public.

Security needs include:

- site security (external and internal with some officers in plain clothes),
- parking lot(s),

- security around the perimeter, and
- traffic control.

If there will be more than one FAC site, security will be needed at all sites.

Recommendation: have a law enforcement representative on the FAC site selection team to assess potential security issues when the site is being selected.

### **Basic Infrastructure Needs**

When identifying potential facilities and their infrastructure capabilities, it is also important to determine and understand capacity. Base capacity requirements on the expectation of 8-10 family members for each potential victim plus the FAC staffing requirements. Understanding the limits of a facility will lead to more effective facility selection, planning and setup.

- Electrical Power
- Multiple Land Lines (telephones) and Cellular Telephone Reception
- Internet Service
- Controlled Heat/Air Conditioning (depending on climate)
- Hot and Cold Running Water
- Multiple Rest Rooms (allowing for separate areas for families and staff)
- Sewage
- Food Service Capability
- Adequate Parking
- Security Provisions (controlled access with perimeter for privacy from media and intruders)
- Accommodations for Disabled Family Members/Staff
- Screening (from view of the media).

### **Space and Floor Plan Requirements for FAC Functions**

The floor plan must accommodate simultaneous and effective performance of many services for the families and friends of victims. The space must be large enough to accommodate needed services.

#### ***Separate Entrances for Staff and for Families***

The entrance for families should allow protection of family privacy and be away from media access.

The separate entrance for staff is important so that staff can check-in, be briefed, and receive their assignments before they interact with families.

#### ***Reception and Information Desk***

The reception and information desk area serves as a gatekeeper for the FAC to ensure

that only family members and friends of possible victims and invited guests come to the FAC. FAC staff will greet families, gather basic information, provide information on FAC services, and provide instructions for signing in and out of the FAC. Desks/tables with chairs, phones, and a system for creating photo ID badges for family members and friends will be needed.

### ***Large General Assembly Room with Public Address System***

This room will need to be large enough to accommodate all families and friends (8-10 per potential victim) for the family briefings. It must be able to accommodate a phone that enables families away from the FAC to participate in the family briefings via speaker phone with a toll-free number and facilitate translation services, including sign language, as needed.

In the family briefing room, you may want to consider:

- Signs requesting attendees to turn off pagers and cellular phones during the family briefings to prevent interruptions and help keep the focus on the families.
- Displays with newspaper biographical articles about each victim, obituaries as they appear in the paper, family information needs (diagram of FAC, information on available services, meeting notes from family briefings, etc.).
- A long memorial table(s) where families can place photos and other remembrance items.
- Tables (on the opposite side of the room) with donated gifts, cards and letters of condolence from people and agencies.
- A question and comment box for families to express their needs and make recommendations to the FAC staff. Every comment and question should receive a response, usually from the JFAC OIC.
- Tissue boxes on tables where families enter and exit the room.

### ***Reflection Room***

This is space for families and friends to quietly reflect, meditate, pray, seek spiritual guidance, and observe religious practices. The reflection room must be designed and furnished to respect diverse cultures and beliefs.

### ***Interview Rooms for Antemortem Data Collection/Death Notifications***

These rooms are used by the ME/C Office to collect antemortem information for identification and for death notifications. At least some of the rooms should be large to accommodate large families and a death notification team. They must be quiet and private because these meetings are often emotionally charged and long.

*Suggested Number of ME/C Interview Rooms:*

6 rooms if estimation of decedents and injured is  $\leq 100$ .

12 rooms if estimation of decedents and injured is 101 to 200.

15 rooms if estimation of decedents and injured is  $\geq 201$ .

If hotel rooms are used, replace the bedroom furniture with couches and chairs.

It may be preferable for death notification teams to go to families home rather than require families to come to the FAC. Cars will need to be available for families who prefer to have the death notification team come to their homes.

### ***Counseling/Spiritual Care/Emotional Support Rooms***

Several rooms should be available to provide a private space where families can receive counseling and emotional support from clergy, mental health professionals and grief counselors. These rooms can also be used for family members to spend time together and to use the telephone to contact other relatives and friends.

#### *Suggested Number of Rooms for Counseling/Emotional Support:*

≤ 100 fatalities: 3-5 rooms

101-200 fatalities: 10-12 rooms

≥ 200 fatalities: 15-25 rooms

If hotel rooms are used, replace the bedroom furniture with couches and chairs.

### ***Medical Aid Station***

Family members and friends of victims may require medical attention. An ambulance should be on standby at all times to transport patients to area hospitals if necessary.

This area may be very busy during the first few days.

*The FAC medical area for the Oklahoma City bombing had eight beds and was staffed by registered nurses, paramedics and doctors.*

### ***Call Center***

Requirements for the call center are:

- Quiet area where access can be controlled that is separated from primary FAC activity.
- Dedicated phone lines (toll-free numbers). Telephone contract support services should be established and services should include the capacity to roll calls over and expand telephone lines during peak hours, ability to monitor calls, and the capability to produce reports of call activity.
- Layout: arrange in classroom style with
  - 2 rows of long tables with 5 tables on each side of the room.
  - 1 long table in the front of the room for information materials pertinent to the operation.

### ***Child Care Center***

A child care center is recommended to provide an area for children to be cared for during families' lengthy, emotionally challenging stays at the FAC. Consult local licensing requirements for child care centers.

Suggested requirements based on recent mass fatalities are:

- Secluded area of the facility away from high traffic areas.

- Controlled entrance.
- Easily accessible bathroom facilities.
- Running hot and cold water.
- Area for diaper changing.
- Trash storage.
- Sufficient space to support children’s play and movement, but limit running opportunities.
- Telephone.
- Secondary space should be available to support overflow, separate ages (infants, pre-K/Kindergarten aged, elementary aged, and middle school aged children), and allow for nap time.

Required safety features:

- Ground level (if possible).
- Protection for children against sharp corners.
- Covered electrical outlets.
- Controlled hot water temperature to prevent scalding.
- Toys that are age appropriate.
- Elimination of choking hazards.
- Evacuation directions (parents have responsibility re: evacuation—designate a central meeting point outside).

### ***Command and Control Center and Administrative Offices***

An operations center is necessary to allow the different service groups and organizations to meet—requiring a large meeting room for daily meetings for briefings at the beginning of each shift and for debriefings at the end of each shift. This room can also be used for team trainings.

In addition, administrative offices should be available for:

- all FAC leadership and support staff.
- tech support.
- data entry.
- the different teams including mental health professionals, clergy, and medical examiners.
- all key organizations including the American Red Cross and Salvation Army.

Since these administrative offices will hold files and confidential information generated by the FAC, they must be kept secure.

## ***Associated Tools and Resources***

*Priority Action Checklist for FAC Startup (Pentagon FAC with slight modification)*

## Job Responsibility Checklists

The job responsibility checklists in this toolkit present a general summary of actions. It should be understood that:

- Some required actions may not be listed, but must be identified and assumed by the appropriate position.
- Some actions may be the primary responsibility of a particular position, but may require assistance and coordination from other position(s).
- The actions are listed in a general chronological order, but deviation may be required to meet incident objectives.

The Common Responsibilities Job Checklist presents general actions that pertain to ALL personnel at the FAC. In addition to instructions listed in their respective job responsibility checklists, all personnel are responsible for the Common Responsibilities. The Common Responsibilities Job Checklist is only included with the *Command and Control* section of this toolkit.

The following job responsibility checklists are attached.

- Family Assistance Center Officer in Charge.
- Family Assistance ME/C Officer in Charge.
- FAC Logistics Officer.
- Common Team Leader Responsibilities.

Responsibilities of the:

- Antemortem Group Officer in Charge,
- Data Collection Specialist,
- Notification Specialist, and
- Family Care and Communication Group Officer in Charge

are available in the California Governor's Office of Emergency Services Law Enforcement Branch's *Coroner Mutual Aid, California Coroner Operations Guide* at:

<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. Then click on Coroner's Mutual Aid.

## FAC Forms

- *FAC Daily Status Update* (Modified Pentagon FAC Form)
- *FAC Daily Staff Registration*
- *FAC Family/Friend Registration*
- *FAC Daily Sign In Log*
- *VIP/DMORT* (Victim Identification Profile) *Personal Information Questionnaire*
- *Requested Record List*
- Call Center Form Options:
  - *Call Record And Family Member Contact Form* (a Pentagon FAC form that is scripted for standard call processing and data collection and can be modified as needed)

- *Crisis Call Center Intake Form*
- *Release Authorization*

## Resources:

- *Identifying Victims Using DNA: A Guide for Families*, Appendix G in the National Institute of Justice's *Lessons Learned From 9/11: DNA Identification in Mass Fatality Incidents*, September 2006. The family guide is available in English and Spanish at: <http://www.ncjrs.gov/pdffiles1/nij/214781.pdf>.
- *Pentagon Family Assistance Center Call Center Staff Resource Information and Training Manual* in Appendix C, the *Pentagon Family Assistance Center Operations Component Source Documents*. This is an information and training manual for call center staff. It is available at: <http://www.defenselink.mil/mapcentral/actionrpt.html>.
- *Psychological First Aid, Field Operations Guide 2<sup>nd</sup> Edition* by the National Child Traumatic Stress Network and the National Center for PTSD. Psychological First Aid (PFA) is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and foster short and long-term adaptive functioning. The guide includes:
  - An introduction and overview of PFA.
  - Preparing to deliver PFA.
  - Core actions.
  - PFA Provider Care.
  - Provider worksheets.
  - Handouts for survivors.

PFA is used by mental health specialists including first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizens Corps in diverse settings.

It is available at:

[http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/nc\\_manual\\_psyfirstaid.html](http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/nc_manual_psyfirstaid.html).

- Training by the Palo Alto Medical Reserve Corps for their 3-stage treatment alternative to Critical Incident Stress Debriefing—Phase I: psychological first aid, Phase II: intermediate support/anxiety control, and Phase III: continued support/control or support/control plus prolonged exposure. All three phases are empirically derived therapeutic interventions for acute stress reactions following mass casualty trauma. Contact information for the Palo Alto Medical Reserve Corps is available at: <http://www.paloaltomrc.org/Home/tabid/37/Default.aspx>.

# Public Communications

Effective public communication is an essential component of mass fatality management. In the aftermath of a mass fatality, the demand for information will be immediate and great.

Understanding what is involved in mass fatality management; the needs of victims' families and loved ones; and the communications message and operational considerations, including establishing a Joint Information Center (JIC), will enable a jurisdiction to enact effective communications strategies immediately following a mass fatality event.

## Overview of Section

This section identifies:

- The purpose and objectives of public communications following a mass fatality incident.
- Who is responsible for public communications and how communications are managed.
- The role of the Medical Examiner/Coroner (ME/C) Office in public communications.
- Communications message and operational considerations in a mass fatality.

Resources:

- Information on the purpose and objectives of public communications and on Joint Information Centers was provided by the *Santa Clara Valley Health and Hospital Crisis Emergency Risk Communications (CERC) Plan*. This plan and additional Joint Information Center information is available at: [www.sccphd.org](http://www.sccphd.org).
- Communications message and operational considerations in a mass fatality were drawn from the resources used and identified throughout the development of the mass fatality toolkit.

## Key Assumptions

The following are the key assumptions underlying mass fatality public communications.

- A mass fatality is an overwhelming event that creates widespread traumatic stress that can impact an entire community's sense of safety and security.
- Calming the fear and anxiety of families and loved ones of potential victims and of the impacted community is a primary goal.
- Family members and the public will have high expectations regarding mass fatality management:
  - The identification of the deceased,
  - The return of loved ones, and
  - Ongoing information and updates.

- There will be persistent media requests for interviews with city state and federal officials, survivors, family members, and rescue workers.
- A Joint Information Center will be established to ensure that information released to the public will be accurate, consistent, and coordinated across the responding agencies.

## Proposed Approach

This section identifies who is responsible for public communications, provides an introduction to establishing and organizing a Joint Information Center, and identifies communications message and operational considerations in a mass fatality.



Discuss public communications with the Public Information Officer in charge of your jurisdiction's risk communications plan and with your Office of Emergency Services (OES). Review the information provided below with the PIO and OES. Together you can determine the best location and use for the following information on public communications in the event of a mass fatality.

## ***Developing Your Jurisdiction's Public Communications Response for a Mass Fatality***

### **Step 1: What is the purpose of public communications in a mass fatality?**

The purpose of emergency risk communications in a mass fatality event, similar to any large-scale emergency, is to communicate needed information to key audiences, including the general public and news media, during and after the event.

When a mass fatality event occurs, staff assigned to public information functions will develop key messages and deliver sound and thoughtful communications. These communications can help to prevent ineffective, fear-driven and potentially damaging response to a serious event.

In any emergency event, it is paramount that information be timely, accurate, empathetic, consistent, caring, pertinent and credible. Additionally, communications should disclose what is known, acknowledge any uncertainty, and recognize fears and concerns. Providing accurate, consistent and timely information assists responding agencies in maintaining the public's confidence. These communications objectives will be met through working in a Joint Information Center reporting to the Incident or Unified Command.

It is important to remember that the emergency will happen with nearly impossible time constraints and people will have to decide what steps to take within the parameters of imperfect choices during the event. Decisions are typically made with narrow time constraints, decisions may need to be made with imperfect or incomplete information, and decisions may be

irreversible. Emergency risk communication provides expert opinions and accurate information in the hope that it benefits key audiences and advances a behavior or action that allows for rapid and efficient recovery from the event.

## **Step 2: Determine who is responsible for public communications.**

In the event of a mass fatality, the Incident or Unified Command will appoint a Lead Public Information Officer (PIO) to establish a Joint Information Center within the Incident Command System (ICS). This is typically the PIO with ICS experience and/or experience in a Joint Information Center.

The Lead PIO reports to the Incident Commander and is a member of the Incident Command Staff at the Emergency Operations Center (EOC). He/she is responsible for assuring that:

- Accurate and timely information is provided to the public, as well as to government officials and collaborating agencies.
- Information that is released is coordinated across responding agencies.
- Information is verified and approved through the appropriate Chain of Command (e.g., Incident Commander).

### **Joint Information System (JIS) and Joint Information Center (JIC)**

The Joint Information System (JIS) provides the process for the JIC—gathering information, coordinating information, preparing it for dissemination, and releasing information. It is a framework and system that includes plans, protocols, and structures for providing information to the public.

A Joint Information Center (JIC) operating under the Joint Information System (JIS) enables coordinated:

- Gathering of information and intelligence.
- Development of consistent and coordinated messages.
- Dissemination of messages and information.

The Joint Information Center (JIC) is a temporary organization where public information efforts are coordinated. The JIC is staffed by PIOs from all agencies involved in the emergency response. The JIC allows for the co-location of key PIOs and provides a ‘one-stop shop’ for the media and public to get all of their communication needs met. It enhances the likelihood that information released to the public will be accurate and coordinated across responding agencies and jurisdictions.

The Lead Public Information Officer consults with Command regarding selection of a Joint Information Center location, if it has not been established yet. The JIC should be distant from the location of deceased victims and from the Family Assistance Center.

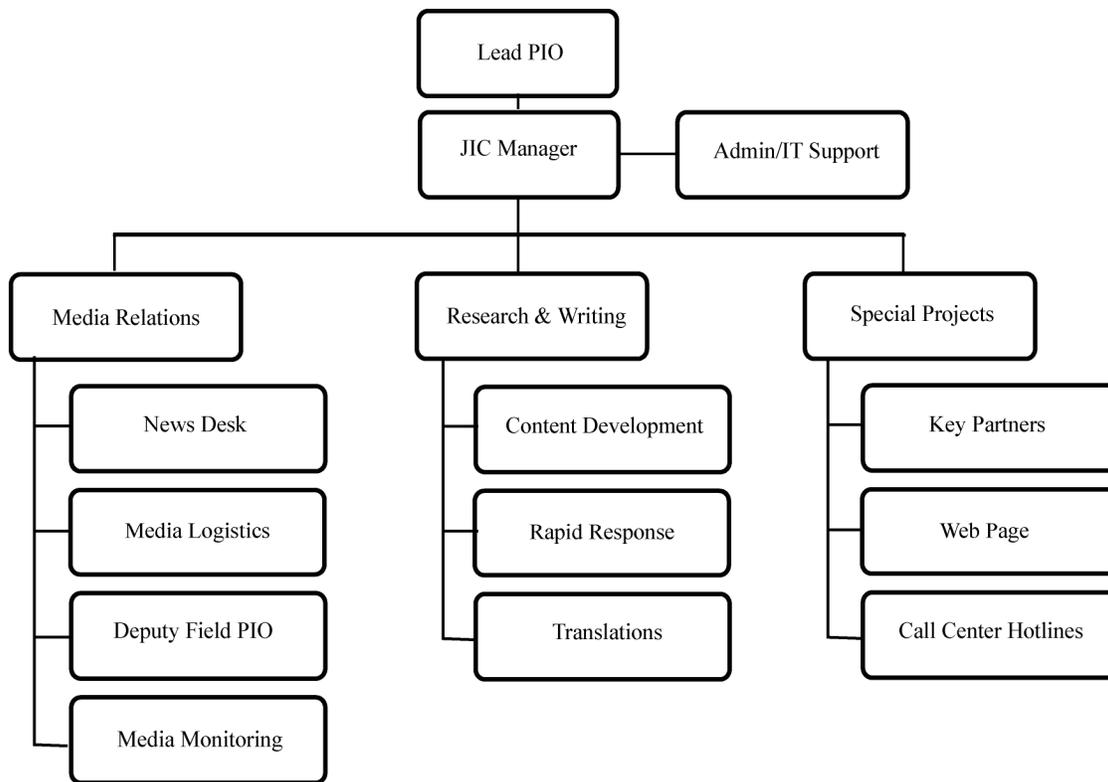
It is important to understand the general framework of a JIC and how it is structured because

precisely how it will operate in a large-scale emergency cannot be determined prior to the emergency. They may be large or small in size and/or a combination of physical and virtual JICs if communications staff cannot all get together. The base of operations for a JIC may be federal, state, and/or local, and its resources may flow from any of these sources.

As with the ICS, the JIC may be scaled to fit the situation by expanding or collapsing its services and resources.

### Joint Information Center Organization

A well-organized JIC can increase the ability to release accurate information that is coordinated across responding agencies quickly and effectively. The following is an example of a JIC organization.



The **Lead Public Information Officer (PIO)** in a JIC is responsible for overall JIC operations and for providing prompt and organized responses to the news media. The Lead PIO coordinates all public information efforts out of the JIC, ensures protocols are followed, ensures that all messages are approved by the Incident Commander before release, attends EOC Command briefings, and coordinates these efforts with local, state, and federal partners.

The **JIC Manager** manages the operations of the JIC and coordinates the flow of information between functional areas and staff. He/she acts as the Lead PIO when the Lead PIO attends EOC Command briefings.

The **Admin/Information Technology Support** unit provides administrative, clerical, documentation, technical, and information technology support for the entire JIC operation.

**Media Relations** unit is responsible for dealing with all media requests and logistics. They distribute news releases, brief and support spokespersons, determine and set up media-briefing area(s), generate reports, and obtain approvals from the Lead PIO.

**Research and Writing** unit is responsible for researching, verifying information, and writing media advisories, releases and other materials. They generate reports and obtain approvals from the Lead PIO.

**Special Projects** unit is responsible for working with key partners, posting accurate information to Web sites, and making sure information is distributed to non-media partners, organizations, agencies and audiences. They monitor Web sites, generate reports, and obtain approvals from the Lead PIO.

Additionally, in a mass fatality event, **Deputy/ Field PIOs** will be stationed in the field (incident site, incident morgue and Family Assistance Center) to handle on-site media inquiries and requests. The Deputy/ Field PIO coordinates with the Media Relations Lead and the Incident Commander in the field and reports information back to the JIC.

Job Action Sheets for the key JIC positions and for the Deputy/Field PIO are included as tools with this section.

### **Step 3: What is the Medical Examiner/Coroner Office role in public communications?**

The Medical Examiner/Coroner (ME/C) has a significant role in the approval of information released regarding the mass fatality operation, determining the sensitivity of information releases and how they affect the surviving families. A trained and experienced PIO from the ME/C Office is an integral member of the JIC Leadership and staff for a mass fatality event. If there is not a ME/C PIO available, the Coroner's Services Branch Director will assign a ME/C Office representative to the Joint Information Center (if staffing permits) and will designate ME/C representatives from the incident site, morgue and Family Assistance Center for news conferences and interviews as requested by the JIC.

When requested, ME/C Office personnel and representatives will provide information to the JIC to coordinate the release of information to the media and public. ME/C Office staff and

representatives will refer all media requests to their supervisors, who will in turn refer requests to the JIC.

## **Step 4: What are the public communications messaging considerations in a mass fatality?**

The public communications messaging considerations below are based on experience and lessons learned from recent mass fatalities.

### **General Mass Fatality Messaging Considerations**

- Information must first be provided to the family, then to the media.
- Recovery operations (progress, staffing levels and assistance provided, and estimate of time to complete recovery/identifications).
- The victims (total number, condition of the bodies, and numbers of missing persons reports).
- Identifications (names of identified victims and methods used to identify victims).

### **Family Messaging Considerations**

- Remember that victims' families are the priority in a mass fatality.  
Resource: See *Family Concerns and Religious/Cultural Considerations* section of the mass fatality toolkit for guidance on topics of interest to families.
- Keep the families and loved ones of potential victims in mind in *all* communications.
  - Respect families' sensitivities, such as, continued hope for survivors.Resource: See *Family Concerns and Religious/Cultural Considerations* section of the mass fatality toolkit for recommended language to use and to avoid.
- Communicate awareness of and sensitivity and respect for the cultural/religious practices of the victims and their families.  
Religious and cultural beliefs and practices surrounding death will be important to survivors. However, in a mass fatality, it is unlikely that the ME/C Office will be able to be responsive to family requests regarding their beliefs and practices.  
Resource: *Family Concerns And Religious/Cultural Considerations* section of the mass fatality toolkit.
- Only coordinate media interviews of victims' family members who are willing to be interviewed by the media.
  - Protect the privacy of families and loved ones of potential victims who do not want to be interviewed.

- Do not allow ‘public interest’ to become a legitimization for inquiry that is so intensive and invasive that it overrides concerns about sensitivity for the bereaved.

### **Community Health and Safety Messaging Considerations**

- Only disseminate information based on scientific fact.  
There may be a public belief and concern over a disease epidemic caused by dead bodies. Dispelling this myth and calming public fear and anxiety will require a concerted and coordinated effort.  
Resource: See *Infection and Other Health and Safety Threats* section of the mass fatality toolkit for further information.

### **Response Worker Messaging Considerations**

- Remember that all emergency response workers—at the incident site, the morgue and the Family Assistance Center—will be working under extreme emotional duress. Consider this in communications and when scheduling interviews for them with the media.
- Do not allow ‘public interest’ to become a legitimization for inquiry that is so intensive and invasive that it overrides concerns about sensitivity for responding personnel.

## **Step 5: What are the public communications operational considerations in a mass fatality?**

The public communications operational considerations below are based on experience and lessons learned from recent mass fatalities.

### **Potential Crime/Terrorist Act**

- If the incident is the result of a suspected crime, public communications must take into consideration the future prosecution of the crime.
- The Federal Bureau of Investigation (FBI) will be in charge of the investigation if terrorism is suspected. The FBI can provide consultation regarding public communications.

### **Mass Fatality Site Operations**

Experience in recent mass fatalities strongly urges that the media have very limited, if any, access to mass fatality site operations. However, your state’s laws regarding media access will take precedence over recommendations.

- Be prepared to assign a field PIO to each site and to utilize strategies that address media needs while protecting the integrity of mass fatality operations.

Consider the following suggestions.

### ***Incident Site***

- Accommodate the media at the incident site. News media serve as the eyes and ears of the people. Providing preferred vantage points and the ability to understand what is going on at the incident site serve legitimate public interest. The incident command post should have at least one person at the incident site that is dedicated to assuring that media representatives have appropriate access when possible without creating safety hazards.

### ***Incident Morgue***

- Restrict the media from entering the morgue. If media tours are provided, do not allow any pictures—cameras or cell phones.
- Establish a morgue briefing area near but not in the morgue.
- Remind the media of the morgue’s critical objectives and to consider victims’ families when information on morgue services is communicated.

At the incident morgue there is substantial pressure to preserve remains to facilitate identification and to collect and preserve evidence. Morgue services are performed in accordance with professional protocols to achieve these objectives.

### ***Family Assistance Center***

- Restrict the media from entering the Family Assistance Center (FAC). The FAC is a private place for families.

The literature on mass fatality family assistance often says to never permit the media to enter the FAC.

- If media tours are provided, do not allow any pictures—cameras or cell phones.
- Remind the media of the trauma and grief the families are experiencing and of the need to respect families wishes for privacy at this difficult time.
- Establish a media briefing area near/next to but not in the Family Assistance Center.
- Coordinate media interviews with family members who are willing to be interviewed; conduct interviews at the media briefing area and not in the Family Assistance Center.
- When managing VIP visits by public figures to the Family Assistance Center, remind the VIPs that the needs of families and loved ones of victims always remain the priority.
- Coordinate the collection of biographical information and photos of the victims and prepare a formal presentation of this information for the Family Assistance Center that is updated daily as necessary.

Resource: See the *Family Assistance* section of the mass fatality toolkit for suggestions on strategies used in recent mass fatalities (e.g., the Heroes Board, Memorial Table, and Incident Site Diagrams and Charts) that families identified as supportive and meaningful.

### ***Managing the Media at all Sites***

- Consider setting up a system for issuing one-time credentials for journalists and requesting members of the news media to bring their current credentials and/or business identification (business card). Planning for this must include setting standards for separating true journalists from those who just want a closer look.

### **Coordinating Public Communications and Family Briefings**

- Make keeping the Family Assistance Center leadership informed a priority. This will enable them to anticipate potential crises for families and to better meet families' needs.
- Do not release information to the media unless it has been discussed with families of potential victims first and approved by Incident Command through the JIC.
  - Families will be kept informed through regularly scheduled family briefings by the ME/C Office—a minimum of two per day—at the Family Assistance Center.

### **Meeting the Needs of Response Workers**

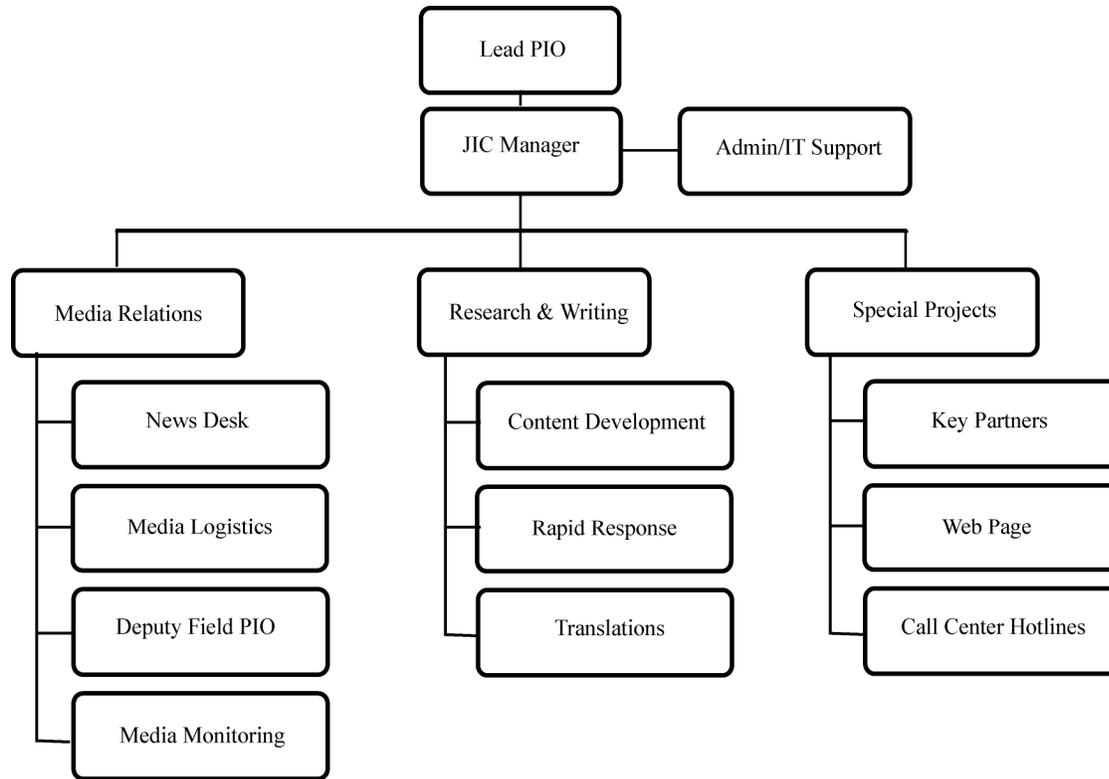
- Remember that emergency response workers are one of your audiences. Keep them informed, perhaps through end-of-shift briefings.

A frequently mentioned problem in recent mass fatalities is that on-site response workers knew less than those at home watching television.

- Consider a “Faces of Service” campaign to inform the public about the organizations and individuals involved in the response and to highlight their contributions.

## Associated Tools and Resources

### Joint Information Center Organization Chart



### Joint Information Center (JIC) Job Action Sheets for:

- JIC Lead Public Information Officer (PIO).
- JIC Manager.
- JIC Media Relations Lead.
- JIC Research and Writing Lead.
- JIC Special Projects.
- JIC Field Deputy PIO.

### Decedent Operations

A one-page chart depicting the organization of decedent operations in a mass fatality that can serve as a snapshot of mass fatality operations

# Death Certificates and Permits for Disposition of Human Remains

Timely registration of deaths and permits for disposition is an important part of mass fatality management. The agency in charge of this function, which is part of a state's vital records system, has an important role in your jurisdiction's mass fatality response because all deaths are registered in the jurisdiction in which they occur and permits are required for disposition of human remains.

## Overview of Section

This section identifies the purpose of death certificate registration and of permits for disposition of human remains; who is responsible for the vital records system; the role of the Medical Examiner/Coroner (ME/C) Office and how its standard operating procedures are changed in a mass fatality; and guidelines for establishing the vital records system's preparedness in the event of a mass fatality.

The key resource for this section is the State of California Department of Health Services Office of Vital Records' *Birth and Death Registration Handbook*. Identify the comparable document for your state. It will provide information on your state's vital records system and may include specific directions for changes in standard operating procedures in the event of a mass fatality.

## Key Assumptions

The following are the key assumptions.

- A mass fatality will result in a surge in requests to register deaths that occur in the jurisdiction and for certified copies of death certificates for victims of the mass fatality that may create problems for overall mass fatality management.
- A mass fatality will result in a surge in requests for permits for disposition of human remains, including transit permits, that may create problems for overall mass fatality management.
- A plan to manage the surge will be needed in the event of a mass fatality.
- The nature of the mass fatality—particularly the complexity of the recovery process and the length of time recovery will take—will determine the level of surge capacity that will be required of the vital records system to manage its responsibilities in the mass fatality effectively.

## Proposed Approach

This section is intended to provide guidance for identifying ME/C standard operating procedures regarding vital records that change in a mass fatality and for working with the agency responsible for the vital records system in your jurisdiction. Its focus is on identifying changes in ME/C standard operating procedures and on identifying the agency in charge of the vital records system and on recommendations for assisting that agency with surge capacity planning in the event of a mass fatality.



The key stakeholders for this section are the ME/C Office and the agency responsible for the vital records system for your jurisdiction.

## ***Developing Your Jurisdiction’s Plan for Registration of Deaths and for Permits for Disposition in a Mass Fatality***

### **Step 1: What is the purpose of the vital records system?**



The information below is in accordance with California law. If your jurisdiction is in California, it can be used as is. If you are in another state it will need to be modified in accordance with your state’s law.

The purpose of the vital records system is 1) to establish a permanent record that is legally recognized as prima facie evidence of the facts stated in the record, and 2) to provide a means for studying the statistical data for health evaluation and planning purposes.

All deaths require registration in the jurisdiction in which they occur. For example, in California, each death must be registered with the local registrar in the district in which the death was officially pronounced or the body was found within eight days after the death and prior to any disposition.

Upon registration by the local registrar, the death certificate becomes the State’s legal record of the death. The purpose of a certified copy of a death certificate is:

- To serve as the legal record of death and thus be prima facie evidence of the death in all courts
- In addition, a certified death certificate is used:
  - To settle the decedent’s estate
  - To apply for insurance benefits
  - To settle pension claims
  - To verify transfer of title or real and personal property.

A permit for disposition of remains can only be issued by the local registrar after the death certificate has been registered.

The purpose of the permit for disposition is:

- To specify the disposition being authorized by the local registrar—burial, cremation, disposition of cremated remains other than in a cemetery, scientific use, temporary entombment, and/or transit to another state or country for disposition
- To allow for the disposition of human remains.

## **Step 2. Determine who is responsible for your jurisdiction’s vital records.**

Each state is responsible for managing its vital records system. Your state’s laws regarding vital records will specify the agency responsible for the registration of deaths and for permits for disposition of human remains in your jurisdiction. Identify your jurisdiction’s local registrar and the agency or department responsible for death certificate registration and issuance of permits for disposition of human remains in your jurisdiction.

Using Santa Clara County, California as an example, California Health and Safety Codes Section 102175 through 102250 sets out requirements for the California Vital Records System. By statute, the State Office of Vital Records (OVR) oversees the registration of vital records in California. Under OVR supervision, each local registrar registers and transmits the original records for events occurring in the local registration district to the State office for filing and indexing. Santa Clara County is a local registration district. The Health Officer, by statute, is the local registrar and is responsible for appointing a chief deputy registrar to direct and supervise the overall registration of births, fetal deaths, and deaths in the county. In Santa Clara County, the chief deputy registrar heads Vital Records and Registration, which is within the Public Health Department.

## **Step 3: What is the Medical Examiner/Coroner Office role?**

The following are specific changes in ME/C standard operating procedures specific to a mass fatality.

Upon determination of a mass fatality incident in California, the ME/C Office is responsible for:

- Contacting the Policy Manager of the State Office of Vital Records (OVR). The Policy Manager will request that a list of all known fatalities be provided to OVR and the local registrar’s office.
- Updating this list as additional information becomes available, including the type of certificate, court ordered or standard, that will be prepared for each decedent.
- Filing a single verified petition using the latest version of the Court Order Delayed form

with the Superior Court to judicially establish the fact, time, and place of death for individuals who die in the mass fatality, but for whom no remains are found and/or identified.

- *Not* preparing a standard certificate if remains are later located and identified for an individual where a court-ordered delayed certificate was prepared.
  - Requests to replace a court-ordered certificate with a standard certificate must be referred to the OVR Policy Manager.
  - If remains are found after a court-ordered delayed certificate has been filed, the remains should be disposed of following regular state laws and guidelines. The court-ordered delayed certificate may be amended to reflect the disposition of remains.

The OVR will work closely with the ME/C and local registrar's office to ensure that all certificates are registered in an expedited manner and that only one certificate is registered for each fatality.

## **Step 4: Considerations/recommendations for Working with Your Local Registrar**

- Meet with the local registrar to discuss mass fatality management planning.
- Identify specific changes in standard operating procedures related to the vital records system in the event of a mass fatality.
- Identify how the ME/C Office, funeral directors, doctors and hospitals submit death certificates to the local registrar.
  - What processes are in place now? Examples may include electronic filing such as the Electronic Death Registration System (EDRS); Hand-Filing; Cross-Filing between health jurisdictions; and/or Fax Filing.
  - Are there any alternatives to shorten this process?
  - If the fastest method is not being used now, can that capability be developed?
- Identify strategies for streamlining the process for applying for and obtaining permits for disposition.
- Does the local registrar have a continuity of operations plan? A surge capacity plan? If no, encourage this planning regarding mass fatalities.
- Determine how the ME/C Office and the agency in charge of vital records will work together in the event of a mass fatality.

# Death Care Industry

The death care industry includes funeral home or mortuary services, cremation services, and cemetery services. These services are locally owned and corporately owned licensed businesses that comply with federal, state, and local laws applicable to the handling of human remains.

While funeral practices and rites vary greatly among cultures and religions, funeral practices share some common elements—removing the deceased to a mortuary, preparing the remains, performing a ceremony that honors the deceased and addresses the spiritual needs of the family, and carrying out the final disposition of the deceased.

Funeral directors consult with families regarding their wishes and arrange and direct the above services for families based on their wishes. This includes arranging and handling the logistics of funerals, completing and filing the death certificate with the local registrar within eight days of the date of death, and applying for and obtaining a permit for disposition from the local registrar.

## ***Overview of Section***

This section identifies the purpose of the death care industry, who is responsible for death care industry services, the role of the Medical Examiner/Coroner (ME/C) Office, and considerations/recommendations for working with representatives of the death care industry regarding mass fatality planning.

## **Key Assumptions**

The following are the key assumptions.

- A mass fatality will result in a surge in demand for death care industry services.
- The surge in demand may overwhelm the death care industry and may create problems for overall mass fatality management.
- The nature of the mass fatality—particularly the complexity of the recovery process, the length of time recovery will take, and the number of decedents that are residents of the jurisdiction—will determine the level of surge capacity that will be required to manage the mass fatality effectively.

## **Proposed Approach**

This section is intended to serve as guidance for working the death care industry in your jurisdiction. Its focus is on identifying the funeral directors, funeral homes, cemeteries, and

cremation services located in your jurisdiction, determining local capacity for processing the final disposition of human remains in a mass fatality, and identifying any changes in standard operating procedures for the Medical Examiner/Coroner Office. It also includes considerations and recommendations for working with the death care industry in your jurisdiction on mass fatality planning.



The key stakeholders for death care industry planning are your local funeral directors, funeral homes, cemeteries, cremation services, and your state’s funeral directors association.

## ***Developing Your Jurisdiction’s Plan for Death Care Industry Services in the Event of a Mass Fatality***

### **Step 1: What is the purpose of death care industry services?**

The purpose of the death care industry is to carry out the final disposition of human remains. In general, this includes:

- Removing the deceased to a mortuary,
- Preparing the remains,
- Performing a ceremony that honors the deceased and addresses the spiritual needs of the family, and
- Carrying out the final disposition of the deceased.

Completing and filing the death certificate with a local registrar within eight days of the date of death and applying for and obtaining a permit for final disposition from a local registrar are part of the process of final disposition.

### **Step 2: Determine who is in charge of the death care industry?**

While the death care industry complies with federal, state and local laws pertaining to the disposition of human remains, there is no single agency or organization in charge. Funeral home or mortuary services, cemetery services, and cremation services are provided by licensed businesses that are locally owned and corporately owned.

To determine who is in charge of these services in your jurisdiction, it will be necessary to identify all of the funeral homes or mortuary services, cemetery services, and cremation services in your jurisdiction and determine who is in charge of each one.

### **Step 3: What is the Medical Examiner/Coroner Office role?**

The ME/C Office role is to work with the death care industry to facilitate final disposition of human remains, an important function in overall management of a mass fatality.

ME/C Office actions in a mass fatality that are not standard operating procedures are:

- The ME/C Office will alert funeral homes, cemeteries, and cremation services in the event of a mass fatality.
- It is likely that the ME/C Office will be requesting death care industry assistance in search and recovery at the incident site, in morgue operations, and at the family assistance center.
- As victims are identified, the ME/C Office will coordinate with the funeral home or cremation service requested by each victim’s family to arrange for final disposition—the release of remains with a death certificate signed by the ME/C from the incident morgue to the funeral service selected by the family.

### **Step 4: Considerations and Recommendations for Working with Your Jurisdiction’s Death Care Industry**

- Identify the funeral homes, cemeteries, and cremation services in your jurisdiction. Invite them to participate in mass fatality planning in your jurisdiction.
  - Participation can mean meeting to create a plan for managing the final disposition of human remains in the event of a mass fatality and/or providing information upon request that will inform planning.
- Determine your jurisdiction’s capacity for processing human remains—identify at what point the mortuary system is overwhelmed.

Identify capacity for:

- Mortuary storage:
  - Determine mortuary storage capacity for all funeral homes and crematoriums.
  - Identify religious groups that maintain facilities such as small morgues, crematoriums, and other facilities to meet their specific religious/cultural directives about how bodies are managed after death and determine their capacity.
- Number of burials that can be handled in a week by funeral homes/cemeteries:
  - Determine the number of decedents that can be processed in a week for

each of the following categories:

- To embalm only
  - To embalm and complete necessary paperwork
  - To embalm, complete necessary paperwork, and provide traditional funeral services
  - Consider staff availability and impact of supplies on hand (e.g., embalming fluid, caskets, vehicles to transport remains, etc.).
  - Consider maintaining a rotating six-month inventory of supplies.
  - Consider availability of grave diggers, cemetery space, including vaults for possible temporary storage, and seasonal variables that may impact burials (e.g., winter weather).
  - Consider availability of churches and personnel for services.
- Number of cremations that can be handled in a week:
    - Determine the number of decedents that can be cremated without damaging equipment in a week.
    - Consider staff availability and impact of supplies on hand (e.g., crematorium supplies, vehicles to transport remains, urns, etc.).
    - Consider maintaining a rotating six-month inventory of supplies.
    - Consider availability of churches and personnel for services.
  - Determine the maximum number of deaths your jurisdiction’s death care industry can handle in a one-week time period.
  - Subtract the average number of deaths that occur in your jurisdiction in a week. Remember, deaths due to other causes will continue to take place in your jurisdiction.
  - Then, reconsider and modify this number based on the likely involvement of death care industry personnel in human remains recovery, morgue services, and family assistance—from within your jurisdiction and other jurisdictions as needed and available.
- Once the trigger point (number of deaths at which the mortuary system becomes overwhelmed) has been identified, identify strategies the death care industry will pursue to manage final disposition in a mass fatality that is projected to overwhelm the mortuary system. The following are some strategies to consider:
    - Requesting assistance from funeral homes, cemeteries and cremation services in neighboring jurisdictions, if the mass fatality is a localized event. Your state’s funeral directors association could provide important assistance with this strategy.
      - Assistance could involve sending temporary staff and equipment/supplies to your jurisdiction through the State Office Of Emergency Services or carrying out final disposition for some decedents in neighboring jurisdictions.

- Expanding refrigerated storage capacity for human remains that have been identified and are awaiting final disposition.
- Working with the state office of vital records and your local registrar to develop strategies to streamline completion and filing of death certificates and applications for permits for disposition.
  - Expedited cremation certificates, burial permits, and transit permits.
- Expediting the embalming process by providing aftercare services (embalming and casketing) at the temporary incident morgue to reduce the burden on local funeral homes.
- Securing temporary storage for embalmed and casketed remains in vaults—existing vaults and/or creating temporary vaults.
- Consolidating and coordinating resources under a single unified mortuary command structure at a single facility. Baron County in Wisconsin (population ~ 200,000) has developed a plan that employs this model in its Pandemic Influenza Mortuary Planning Guidelines. This resource is available at: <http://flutrackers.com/forum/showthread.php?t=47605>.
- Develop strategies for:
  - How religious/cultural requirements/preferences will be handled.
  - When unable to contact next of kin.
- Once a plan has been agreed upon, consider signing a Memorandum of Understanding that indicates the funeral homes, cemeteries, and crematoriums agree to the plan and will operate in accordance with it in the event of a mass fatality to the best of their ability at that time. It may be helpful to indicate that the agreement is not a legally binding contract on the bottom of each page.
- Encourage funeral homes, cemeteries and crematoriums to develop and maintain continuity of operations plans that include surge capacity plans for maintaining and increasing services in the event of a mass fatality.

# Mass Fatality Management Plan Maintenance

This section of the toolkit addresses how the Medical Examiner/Coroner Office plans to ensure that the mass fatality management plan contains the most current information. It describes the organization's plan maintenance strategy.

Plan exercises are also addressed because of their important role in familiarizing staff members with their roles and responsibilities during a mass fatality, in evaluating the plan, and in providing detailed feedback that is valuable to plan maintenance.

However, the reality is that emergency operations plan maintenance, training and exercising are resource and time consuming activities. At a minimum, a plan should be reviewed annually. To provide support for maintenance and exercises make it a priority when grants, proposals and budget activities are available to support these activities.

## ***Plan Maintenance***

The Medical Examiner/Coroner (ME/C) Office, the organization identified by law as responsible for mass fatality management, is responsible for plan maintenance.

Identify a specific person in the ME/C Office (preferably by title and not by name) or a team (by titles and not by names) as responsible for maintaining the plan.

## **Maintenance Strategy**

Maintaining a mass fatality plan is important.

- Develop a system for storing relevant information between plan updates in one place so that it is easily accessible when it is time to update the plan:
  - Procedure changes.
  - After Action Reports/Improvement Plans/plan comments/feedback.
- Develop a system for identifying:
  - new mass fatality planning guidance documents,
  - changes in national or state direction, and
  - new lessons learned in the event of a mass fatality in another jurisdiction.
- Maintain a list of plan gaps to be addressed as time and budget allow. Examples include:

- Development of staff support and supply lists scaled to activation levels.
- Assessment and analysis of alternate storage strategies for human remains.
- Development of alternative standards of death care.
- An interoperable communication plan and equipment to support the mass fatality plan.
- Development of memorandums of understanding with supporting organizations and facilities.

Once you have a system for collecting and organizing relevant information in between updates, determine a process for updating the plan.

- Specify how often the plan will be updated—ideally once a year.
- Specify who will review the plan.
- Identify who is responsible for incorporating all changes into the plan.
- Identify who is responsible for approval of the plan after it is updated.

## ***Mass Fatality Plan Exercises***

Exercises 1) provide training and practice for emergency events that test readiness, 2) evaluate your mass fatality management plan, and 3) provide detailed feedback for maintaining the plan.

Exercises can be costly and time consuming. However, they are the best way to test a plan prior to a mass fatality incident. The following is some basic information on exercises.

### **Discussion-Based Exercises**

At a minimum discussion-based exercises are recommended. Both orientation exercises and tabletops fall into this category.

Orientation exercises can be designed to introduce staff to the plan and collect their feedback. This can be done by phone, e-mail, and/or questionnaires. It can be a good way to familiarize personnel with the plan and to get their input.

For tabletop exercises, everyone is invited to meet for a scenario-based discussion designed to test an aspect of the plan, such as incident notification, the incident command system, etc. It is a good way to orient staff to the plan and their role and to bring partner agencies/organizations together to become familiar with one another and their roles. Through collective input, strengths and weaknesses in the plan will be identified.

Key advantages of discussion-based exercises are that they are cost effective (least expensive), improve individual and agency familiarity with the plan thus creating improved readiness, satisfy state and federal requirements, and are generally low stress and designed as a no fault environment.

## Operations-Based Exercises

Operations-based exercises include drills, functional exercises, and full-scale exercises. These exercises provide valuable information by testing Incident Command System (ICS) adherence, testing performance of people and equipment, identifying gaps in resources, clarifying roles and responsibilities, and improving individual and team performance.

Operations-based exercises require greater planning, time, staff and resource commitment. Coordinating an operations-based exercise of the mass fatality plan with another emergency plan's exercise (for an event that is likely to result in multiple fatalities) can be very cost and time effective.

## Exercise Evaluation

The exercise's evaluation is a very critical component of the exercise. Evaluation includes: evaluation planning, observation and data collection, analysis of the data, determination of whether or not goals and objectives are met; and completion of an After Action Report/Improvement Plan.

The After Action Report/Improvement Plan can then become a component of maintaining the mass fatality plan.

## Training and Exercise Plan for a Mass Fatality Plan

In this section of your mass fatality plan, present a plan for training and exercises. Include:

- The functions and/or parts of the plan you will be exercising.
- The type of exercises (discussion-based vs. operations-based).
- How you will evaluate the exercises.
- A timeframe within which the exercise will be done.

## Some Ideas for Possible Exercises

Begin by planning exercises that ensure that everyone in the ME/C Office is familiar with and understands the mass fatality management plan. At the very minimum, review the mass fatality plan every year and update it as needed.

This can be followed by exercises geared to orienting others outside of the ME/C Office to the plan and/or ensuring that other organizations have determined how they will handle surge capacity for decedent operations for which they are responsible. For example,

- Has the organization responsible for vital records developed a surge capacity plan? How will their work with the ME/C Office and with the death care industry differ in the event of a mass fatality?

- Is the Public Information Officer familiar with the general framework of a Joint Information Center and how it is structured and/or lessons learned in communications message and operational considerations from recent mass fatalities?
- How will the ME/C Office and the death care industry change their operations in the event of a mass fatality?

Finally, recognizing that some mass fatality plan operations are more familiar to the ME/C Office than others and that there is a wealth of lessons learned from recent mass fatalities, it may be best to focus exercises on parts of the plan that are least familiar or potentially more challenging. Examples of functions that could be considered are:

- Setting up and managing a family assistance center. The ME/C Office is charged with this responsibility, but often does not have experience managing it unless it has dealt with a previous mass fatality.
  - *Family Reception Center Exercise Guidelines, Disaster Mental Health: A Critical Response Instructor's Guide*, University of Rochester, 2006 is provided as a tool that can be modified as needed to test providing family assistance in your jurisdiction. To request a copy of this guide, contact Jack Herrmann, Senior Advisor Public Health Preparedness for the National Association of County & City Health Officials at [jherrmann@naccho.org](mailto:jherrmann@naccho.org).
- Determining the equipment and practices needed to protect emergency responders based on the most likely scenario in your jurisdiction. This is an exercise that could involve public health, environmental health, emergency medical services, and all police and fire departments in a jurisdiction. Based on the scenario, the exercise can be used to identify problems that have created conflict in recent mass fatalities by answering questions, such as:
  - Are conflicting safety messages among the responder organizations likely? If yes, how will differences be handled?
  - What types of equipment do departments in the jurisdiction currently use/purchase? Are the types of equipment different or the same? Are they interoperable?
  - Is there enough personal protective equipment for all responders? At the time of the incident as well as for a sustained campaign?
  - Do responders recognize why personal protective equipment is important? Have staff been trained in its purpose and use? Is it viewed as something that impedes a responder's ability to accomplish his/her mission?
  - Who will determine what personal protective equipment is required in a mass fatality incident? What organization will be responsible for requiring its use? What are the plans for establishing a unified command to coordinate/handle responder health and safety/personal protective equipment in the event of a mass fatality?

Determining what functions or parts of the mass fatality plan will be exercised is the responsibility and choice of the jurisdiction.

# Security

Security is critical to effective mass fatality management. A lack of security can derail the best plans.

In the event of a mass fatality, the incident site, incident morgue, and the family assistance center will require security and traffic control. The law enforcement agency for the jurisdiction where the incident takes place will be responsible for these operations. When the emergency operations center is activated, the law enforcement branch in the operations section will provide oversight and coordination of law enforcement mutual aid that is called in to assist with site security and traffic control.

A written security plan and traffic control plan that outlines procedures and requirements of the operation is recommended for the incident site, incident morgue, and the family assistance center during the early stages of mass fatality operations.

Many law enforcement agencies will have established protocols and procedures for developing security and traffic control plans. However, when the Medical Examiner/Coroner (ME/C) Office requests security support for its mission, it needs to be appropriately prepared. That means being prepared to request the right number and type of security resources that will be needed and being able to promptly provide law enforcement with the information it will need to achieve success in its support mission. That is the purpose of this section of the toolkit.

## ***Overview***

Mass fatality security requirements, security objectives, and information to request when selecting sites for mass fatality operations are described below. This information is followed by a description of the associated tools included with this section. The associated tools are a questionnaire that can be used to perform a physical security assessment, a security plan template, and a traffic control plan template. These resources have been developed to assist the ME/C Office and the local law enforcement agency in effective mass fatality management.

## ***Security Requirements***

In a mass fatality, the nature of the incident will dictate required security. The following are general security requirements to anticipate:

- Incident Site.
- Morgue (jurisdiction's morgue, temporary incident morgue, and long-term examination center/sifting site, if one is required).
- Family Assistance Center(s)/Reception Center(s).
- Traffic Control at all sites.

In addition, agencies tasked to provide security for mass fatality operations may also be tasked with providing heightened security throughout the jurisdiction.

## ***Security Objectives***

Key considerations for securing all mass fatality operations sites are:

- Controlling access into, within, and out of the facility.
- Perimeter protection.
- Parking lot protection.
- Traffic control.
- Establishing and protecting landing zones as needed (e.g., for the delivery of Disaster Mortuary Operational Response Team's portable morgue unit).
- Crowd control.

The following are the general security objectives for each site.

### **Incident site objectives are:**

- To control site access 24/7
  - All authorized personnel, volunteers, and approved visitors must have photo ID security badges that reference function and access.
- To recover human remains.
- To preserve evidence:
  - To facilitate identification of victims.
  - If a crime or terrorism is suspected.
- To protect response personnel and volunteers.
- To protect the public from potential physical dangers (e.g., building collapse) and when chemical, biological, and/or radiological agents are involved.
- To escort vehicles transporting human remains from the incident site to the morgue (as needed).
- To secure parking areas.

### **The morgue services objectives are:**

- To control site access 24/7.
  - All authorized personnel, volunteers, and approved visitors must have photo ID security badges that reference function and access.

- To preserve evidence:
  - To facilitate identification of victims.
  - If a crime or terrorism is suspected.
- To protect morgue personnel and volunteers.
- To protect the deceased.
- To secure parking areas.

### **Family assistance center objectives are:**

- To control site access 24/7.
  - All authorized personnel, volunteers, and approved visitors must have photo ID security badges that reference function and access.
  - All family members and loved ones of potential victims must have photo ID security badges that reference their roll and access.
  - No media, curiosity seekers, general public, etc. are to be admitted under any circumstances without authorization.
- To ensure that families feel protected when visiting the family assistance center.
  - May want to consider police in plain clothes who patrol inside the family assistance center to ensure that no unauthorized persons have gained entry.
- To protect response personnel and volunteers.
- To secure parking areas.

Security is a high priority at the family assistance center.

## ***Information to Request for Security Planning When Selecting Sites for Incident Morgue and Family Assistance Center***

Other than the incident site itself, the Emergency Operations Center Logistics Section will be responsible for site selection—the incident morgue and the family assistance center. The following are security-related recommendations when selecting sites:

- Involve law enforcement in site selection so that major security risks can be identified immediately.
- Collect the following information, as available, for each site:
  - Exterior and interior photos.
  - Map-wide view.
  - Map-tight view.
  - Aerial photo—wide view.
  - Aerial photo—tight view.
  - Facility’s floor plan diagram.
  - Parking plan.
  - Mass transit map.

Give this information with the ME/C's proposed floor plans/layouts for the temporary incident morgue and for the family assistance center to the law enforcement branch to assist them with development of security and traffic control plans.

## ***Overview of Physical Security Assessment***

A *Physical Security Assessment* is included as a tool with this section. It contains the following sections:

- Physical security assessment: exterior of the site.
  - Perimeter.
  - Lighting.
  - Parking areas.
  - Landscaping.
- Physical security assessment: interior of building(s).
  - Doors, windows, and other openings.
  - Ceilings and walls.
  - Emergency power system.
  - Lighting.
- Physical security assessment: specific security devices, technologies and machines.
  - Alarms.
  - Fire protection.
  - Utility control points.
  - Attic, basements, crawl spaces, and air-conditioning and heating ducts.
  - Communications.
- Physical security assessment: roadway access.
- Physical security assessment: neighborhood characteristics (within four blocks of the site)
- Physical security assessment: standard operating procedures.
  - Public areas (waiting areas, restrooms, and hallways).
  - Offices within the facility that handle money.
  - Security procedures.

These questions are followed by a space for any specific security concerns and a summary rating system to present an overview of security issues and requirements.

## ***Overview of Security and Traffic Control Plan Templates***

The *Security Plan Template* includes the following sections:

- Security plan staffing and postings.
- Security postings, interior.
- Security postings, exterior.
- Site specific security operations plan and comments.
- Diagram and photos of facility utility shut-off controls.

The *Traffic Control Plan Template* includes the following sections:

- Traffic control plan staffing and postings.
- Traffic control postings.
- Site specific traffic control operations plan and comments.

Once the security and traffic control plans have been completed, standard operating procedures, will be needed. It is expected that law enforcement agencies will modify existing applicable operating procedures as required to implement the security and traffic control plans.

## ***Associated Tools***

The *Physical Security Assessment*, *Security Plan Template*, and *Traffic Control Plan Template* are included as tools to assist jurisdictions in developing mass fatality security and traffic control plans.

These tools are based on the work of the Los Angeles County Department of Public Health Emergency Preparedness & Response Program's multi-disciplined Strategic National Stockpile Force Protection Committee's work on security for Points of Dispensing (POD) Preplans.

# Mass Fatality Information Systems

The management of fatality-related data is critical to the successful outcome of a mass fatality operation. Robust software programs capable of handling antemortem and postmortem record management are essential.

In the event of a mass fatality, the jurisdiction's Medical Examiner/Coroner (ME/C) has the authority to determine what software will be used to manage mass fatality related data. If the ME/C Office is already using an electronic case and workflow management system, this decision becomes more difficult. Some considerations include:

- Does the existing system capture antemortem data and have antemortem and postmortem matching capability?
- Does double data entry make sense, e.g., using existing software and software developed specifically for mass fatalities?
- Is it possible to export data from one system to the other system?
- Since many volunteers from other agencies will be assisting, what information systems experience will the volunteers bring with them? How will onsite training be managed?

Information is presented for:

- DMORT Victim Identification Profile,
- WinID, and
- DNA Retrieval software/computer tips.

This information is presented to encourage preliminary planning for your jurisdiction. As with any software application, determining the latest version and confirming its functionality and system requirements is necessary prior to use.

## ***Victim Identification Profile***

The DMORT Victim Identification Profile (VIP), developed by Don Bloom (DMORT Family Affairs Division), is a software program that has been used since 1994 for all mass fatality events where Federal Government assistance has been requested. Its collection of both postmortem and victim antemortem data combined with its matching capabilities is what has made it so effective in the positive identification process.

VIP Version 8.5, built on a customized FileMaker Pro 8.5 relational database platform, is user friendly, requires very little training, and allows photographs and illustrations to be inserted or accessed easily. Its relational table structure allows for unlimited field choices, along with faster searches and finds. VIP mirrors the DMORT mass fatality forms used to collect postmortem and antemortem data. Additional questions/forms can be added upon deployment.

## Key Features

### Data Collection:

- Collection of postmortem and antemortem data.
- Easy integration of all Digital media, enabling Investigators to look at all antemortem and postmortem records including Digital media.
- VIP data can import or exchange data with a SQL data source or any popular databases.
- VIP data has powerful reporting on all data fields for data analysis in-house or for export to various data sources.

### Matching Capabilities:

- Search and find criteria and advanced matching capability.
- Manages VIP information by giving instant access to all details, exploiting the Fast Match feature that lets users quickly search data without the time-consuming burden of typing.
- Fast comparisons of Clothing and Jewelry inventory between the antemortem and postmortem screens.

### Features Specific to Working with Families of Victims:

- VIP can be deployed to multiple sites with web publish of the 8 page VIP Interview Form that collects antemortem data.
- Next of kin lists tied to victim.
- DNA work lists for tracking DNA workflow.
- Call logs to record multiple contacts with families.
- Release work lists to allow those working in release to better track workflow, keep updated with family contacts, and communicate with the morgue operations.

### Authentication:

- Access controls.
- All users have their own user name and password.

### Auditing:

- The VIP database and the Web Publishing feature of VIP both produce audit trails that are stored as ASCII text files.
- Audit trail information can be used for non-attack problems. The information can help locate mistakes made by authorized users and identify users who should receive additional training.

## General VIP Requirements

VIP Version 8.5 is built on a customized FileMaker Pro 8.5 relational database.

VIP will run on both Windows and Macintosh platforms including a mixed environment.

VIP can be used in conjunction with SAS analytical software to identify and correct data entry errors, such as zip codes that are accidentally keyed into address fields.

## Postmortem Section Requirements at the Morgue

- Mid-range computers, monitors, and keyboards or laptops at all morgue stations. These computers should be equipped with a CD drive and burner and external drive (250-500GB) for data transfer and archiving, and be fully network capable.
- Digital cameras and ports for both memory card and USB input of images.
- Scanners with both document and film scan capability.
- Printers.
- Microsoft office Professional 2007 and Filemaker Pro 8.5 or 9.

## Antemortem Section Requirements at the Family Assistance Center

- Mid-range computers, monitors, and keyboards or laptops. These computers should be equipped with a CD drive and burner and external drive (250-500GB) for data transfer and archiving, and be fully network capable.
- Digital cameras and ports for both memory card and USB input of images.
- Scanners with both document and film scan capability.
- Printers.
- Microsoft office Professional 2007 and Filemaker Pro 8.5 or 9.

To increase accuracy of data, it is recommended that these *DNA Retrieval Data Management Suggestions* workstation suggestions be considered when collecting antemortem data.

- Two monitors, one oriented toward the individual performing the data entry, the other oriented toward the family member (allowing the family member to validate information as it is entered).
- A device that electronically captures the donor's signature; these devices are already in use in some retail stores (if needed).
- A printer for creating copies of forms to be given to the donor at the end of the interview.
- A digital camera to photograph personal items.

## Comparison Section Requirements at the Morgue Information Resource Center

- Two mid-range computers, monitors, and keyboards or laptops. These computers should be equipped with a CD drive and burner and jump drive (100MB-1G) drive for data transfer and archiving. These computers are networked together for instantaneous image file transfer.
- Printer.

## Resources

The VIP runtime database can be downloaded at: <http://www.dmort.org/forms/index.html>. This will allow full access to the VIP Program but will not allow for network capabilities.

For use on a deployment the following requirements are suggested:

- Filemaker Pro Advanced Server 9.0.
- Filemaker Pro 9.0 (minimum of 10 licenses).
- Microsoft Office Professional 2007.
- Photoshop CS.
- Adobe PDF software.

## ***WinID Dental Comparison Software***

WinID, developed by James McGivney, DMD (DMORT VII), is a Windows-based software program used to facilitate the comparison of ante- and postmortem dental records. It has proven useful in mass disaster situations and in the creation and maintenance of missing person databases. WinID is currently used by the California Dental Identification Team, a team of forensic dentists that assist California jurisdictions during mass disasters that involve a large number of deceased persons.

WinID stores data in a Microsoft Access Database. WinID and Access provide extensive data filtering and data sorting capabilities. It makes use of dental and anthropometric characteristics to rank possible matches. Information about restored dental surfaces, physical descriptors, and pathological and anthropologic findings can be entered into the WinID database.

The WinID user can easily switch between English, French, German, Italian, Portuguese and Spanish language editions, which can be invaluable in mass fatalities involving international victims.

The integration of WinID and Dexis (a digital dental imaging system) provides an “instant” radiographic image that can be displayed and compared with great rapidity in making dental “matches.” Both WinID3 and Dexis have unique data interpretation abilities, such as deciphering various tooth numbering systems. This increases its application in both foreign and domestic disasters involving international victims.

## **Basic WinID Requirements**

WinID3 is a Windows based program developed with Microsoft Visual Basic 6 and Microsoft Access2000. WinID3 uses ADO data structures.

WinID3 will run on Windows 95, Windows 98, Windows ME, Windows 2000, Windows NT, and Windows XP platforms.

WinID3 has been successfully used in network installations where each individual computer has a copy of winid.exe and the database for the specific incident has been placed on the server.

### **Postmortem Section Requirements at the Morgue Dental Station**

- A mid-range computer, monitor, and keyboard or laptop. This computer should be equipped with a CD drive and burner and external (250-500 GB) drive for data transfer and archiving.
- Digital camera and port for both memory card and USB input of images.
- Scanner with both document and film scan capability.
- Printer.
- Software to include installation disks and drivers for all peripheral hardware, Windows 98 or newer versions, WinID3, Dexis imaging software (if digital radiography is used), Microsoft Access, Adobe Photoshop (to label, change formats, size and resolution of images).

### **Antemortem Section Requirements at the Family Assistance Center**

- A mid-range computer, monitor, and keyboard or laptop. This computer should be equipped with a CD drive and burner and external (250-500 GB) drive for data transfer and archiving.
- Scanner with both document and film scan capability.
- Printer.
- Software to include installation disks and drivers for all peripheral hardware, Windows 98 or newer versions, WinID3, Microsoft Access, Adobe Photoshop (to label, change formats, size and resolution of images).

### **Comparison Section Requirements at the Morgue Information Resource Center**

- Two mid-range computers, monitors, and keyboards or laptops. These computers should be equipped with a CD drive and burner and external drive (250-500GB) drive for data transfer and archiving. These computers are hardwired together for instantaneous image file transfer.
- Printer.
- Software to include installation disks and drivers for all peripheral hardware, Windows 98 or newer versions, WinID3, Dexis imaging software (if digital radiography is used in the morgue), Microsoft Access, Adobe Photoshop.

## Resources

- WinID3 can be downloaded at <http://www.winid.com/Download.htm>.
- The WinID3 Users Manual is available at: <http://www.winid.com/Download/AdditionalFiles/UseMan.doc>.
- A comprehensive step-by-step manual and a *PowerPoint* tutorial that can be used at advanced on-site trainings have been developed by DMORT to assist responders in utilizing WinID3 with the Dexis digital dental imaging system.

## ***DNA Retrieval Data Management Suggestions***

The DNA software used will be determined by the DNA lab that is analyzing samples and whether or not the Armed Forces DNA Identification Laboratory (AFDIL) is involved. The information below is focused on recommendations for the data collection process at the Family Assistance Center.

Traditionally, the metadata associated with a reference sample are collected on paper, then transferred to computer. Ideally, however, all information is entered directly into a database during the collection process. This helps reduce transcription and other data entry errors, such as those resulting from illegible handwriting. It would be helpful, for example, if a specialized collection workstation could be constructed to streamline the collection procedure and guarantee greater accuracy. Features of a specialized collection workstation—many of which are included in the software that the Armed Forces DNA Identification Laboratory (AFDIL) uses to collect reference samples—might include:

- Two monitors, one oriented toward the individual performing the data entry, the other oriented toward the family member (allowing the family member to validate information as it is entered).
- A device that electronically captures the donor's signature; these devices are already in use in some retail stores.
- A printer for creating copies of forms to be given to the donor at the end of the interview.
- A barcode printer; for example, buccal swabs and personal items could be immediately barcoded for the laboratory's sample tracking system.
- A digital camera to photograph personal items.

An additional resource to consider is a software program that estimates whether a specific kinship sample will benefit the identification. For example, suppose buccal swabs have been collected from a victim's father and sister. Will collecting DNA from the victim's grandson help meet the statistical threshold for making an identification? Charles H. Brenner, Ph.D., developed such a program to assist in the World Trade Center identification efforts (see <http://dna-view.com/simulate.htm>).

## Resource

*Lessons Learned from 9/11: DNA Identification in Mass Fatality Incidents*, National Institute of Justice, September 2006, available at: <http://www.massfatality.dna.gov/>.

# Staff/Volunteer Processing Center

Recent large-scale mass fatalities have demonstrated the need for trained and prepared disaster response personnel. In the event of a mass fatality, jurisdictions can expect that they will need to rely on intermittent disaster-related staff and volunteers to meet personnel needs for mass fatality response operations.

There are several existing systems for advance registration of volunteers to help deliver volunteer resources during a declared disaster or public health emergency. These systems perform the registration, screening, resource typing, emergency verification of the identity, credentials and qualifications of volunteers and often provide training prior to a disaster. This is a major asset in the aftermath of a disaster in what is often an early chaotic period of disaster response.

In addition to working with the existing systems that have pre-registered potential volunteers, it will be important to be prepared to manage volunteers that come forward in the days and weeks after the mass fatality incident. It is common for well-meaning individuals to converge at disaster scenes or emergency operations sites to offer their assistance. Although they may be licensed, certified, or otherwise credentialed to assist with critical services, they lack knowledge of how to interact with the disaster response system and may actually complicate response efforts. Being prepared to manage these volunteers will facilitate their useful contribution and effective response.

The physical, mental, emotional, and spiritual demand placed upon mass fatality workers involved in the search, recovery, transportation, morgue services, identification, and family assistance functions exceeds that of any event typically encountered in daily life and work. This is a major consideration in staff and volunteer screening and assignment. It is highly recommended that trained personnel, whether volunteer or paid staff, be used in direct mass fatality response operations whenever possible.

## ***Purpose of the Staff/Volunteer Processing Center***

The purpose of the staff/volunteer processing center is to manage the additional staff and volunteers that will be required for effective response by:

- Assigning registered volunteers.
- Managing unregistered volunteers.
- Providing orientation for all volunteers.
- Providing Just-In-Time training for assigned functions.
- Providing medical and/or behavioral health assessments and interventions as necessary.

## ***Who is Responsible for the Staff/Volunteer Processing Center?***

The staff and volunteer processing center is the responsibility of Emergency Operations Center Logistics. It is likely that Logistics will work with the jurisdiction's human resources department, a local volunteer center, and/or similar organization to manage the staff/volunteer processing center.

## ***Existing Systems for Advance Registration of Volunteers***

There are several existing systems that have volunteer resources that can assist in a mass fatality and are available to help deliver volunteers during a declared disaster or public health emergency.

The key advantage of these systems is:

- Volunteer registration, screening, resource typing, and emergency verification of the identity, credentials and qualifications of volunteers is complete prior to the disaster.
- Training has often been provided.
- Clear protections for volunteers have been established beforehand (e.g., liability of volunteers and hosts, worker's compensation, allowance for sharing of health volunteers across state lines, and privacy).

An important part of mass fatality planning is to determine the protocol for accessing existing resources in the event of a mass fatality.

## **Disaster Mortuary Response Team (DMORT)**

DMORT is part of National Disaster Medical Services (NDMS) and is the federal resource most likely to be required in a mass fatality. DMORT teams possess the Medical Examiner/Coroner (ME/C) Office personnel skill set. They aid in the evaluation of the incident; in the assessment of personnel and equipment needs; in the recovery, identification, and processing of deceased victims; and in setting up, assisting and advising on family assistance best practices.

Additional ME/C Office personnel are also accessed through a state's coroner mutual aid system and/or through the Emergency Management Assistance Compact. The local ME/C is responsible for initiating the request for this assistance.

## **The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)**

ESAR-VHP is a registry for volunteer health professionals. It is a national, state-based volunteer registry system that is being developed in every state under the auspices of the state health department or the state emergency response system.

## **Disaster Medical Assistance Team and the National Nurse Response Team.**

Both teams are part of the National Disaster Medical System (NDMS). The Disaster Medical Assistance Teams (DMAT) are highly organized and trained teams of health professionals dedicated to providing medical care during a disaster. The National Nurse Response Team (NNRT) is a specialty team of registered nurses dedicated to providing chemoprophylaxis, managing a mass vaccination program, or responding to a use of a weapon of mass destruction that requires surge capacity of registered nurses.

## **The Medical Reserve Corps (MRC)**

The MRC includes teams of local volunteer medical and public health professionals who can be used to supplement existing emergency and public health resources. While the MRC national office functions under the auspices of the U.S. Surgeon General, the MRC units are organized and managed at the community level.

## **The American Red Cross (ARC)**

The American Red Cross is a well-known humanitarian organization that provides relief to victims of disasters while also working to prevent, prepare for, and respond to emergencies. The Red Cross provides significant opportunities for training in a variety of response missions through its local chapters. The American Red Cross Disaster Services functions and activities that may be available as part of a mass fatality response and for which the ARC recruits and trains volunteers include:

- Administration and management of all ARC staff and volunteers.
- Personnel for family assistance center operations and for staff support functions at the incident site and at the morgue, including disaster mental health services, spiritual care, and medical care.
- Additional family assistance center services, including family assistance center setup, family escorts, hotline, child care, interpretation and translation services, public affairs, supervision and management of staff and family dining areas, and coordination of therapy dogs.
- Logistics Support to address facility requirements and daily supply needs at the family assistance center and for staff support functions at the incident site and at the morgue.

## ***Staff/Volunteer Processing Center Overview***

The information provided includes staff volunteer processing center facility selection; guidelines for mass fatality staff; and staff/volunteer processing center functions.

### **Facility Selection**

The staff/volunteer processing center can be set up at one or at several sites. Hotels, office buildings, vacant commercial buildings, and personnel training facilities operated by the jurisdiction or a local corporation are all possible facilities for this function.

### **Guidelines for Mass Fatality Staff**

In order to mitigate potential long-term psychological and physical health problems resulting from mass fatality response operations, the following guidelines are recommended for mass fatality staff:

- Provide training regarding the unique aspects of mass fatality incidents, including exercises in recovery, morgue operations, the handling of personal effects, and family assistance.
- Provide an introduction to the Incident Command System.
- Provide training that includes an introduction to the local mass fatality incident management plan and organizational structure.

#### Considerations:

- Individuals who are directly affected by the mass fatality incident should be considered to be at higher risk for psychological damage.
- Individuals who have experienced a recent death of a loved one should be considered to be at higher risk for psychological damage.
- Individuals who have experienced a recent life-threatening or traumatic event should be considered to be at a higher risk for psychological damage.
- Individuals assigned to mass fatality response operations must be able to work long hours without physical impairment.

These guidelines should be integrated into the staff/volunteer processing center's operations.

### **Incident Site Search and Recovery and Morgue Services**

Personnel assigned to these functions will require previous training in their assigned functions.

## **Family Assistance Center**

All personnel—staff and volunteers—that are involved in providing family assistance must demonstrate compassion, sympathy, technical expertise, and professionalism. There may also be specific requirements for each team, such as

- A minimum level of maturity/experience and possibly some behavioral health related experience for call center/hotline staff.
- A minimum baseline of experience for mental health/grief counselors and skill at distinguishing between persons experiencing normal grief and persons who are having more serious problems.
- Child care and education experience as well as emergency response training (e.g., CPR) for child care staff.

## **Staff/Volunteer Processing Center Functions**

### **Assign registered volunteers to duties.**

For volunteers in existing systems for advance registration of volunteers:

- Provide official disaster-response identification.
- Assign to duties.
- Provide information re: time to report, immediate supervisor, and directions to site.

### **Manage unregistered volunteers.**

- Verify identity and credentials.
- Identify and assess skills.
- Provide official disaster-response identification.
- Assign to duties.
- Provide information re: time to report, immediate supervisor, and directions to site.

Careful consideration should be given to choosing and using volunteers. Experience indicates that it is necessary to be wary of volunteers with ulterior motives. All volunteers should be assigned according to their knowledge, skills, and abilities as well as within liability limitations.

### **Provide orientation for all volunteers.**

Orientation should include:

- Overview of the mass fatality event's unique characteristics.
- An introduction to the local mass fatality incident management plan and organizational structure.
- Risk factors and safety issues.
- Overview of incident command system.
- Importance of self-care and breaks.
  - Emphasize that the physical, mental, emotional, and spiritual demand placed upon mass fatality workers involved in the search, recovery, transportation,

identification, and family assistance functions exceeds that of any event typically encountered in daily life and work.

- How to deal with emergencies—access the supervisor, medical care and behavioral health assistance.

### **Provide Just-In-Time training for assigned functions.**

- ***Training for staff assigned to the incident site.***
  - What to expect.
  - Incident management—direct supervisor.
  - Site/facility layout and flow of operations.
  - Location.
  - Risk factors and safety issues.
  - Job action guides or function-specific procedures and information on the handling of personal effects (may be done by team leader at incident site).
  
- ***Training for staff assigned to morgue operations.***
  - What to expect.
  - Incident management—direct supervisor.
  - Site/facility layout and flow of operations.
  - Location.
  - Risk factors and safety issues.
  - Job action guides or function-specific procedures and information on the handling of personal effects (may be done by team leader at the morgue site).
  
- ***Training for staff assigned to the family assistance center (FAC).***
  - Incident management—direct supervisor.
  - Site/facility layout and flow of operations.
  - Location.
  - Risk factors and safety issues.
  - Training (which may be done at the FAC):
    - Privacy Act and confidentiality issues;
    - General FAC policies and procedures.
  - Job action guides and/or function-specific procedures (may be done by Team Leader at the family assistance center). Resources include:
    - *Psychological First Aid, Field Operations Guide 2<sup>nd</sup> Edition* by the National Child Traumatic Stress Network and the National Center for PTSD.
    - Training by the Palo Alto Medical Reserve Corps for their 3-stage treatment alternative to Critical Incident Stress Debriefing.
    - Call Center Training: *Pentagon Family Assistance Center Call Center Staff Resource Information and Training Manual in Appendix C, the Pentagon Family Assistance Center Operations Component Source Documents.*

Note: The literature suggests that psychological debriefing may have adverse

effects on some disaster survivors and first responders. As a result, many disaster response organizations have chosen to utilize Psychological First Aid (PFA) as the supportive intervention of choice for responders in the early aftermath of disaster.

### **Provide medical and/or behavioral health assessments and interventions as necessary.**

The physical, mental, emotional, and spiritual demand placed upon mass fatality workers is great. If there is any question about a volunteer's ability to handle the job, medical and behavioral health assessments and interventions are recommended.

## ***Associated Tools and Resources***

### **Mass Fatality Staffing Requirement Tables**

- In the mass fatality toolkit, tables with required staff and alternate staff are provided for:
  - Incident Site/Human Remains Recovery.
  - Morgue Services.
  - The Family Assistance Center.

These tables can be used by the staff/volunteer processing center to identify the staff functions that require volunteers.

### **Mass Fatality Skills Checklist**

A copy of the *DMORT Team Member Data Form* is included as a tool. This form includes background information and a skills checklist specific to mass fatality response. It could be modified to capture needed information for volunteers at the staff/volunteer processing center.

### **Psychological First Aid**

*Psychological First Aid, Field Operations Guide 2<sup>nd</sup> Edition* by the National Child Traumatic Stress Network and the National Center for PTSD. Psychological First Aid (PFA) is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and foster short and long-term adaptive functioning. The guide includes:

- An introduction and overview of PFA.
- Preparing to deliver PFA.
- Core actions.
- PFA Provider Care.
- Provider worksheets.
- Handouts for survivors.

PFA is used by mental health specialists including first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizens Corps in diverse settings.

It is available at: [http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/nc\\_manual\\_psyfirstaid.html](http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/nc_manual_psyfirstaid.html).

### **Three-Stage Treatment Alternative to Critical Incident Stress Debriefing**

Training by the Palo Alto Medical Reserve Corps for their 3-stage treatment alternative to Critical Incident Stress Debriefing—Phase I: psychological first aid, Phase II: intermediate support/anxiety control, and Phase III: continued support/control or support/control plus prolonged exposure.

All three phases are empirically derived therapeutic interventions for acute stress reactions following mass casualty trauma.

Contact information for the Palo Alto Medical Reserve Corps is available at: <http://www.paloaltomrc.org/Home/tabid/37/Default.aspx>.

### **Call Center Training**

*Pentagon Family Assistance Center Call Center Staff Resource Information and Training Manual* in Appendix C, the *Pentagon Family Assistance Center Operations Component Source Documents*. It is available at: <http://www.defenselink.mil/mapcentral/actionrpt.html>.

# Family Concerns and Religious/ Cultural Considerations

## Lessons learned from prior mass fatalities are:

- The priority is to care for survivors—for the families of loved ones who have died.
- This priority must permeate all mass fatality management operations. This does not mean that every family request can be met. It does, however, mean that maintaining sensitivity to family concerns during this difficult time is paramount.
- For the bereaved, cultural and religious beliefs and death practices may lead to requests irreconcilable with the demands faced by the Medical Examiner/Coroner (ME/C) in a mass fatality. Strive to be culturally competent and sensitive—responding to requests when possible and demonstrating awareness and sensitivity when explaining why requests cannot be met. The nature and scale of the mass fatality will be the primary determinant of what can and cannot be done.

It is recommended that all personnel involved in mass fatality management read this section. All responders must be aware of key family issues and concerns so that their approach to their work reflects this awareness. This information is particularly applicable to daily operations for public communications and family assistance personnel.

## ***Family Concerns***

The following are key questions families will have. Topics of concern and language to avoid and to use are presented.

The questions and responses below are excerpts from *Providing Relief to Families After a Mass Fatality: Roles of the Medical Examiner's Office and the Family Assistance Center*, published by the Department of Justice, Office for Victims of Crime.

## **Guidelines for Talking with Families that Impact All Communications with Families and with the Public**

### **How will families be notified if their loved ones are recovered and identified?**

Families need to be assured that the spokesperson is releasing accurate information that was officially issued by the ME/C Office. Warn families that only information and notification provided by the ME/C Office through the Family Assistance Center (FAC) is credible and that information from other sources (e.g. the media, Internet, etc.) may not be correct.

It is extremely important to families:

- where the notification occurs,
- which family members are notified, and
- how they are contacted.

Mass fatality experience indicates that families should be given the choice to be notified at the FAC or at a location they choose that is convenient for them.

### **How are identifications made?**

- Provide information on all methods of identification that will be used.
  - Explain what each method involves and its reliability.
- DNA testing, in particular, involves considerations that should be explained to families.
  - Make copies of *Identifying Victims Using DNA: A Guide for Families*, Appendix G in the National Institute of Justice's *Lessons Learned From 9/11: DNA Identification in Mass Fatality Incidents*, September 2006. This guide is available in English and Spanish at: <http://www.ncjrs.gov/pdffiles1/nij/214781.pdf>.
  - Give families a realistic timeframe for DNA testing (e.g., may take 6-12 months before identifications can be made).
  - Tell families that during the DNA identification process, no material will be released until DNA testing of all common tissue is completed or at the discretion of the ME/C Office in consultation with families.

### **When and how will victims' personal effects and belongings be returned to families?**

- A loved one's personal effect(s) may be very important to the family.
- The process for recovering and returning personal effects must be established as soon as possible after the incident and understood by all involved agencies.
- The process needs to be communicated to families so that they understand it and know how long it will take until personal effects are returned.
  - If the incident is the result of a crime, some or all personal effects may be evidence and cannot be returned until after the trial.

## Can families go to the incident site?

For many families, being able to go to the incident site is extremely beneficial. It allows them to feel close to their deceased loved ones, imagine their last moments, honor them and say good-bye.

- Visits to the incident site should always be coordinated with the organization that has jurisdiction at the site (local ME/C, FBI for crimes, and National Transportation Safety Board for commercial airline accidents).
  - Spiritual care and mental health personnel should be present during visits and available to family members.
- If the visit takes place during recovery, work should stop to show respect.
- Visiting families should not be exposed to bodies, body parts, or personal effects.
- Separate visits should be arranged for families of surviving victims and for families of deceased.
- Prepare families for what they will see—describe conditions, the destruction/wreckage, and the odors.

## What is the condition of the body/bodies?

A common wish of families is to know details of their loved one's final moments before and after death and a desire to know that their dignity was not affronted. How the condition is explained requires compassion, honesty and tact.

- Provide context—explain the condition of physical structures and how the location of a victim in relation to the cause of the incident affects the condition of the body.
- Assure family members that the body of their loved one is treated with the highest degree of respect and dignity, regardless of its condition.
- *Avoid* these words or phrases: “*damage to the body,*” “*fragmentation,*” “*dismemberment,*” “*pieces,*” “*parts,*” “*destroyed body parts,*” “*damage to the body,*” and “*the body is in bad condition.*”
- *Use* these words or phrases: “*severe,*” “*significant,*” “*trauma to the body*” or “*condition of the body.*”
- Often family members prefer the term “loved one” to “victim.”
- Take cues from the family and tell them what they want to know. The amount of information families can handle is usually revealed by the questions they ask and their feedback.

## Will an autopsy be performed?

- The nature of the incident and the decision of the local ME/C determine whether or not an autopsy is performed.
- Family requests, cultural customs, and religious beliefs that prohibit autopsies should be considered.
- If an autopsy is recommended, tell families why it is necessary.

## **How do families know that the information they receive will be accurate?**

- Information regarding a mass fatality will become public through many sources—print media, television, radio and the Internet. Families need to learn about the death of a loved one from a credible source in a compassionate way—not through communications to the public.
- Remind families that information from any source other than officially recognized source(s)—which should be identified—may be inaccurate.
- Provide families with written records to ensure that they have correct information.

## **Can families obtain copies of the ME/C’s report?**

- Many families want to go over the case or see photographs of their loved ones.
- Give families the name of the person to contact in the ME/C Office with contact information and encourage them to call if they have questions.
- The ME/C Office can explain to families how and when the reports will become available.

## ***Religious/Cultural Considerations***

All societies have funeral rituals that have developed over many generations to help people cope with death and loss. Family members and loved ones will have a strong psychological need to identify lost loved ones and to grieve for them in customary ways. Religious and cultural beliefs and practices surrounding death will be important to survivors. There will likely be specific concerns regarding:

- Autopsies.
- Timeframe and handling of the body, including ceremonial washing of the deceased.
- Religious ceremonies and/or items to be left with the dead.

During a disaster, the Medical Examiner/Coroner (ME/C) will need to determine to what extent he/she is able to accommodate various religious beliefs and practices.

## **Approaches to Being Aware of Survivors’ Religious and Cultural Attitudes Surrounding Death**

A mass fatality’s victims may be local residents, a combination of local residents and residents of other communities and/or countries, or predominantly residents of other communities and/or countries. There is no way to predict this beforehand. Strategies for getting information on religious and cultural beliefs and death practices of victims’ families will be important to demonstrating cultural competence and sensitivity in a mass fatality event—even when it is impossible to meet family requests.

Your jurisdiction's population may be very diverse and the ME/C Office may be culturally competent and sensitive.

- Begin by exploring the ME/C Office approach to handling family member requests related to family religious and cultural beliefs and practices.
- Identify approaches and sources the ME/C Office uses to access this kind of information. Examples may include experience of ME/C Office personnel, specific resources or Web sites, contact with leaders of faith communities in the jurisdiction, and/or meetings with representatives of immigrant communities.

Additional strategies for ensuring cultural sensitivity in a mass fatality are:

- To note information when families are interviewed to collect antemortem data at the family assistance center about the family's religious or cultural beliefs, including practices and rituals, daily prayer times, important dates, beliefs about autopsy, and other information that may be relevant to the rescue, recovery and disposition of their loved ones.
- To consult with leaders of the appropriate religious or ethnic communities for guidance on practices and beliefs concerning death as mass fatality victims are identified and cultural/religious backgrounds becomes known.

## **When Requests Cannot Be Met**

A mass fatality is, by nature, a traumatic large-scale event for a jurisdiction that will place extraordinary demands on the local ME/C Office. If the mass fatality is the result of a crime or terrorism, that will further complicate and expand ME/C Office responsibilities.

As a result, religious and cultural beliefs and practices will most likely lead to requests irreconcilable with the demands on the ME/C Office. Whether the ME/C Office is unable to meet requests at all or can only meet some requests partially, it is critical to convey this information with compassion and sensitivity.

- Communicate with families. Explain why requests cannot be met and assure them of the ME/C's commitment to treating their loved ones with dignity and respect.
- Consider having representatives of impacted faith communities bless the incident site and morgue daily.
- Inform appropriate faith and ethnic community leaders about the role of the ME/C Office in a mass fatality:
  - Commitment to treating the dead with dignity and respect.
  - Determination of the deceased's identification.
  - Determination of the cause of death.

- Death notification.

Explain the reasons why requests cannot be met or can be only partially met with compassion and sensitivity. Affirm the ME/C's professionalism and commitment to treating the dead with dignity and respect.

- Seek the support and leadership of appropriate faith/cultural/ethnic communities during this difficult time in providing information to families/communities that are impacted.
- Keep the Joint Information Center informed of these concerns so that public communications are culturally competent and respectful.

## **Resources**

*Providing Relief to Families After a Mass Fatality: Roles of the Medical Examiner's Office and the Family Assistance Center*, published by the Department of Justice, Office for Victims of Crime. This publication is available at:  
([http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf\\_11\\_2001/welcome.html](http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf_11_2001/welcome.html))

King County's Chief Medical Examiner Speaks on Issues of Cultures, Communities and the Medical Examiner's Office is available at:  
[http://ethnomed.org/ethnomed/clin\\_topics/death/me\\_interview.html](http://ethnomed.org/ethnomed/clin_topics/death/me_interview.html).

EthnoMed is a joint project of University of Washington Health Sciences Library and the Harborview Medical Center's Community House Calls Program. It is a website containing medical and cultural information on immigrant and refugee groups. While it contains information specific to groups in the Seattle area, but much of the cultural and health information is of interest and applicable in other geographic areas.

# Infection and Other Health and Safety Threats

There are multiple issues related to controlling infection and managing other health and safety threats resulting from a mass fatality incident. The jurisdiction's Health Officer and other experts who are called in based on the nature of the mass fatality incident will assess the hazards and risks of any specific incident and provide recommendations for maintaining health and safety.

## ***Overview***

General information that addresses public concerns about their health and safety is presented first.

Information that addresses the risks and risk management, especially recommended precautions and personal protective equipment (PPE) for people who must directly handle human remains—recovery personnel, people involved in identifying remains, and people who prepare remains for burial or cremation—follows.

## ***Public Concerns***

In the aftermath of a mass fatality, the public will have multiple concerns. It is critical that accurate scientific-based information be available in a timely manner. It may be helpful to distinguish between being near human remains and handling human remains.

### **First, advise the public not to handle human remains.**

If human remains are found, report it to local law enforcement and do not handle the remains. This is important for several reasons:

- To facilitate accurate identification.
- To preserve evidence, if a crime has been committed.
- To protect the public from possible exposure to blood-borne viruses and bacteria that can be a risk when directly handling human remains.
- To protect the public from other health and safety threats that may be associated with the incident.

**Second, provide accurate information to the public regarding the risk of contagion or infectious disease from being near human remains so that any and all actions taken to manage a mass fatality are based on scientific evidence and not on unfounded fears.**

This is important because the risk of contagion or infectious disease from being near human remains is often a concern for the average person after a mass fatality. However:

- According to the Centers for Disease Control and Prevention, there is no direct risk of contagion or infectious disease from being near human remains for people who are not directly involved in recovery or other efforts that require handling dead bodies.
- Epidemics do not occur spontaneously after a natural disaster and dead bodies will not lead to catastrophic outbreaks of exotic diseases, according to the Pan American Health Organization (PAHO). Dead bodies pose less risk of contagion than a person who is alive and infected—infectious agents do not survive long in dead bodies.
- From the public health perspective of lowering the risk of possible infectious disease transmission, there is no requirement for mass burials or cremation. If available, refrigeration can reduce the rate of decay and facilitate identification. However, it is not required. The sight and smell of decay are unpleasant, but do not create a public health hazard.
  - This is also true for a pandemic influenza event.
    - The body is not “contagious” after death.
    - There is no need for extreme urgency in managing human remains processing, as the bodies of those who died from the event should not pose additional health risks to the community.
- PAHO recommendations regarding mass fatality management include:
  - Avoid mass burials and mass cremations under any circumstances—they violate the human rights of families and survivors.
  - Avoid subjecting response personnel and the general population to mass vaccination against diseases supposedly transmitted by cadavers.
  - Respect cultural and religious beliefs, even when the identities of the dead are unknown. Show respect for the beliefs of those at the site of the tragedy.
  - The identification of the deceased is a technical process to be carried out regardless of the numbers in accordance with established procedures. Departing from these procedures can produce legal consequences.

**Third, identify the real risks to the public related to the mass fatality incident, inform the public, and advise the public on how to protect themselves.**

- In areas affected by the incident, exercise caution to avoid real threats to health and safety, such as injury hazards from sharp debris and from unidentified structural damage to buildings, roads, and industrial facilities.

- Advise the public of any incident-specific threats and how to protect themselves such as:
  - Loss of sanitary infrastructure that results in uncontrolled sewerage,
  - Loss of drinking water treatment capacity,
  - Power failures that result in inability to refrigerate foods and medical supplies that require refrigeration,
  - Flooding when there is significant displacement and/or water sources are compromised, and
  - Situations that involve hazardous material agents—chemical, biological or radiological.
- Manage survivors effectively. How the survivors are managed, rather than how the dead are managed, determines if and when an epidemic may occur. Unsafe food, lack of access to safe water, and lack of facilities for personal hygiene and safe sanitation arrangements all create a risk. When large numbers of people in overcrowded temporary shelters are added, an epidemic is possible.

## **Worker Concerns**

At the outset of the mass fatality incident, public health, environmental health, Hazmat and others will be called in as needed to evaluate the scene, identify risks, and advise on how to manage the risks.

Personal protective equipment (PPE) will be required for all personnel handling human remains. The proper protocol and use of PPE are paramount to achieving successful management of a mass fatality incident.

This section is followed by lessons learned from terrorist attacks regarding protection of emergency responders.

## **Risks for Mass Fatality Recovery Workers**

People who must directly handle human remains—recovery personnel, people involved in identifying remains, and people who prepare remains for burial or cremation—face risks specifically associated with handling remains as well as other hazards specific to the incident.

### **Handling Human Remains—Infectious Diseases** (*potential risks to all who directly handle human remains*)

When the body dies, the environment in which pathogens live can no longer sustain them. However, this does not happen immediately for all pathogens and transmission of an infectious agent from a dead body or fragmented remains to a living person may occur. The most likely

types of infections to which workers who routinely handle human remains—as opposed to someone walking nearby—are exposed include those produced by:

- blood borne viruses (such as hepatitis viruses and HIV),
- gastrointestinal infections (bacterial diseases such as shigella and salmonella), and
- Mycobacterium tuberculosis.

Microorganisms involved in the decay process (putrefaction) are not pathogenic.

### **Handling Human Remains—Pandemic Influenza Specific Risks**

In the event of a pandemic influenza, special infection control measures are not required in the handling of persons who died from influenza, as the body is not “contagious” after death.

However, if the pandemic influenza-infected patient died during the infectious period, the lungs may still contain virus.

- Additional respiratory protection is needed during autopsy procedures performed on the lungs or during procedures that generate small-particle aerosols (e.g., use of power saws and washing intestines).
- Additional respiratory protection is needed during the embalming process when decedents are embalmed in preparation for burials and cremations.

### **Additional Risks Specific to the Mass Fatality Incident**

There are also likely to be additional risks or hazards for which recovery personnel will need protection. The additional hazards will be specific to the mass fatality incident.

The following are key hazards that were identified as typical at a conference sponsored by the National Institute for Occupational Safety and Health (NIOSH) and organized by the RAND Science and Technology Policy Institute on protecting emergency responders. While the conference focused on terrorist attacks, these attacks share some characteristics with large-scale natural disasters.

- Hazards associated with building fires—flames, heat, combustion by-products, smoke.
- Rubble and debris.
- Air choked with fine particles.
- Hazardous materials (e.g., anhydrous ammonia, Freon, battery acids).
- Potential risk of secondary devices or a follow-on attack if the incident is an act of terrorism.

### **Risk Management**

The following are considered best practices for managing risks associated with the multiple hazards mass fatality recovery workers face.

- **Evaluate the scene/worksite and develop a safety plan.**
- **Monitor exposure:**
  - When required by a specific standard (e.g. as specified by OSHA standards for benzene, lead, asbestos, noise).
  - When exposure is reasonably anticipated to be greater than the “action level,” as required by an individual OSHA substance-specific standard. This is recommended for assessing exposure to other chemicals that response and recovery workers may be exposed to. Screening data, previous sampling results, and anecdotal information may be evaluated to assess an employee’s anticipated exposure.
  - When necessary to assess and evaluate specific employee exposure or to investigate and resolve employee complaints and concerns.
  - To verify the adequacy of the implemented hazard control methods.
- **Mitigate hazards according to the hierarchy of controls listed below:**
  - **Elimination or substitution:** Whenever possible, eliminate the hazard from the work area (e.g., repair or remove fallen electrical power lines before allowing other work to proceed in the area). Although desirable, elimination and substitution may not be options for most airborne/chemical hazards created by a disaster.
  - **Engineering controls:** Take steps to reduce or eliminate exposure to a hazard, such as by guarding the pinch points associated with a machine's moving parts, providing ventilation to a permit-required confined space, using heavy equipment with temperature-controlled cabs, and placing barriers around the swing radius of rotating heavy equipment.
  - **Work practice or administrative controls:** Implement work procedures that reduce the probability of exposure. For example, use well-rested crews and daylight hours to perform higher hazard or unfamiliar tasks, take frequent breaks during hot weather, remove non-essential personnel from the area during certain task/operations, and decontaminate equipment and personnel after contact with contaminated floodwater or chemicals. When possible, use water to suppress dust and work up-wind in dusty conditions. Where extensive hot work is performed in the form of cutting and burning, use extended length torch handles to increase the distance from the individual's breathing zone to the generation of toxic fumes.

Performing specific Job Hazard Analyses (JHAs) often will identify important work practice controls. OSHA provides assistance on developing JHAs.

- **Personal protective equipment (PPE):** If other controls are not available, infeasible, or do not provide sufficient protection, select and use PPE appropriate for the hazard and level of exposure. OSHA provides assistance on selecting and using PPE.

## Recommendations for Personnel Handling Human Remains

The following recommendations are provided for personnel assigned to human remains recovery, examination and identification duties, and for personnel in the death care industry who prepare remains for burial and cremation. General recommendations for all personnel handling human remains are followed by recommendations organized by site: incident site, morgue, and funeral service.

All of these recommendations may be modified and/or augmented, based on the nature of the incident.

### General Recommendations for All Persons who Handle Human Remains

The risk of contagion can be minimized with basic precautions and proper hygiene.

Simple measures to reduce the risk of infection associated with handling dead bodies and fragmented remains include:

- Basic hygiene:
  - Hand/face hygiene using antimicrobial aqueous wipes at site of operations,
  - Soap and water hand washing and shower at end of operational period, and
  - Soap and water cleaning of equipment at end of operational period.
- Tetanus and Hepatitis B vaccination.
- Tuberculin testing as a follow-up measure.

Key Engineering Controls and Work Practices:

- Basic instruction about the risks and precautions, especially for response workers who are not experienced handling the dead.
- Use of personal protective equipment (PPE) as directed by the health officer and safety plan.
- Follow universal precautions, including washing any areas of the body or clothing that become contaminated with blood or bodily fluids.
- Wash hands with soap and water every time gloves are removed. In the absence of soap and water, use an alcohol-based hand cleaner after glove removal. However, wash hands with soap and water as soon as feasible.
- Do not wear PPE or clothing that has been damaged or has been penetrated by body fluids.
- When PPE is breached:
  - Skin/mucosal irrigation with clean water or saline.
  - Saline irrigation of wound.
  - Antimicrobial aqueous wipe of skin or of skin around wound (not within wound), cover wound.
  - DoL CA-20.
- Report injuries and exposures to body fluid to supervisor immediately.

- Decontaminate equipment before reuse; do not reuse gloves or other disposable PPE.

## **PPE Recommendations for Incident Site Personnel who Handle Human Remains**

*General PPE* recommended for everyone includes:

- Hard hat for overhead impact or electrical hazards.
- Eye protection with side shields.
- Gloves chosen for job hazards expected (e.g., heavy-duty leather work gloves for handling debris with sharp edges and/or chemical protective gloves appropriate for chemicals potentially contacted).
- ANSI-approved protective footwear.
- Respiratory protection as necessary—N, R, or P95, filtering face pieces may be used for nuisance dusts (e.g., dried mud, dirt and silt) and mold (except mold remediation). Filters with a charcoal layer may be used for odors.

*Additional PPE recommendations for workers at the incident site that will be handling human remains includes:*

- Fluid-proof gloves (e.g., latex, nitrile, rubber). Cover with heavy-duty work gloves if potential for cuts and abrasions (e.g., moving debris).
- Protective clothing appropriate for preventing blood penetrating to underlying skin/clothing.

When additional hazards are identified, PPE requirements will be adjusted to address those specific hazards.

## **Recommendations for Morgue Site Personnel**

Morgue personnel will wear PPE as directed by the ME/C Office. This will include typical morgue PPE and any additional PPE specific to the incident as directed by the Health Officer.

In the event of a pandemic influenza, additional respiratory protection is needed during autopsy procedures performed on the lungs or during procedures that generate small-particle aerosols (e.g., use of power saws and washing intestines) in case the decedent was infectious when he/she died.

Potentially contaminated human remains (e.g., biological such as a category a biological agent, chemical or radiological contamination) must be decontaminated prior to introducing them into the morgue facility.

## **Recommendations for Funeral Service Personnel**

Funeral service personnel that handle human remains will wear typical PPE associated with their profession unless otherwise directed by the Health Officer.

In the event of a pandemic influenza, additional respiratory protection similar to requirements for autopsy procedures will be needed for personnel who are involved in embalming those who die from the pandemic in preparation for burial or cremation in case the decedent was infectious when he/she died.

If funeral service personnel encounter potentially contaminated remains (e.g., biological such as a category a biological agent, chemical or radiological contamination), they must:

- Take steps to protect themselves and other mortuary staff.
- Immediately stop the removal process.
- If removal has already been made to the mortuary, stop all processing efforts.
- Notify the ME/C Office of the circumstances as then known and prepare to release the remains to the ME/C for investigation.

When remains cannot be adequately decontaminated, they will be placed in a sealed container that can be externally decontaminated prior to release to the funeral service by the decontamination team at the incident site. The sealed container must not be reopened prior to final disposition.

### **Further Information**

For further information, the U.S. Army Center for Health Promotion and Preventive Medicine's (USACHPPM) *Guidelines for Protecting Mortuary Affairs Personnel from Potentially Infectious Materials* provides a detailed guide for protecting all workers handling human remains, including a chart that specifies personal protective equipment for specific tasks in recovery and mortuary operations.

## ***Protecting Emergency Responders: Lessons Learned from Terrorist Attacks***

The National Institute for Occupational Safety and Health (NIOSH) RAND Science and Technology Policy Institute Conference for individuals with firsthand knowledge of emergency response to terrorist attacks was convened in December 2001. The impetus for this conference was the realization that after the September 11 terrorist attacks 1) the equipment and practices used to protect emergency responders in the line of duty needed to be reconsidered, 2) preparation is the key to protecting the health and safety of emergency responders, and 3) lessons learned from previous responses are of value for future response efforts. Conference attendees included persons who responded to the 1995 attack on the Alfred P. Murrah Federal Building in Oklahoma City, the September 11 attacks on the World Trade Center and the Pentagon, and the anthrax incidents that occurred during autumn 2001.

The conference identified and focused on *three unique challenges related to the terrorist incidents*:

- Large scale.
- Long duration.
- Complex in terms of the range of hazards presented.

These challenges are also shared by large-scale natural disasters such as major earthquakes and hurricanes.

### **Key concerns regarding personal protective equipment performance and availability during previous responses included:**

- PPE availability was as important as concern for PPE performance.
  - PPE was not supplied in sufficient quantity at the attack sites to meet the scale of the problem.
  - PPE was not typically designed for:
    - the continuous use associated with a sustained response campaign.
    - the range of hazards responders encountered.
  - Many responders suggested that the PPE impeded their ability to accomplish their missions.
  - Respiratory protection elicited the most extended discussion across all of the professional panels.
  - There were serious problems with equipment not being comfortable enough to allow extended wear during demanding physical labor.
- Many types and brands of equipment were used by the various responder organizations or were supplied by various sources.
  - There was no interoperability among the different types of equipment.
  - The large volume of equipment sent to the site and lack of unified command overseeing protection of first responders made it very difficult to match responders with appropriate equipment and supplies.
- Conflicting safety messages from responding organizations complicated responder protection efforts.

## **Recommendations for Protecting the Health and Safety of Emergency**

### **Responders**

The following recommendations were made to help protect the health and safety of workers as they respond to acts of terrorism. Many of the recommendations are also applicable to other major disasters.

## Personal Protective Equipment Performance

- Develop guidelines for the appropriate PPE ensembles for long-duration disaster responses involving rubble, human remains, and a range of respiratory threats.
- Define the appropriate ensembles of PPE needed to safely and efficiently respond to biological incidents, threats, and false alarms.
  - Provide comparable levels of protection for all responders.
  - Address the logistical and decontamination issues associated with large numbers of responders in short time periods.

## Personal Protective Equipment Availability

- Explore mechanisms to effectively outfit *all* responders at large incident sites with appropriate PPE as rapidly as possible.
  - Include PPE for emergency medical technicians who are treating casualties at the disaster site.
- Identify and examine any barriers to equipment standardization or interoperability among emergency responder organizations and develop strategies to reduce barriers.
  - Consider coordinating equipment procurement among local organizations.

## Training and Information

- Define mechanisms to rapidly and effectively provide responders at incident sites with useful information about the hazards they face and the equipment they need for protection.
  - Coordinate training so that all responders are getting the same information.
    - Providing better and more consistent information could motivate responders to wear PPE and could decrease the tendency to modify it or take it off when it becomes uncomfortable.
  - Be prepared for large numbers of workers, particularly construction workers and volunteers, who may not be familiar with most PPE.
- Explore ways to ensure that responders at large-scale disaster sites are appropriately trained to use the PPE they are provided.
  - Before an incident occurs, train those who are likely to be involved in a response on the proper selection and operation of PPE.
- Consider logistical requirements of extended response activities during disaster drills and training.

## Management

- Establish a unified command to coordinate/handle responder health and safety/PPE:
  - Past experience indicates that proper site management had a decisive effect on whether PPE was available, appropriately prescribed, used, and maintained.
- Provide guidelines and define organizational responsibilities for enforcing PPE use at major disaster sites.
  - While such guidelines must address the risks responders are willing to take when the potential exists to save lives (a period early in a chaotic response), they must also consider that during long-term responses, the health and safety of responders should be a principal concern.
  - Identify an organization not directly involved in or affected by the incident to enforce PPE use for all responders, including removing responders from the site if they do not comply with use requirements.
- Develop mechanisms to allow rapid and efficient scene control at disaster sites as early as possible during response.
  - Erect a “hard perimeter,” such as a chain link fence, to make sure only essential personnel operating under the direction of the scene commander are on-site.
  - Avoid situations where personnel with search and rescue or search and recovery responsibilities are personally holding people back and isolating the scene.

The RAND Science and Technology Policy Institute followed their conference monograph with three additional volumes on protecting emergency responders:

Volume 2 in 2003: *Protecting Emergency Responders: Community Views of Safety and Health Risks and Personal Protection Needs*. This volume examines the hazards emergency responders face and the personal protective technology needed to contend with those hazards.

Volume 3 in 2003: *Protecting Emergency Responders: Safety Management in Disaster and Terrorism Response*. Volume 3 provides recommendations for preparing for response to natural disasters and other large-scale incidents.

Volume 4 in 2006: *Protecting Emergency Responders: Personal Protective Equipment Guidelines for Structural Collapse Events* is a technical source of NIOSH incident commander guidelines for emergency response immediately following large structural collapse events.

## Resources

### Public Concerns

Eberwine, Donna. *Disaster Myths That Just Won't Die*. **Perspectives in Health**. 2005; 10(1) is available at: [http://www.paho.org/english/dd/pin/Number21\\_article01.htm](http://www.paho.org/english/dd/pin/Number21_article01.htm).

Morgan, O. *Infectious Disease Risks from Dead Bodies following Natural Disaster*. **Rev Panam Salud Publica**. 2004;15(5):307-12, available at: [http://publications.paho.org/pdf/dead\\_bodies.pdf](http://publications.paho.org/pdf/dead_bodies.pdf).

Pan American Health Organization, *In Natural Disasters, Cadavers Pose No Threat of Disease*, Press Release, September 23, 2004.

World Health Organization's Flooding and Communicable Diseases Fact Sheet, available at: [http://www.who.int/hac/techguidance/ems/flood\\_cds/en/print.html](http://www.who.int/hac/techguidance/ems/flood_cds/en/print.html).

### Worker Concerns

Centers for Disease Control and Prevention's *Interim Health Recommendations for Workers who Handle Human Remains*, January 2005 is available at: <http://www.bt.cdc.gov/disasters/tsunamis/handlerremains.asp>.

*EPA Levels of Protection*, Environment, Health and Safety Online, available at: [http://www.ehso.com/OSHA\\_PPE\\_EPA\\_Levels.htm](http://www.ehso.com/OSHA_PPE_EPA_Levels.htm).

Florida Department of Health—Office of Emergency Operations FEMORS Program, *Handling of Disaster Victim Human Remains*, is available at: <http://www.emlrc.org/pdfs/disaster2005presentations/HandlingofContaminatedHumanRemains.pdf>.

Jackson B. A., Baker J. C., Ridgely M. S., Bartis J. T., Linn H. I. *Protecting Emergency Responders: Safety Management in Disaster and Terrorism Response*. Volume 3. RAND, 2003, available at: [http://www.rand.org/pubs/conf\\_proceedings/CF176/index.html](http://www.rand.org/pubs/conf_proceedings/CF176/index.html).

Jackson B. A., Peterson D. J., Bartis J. T., Latourrette T., Brahmakulam I.T., Houser A., Sollinger J.M. *Protecting Emergency Responders: Lessons Learned from Terrorist Attacks*. Conference Proceedings. Volume 1. RAND, 2002, available at: [http://www.rand.org/pubs/conf\\_proceedings/CF176/index.html](http://www.rand.org/pubs/conf_proceedings/CF176/index.html).

LaTourrette T., Peterson D. J., Bartis J. T., Jackson B. A., Houser A. *Protecting Emergency Responders: Community Views of Safety and Health Risks and Personal Protection Needs*. Volume 2. RAND, 2003, available at: [http://www.rand.org/pubs/monograph\\_reports/MR1646/](http://www.rand.org/pubs/monograph_reports/MR1646/)

OSHA Fact Sheet, available at:

[http://www.osha.gov/OshDoc/data\\_Hurricane\\_Facts/mortuary.pdf](http://www.osha.gov/OshDoc/data_Hurricane_Facts/mortuary.pdf).

*Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employees*, Occupational Safety and Health Administration, U.S. Department of Labor, OSHA 3328-05, 2007, available at [www.osha.gov/Publications/OSHA\\_pandemic\\_health.pdf](http://www.osha.gov/Publications/OSHA_pandemic_health.pdf).

*Scene Operations, to Include Identification, Medico-legal Investigation Protocols and Command and Control of Mass Fatalities resulting from a Pandemic Influenza Event in the United States*, Fatality Management Pandemic Influenza Working Group Conference White Paper, March 2006 is available at: <http://www.pandemicpractices.org/practices/resource.do?resource-id=176&standards-id=4>.

*California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan*, The State of California Governor's Office of Emergency Services, September 2007 is available at: <http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. Click on Coroner's Mutual Aid.

USACHPPM, *Guidelines for Protecting Mortuary Affairs Personnel from Potentially Infectious Materials*. October 2001 is available at: <http://chppm-www.apgea.army.mil/documents/TG/TECHGUID/TG195a.pdf>.

U.S. Department of Labor Occupational Safety and Health Administration Community Support and Public Health Services:

*Removing Human and Animal Remains* is available at:

<http://www.osha.gov/SLTC/etools/hurricane/remains.html>.

*General Recommendations for Working in All Impacted Areas* is available at:

<http://www.osha.gov/SLTC/etools/hurricane/recommendations.html>

Willis H. H., Castle N. G., Sloss E. M., Bartis J. T., *Protecting Emergency Responders: Personal Protective Equipment Guidelines for Structural Collapse Events*. Volume 4. RAND, 2006, available at: <http://www.rand.org/pubs/monographs/MG425/>.

## **Associated Tools**

The Pan American Health Organization's *Frequently Asked Questions on the Management of Cadavers* is attached.

The Pan American Health Organization prepared these frequently asked questions to assist communities that are dealing with mass fatalities. It is a tool a jurisdiction may want to use to inform the community.

# Pandemic Influenza

What is a pandemic?

The word “pandemic” is used to describe a disease that affects people on a worldwide scale. Flu pandemics have occurred roughly every 30 to 40 years throughout history, and it has been nearly 40 years since the last influenza pandemic.

Three conditions must be met to result in a pandemic:

1. The emergence of a new influenza strain.
2. The ability of that strain to infect humans and cause serious illness.
3. The ability to spread easily among humans.

The occurrence of the avian influenza virus (H5N1) presents the possibility of this virus eventually undergoing a major change in genetic composition, allowing it to become transmissible person-to-person. It is this major genetic “shift” that creates a “novel” virus and the potential for a pandemic. Given the current high case fatality rate with H5N1, it is currently estimated that, should this virus become transmissible person-to-person, a worst-case scenario pandemic influenza will result in a case fatality rate higher than that of the 1918 Spanish flu. According to the World Health Organization, we are currently in Phase Three (of six phases) of the Pandemic Alert Period.

Many communities have developed pandemic influenza plans. However, managing the expected large numbers of deaths has not always been addressed.

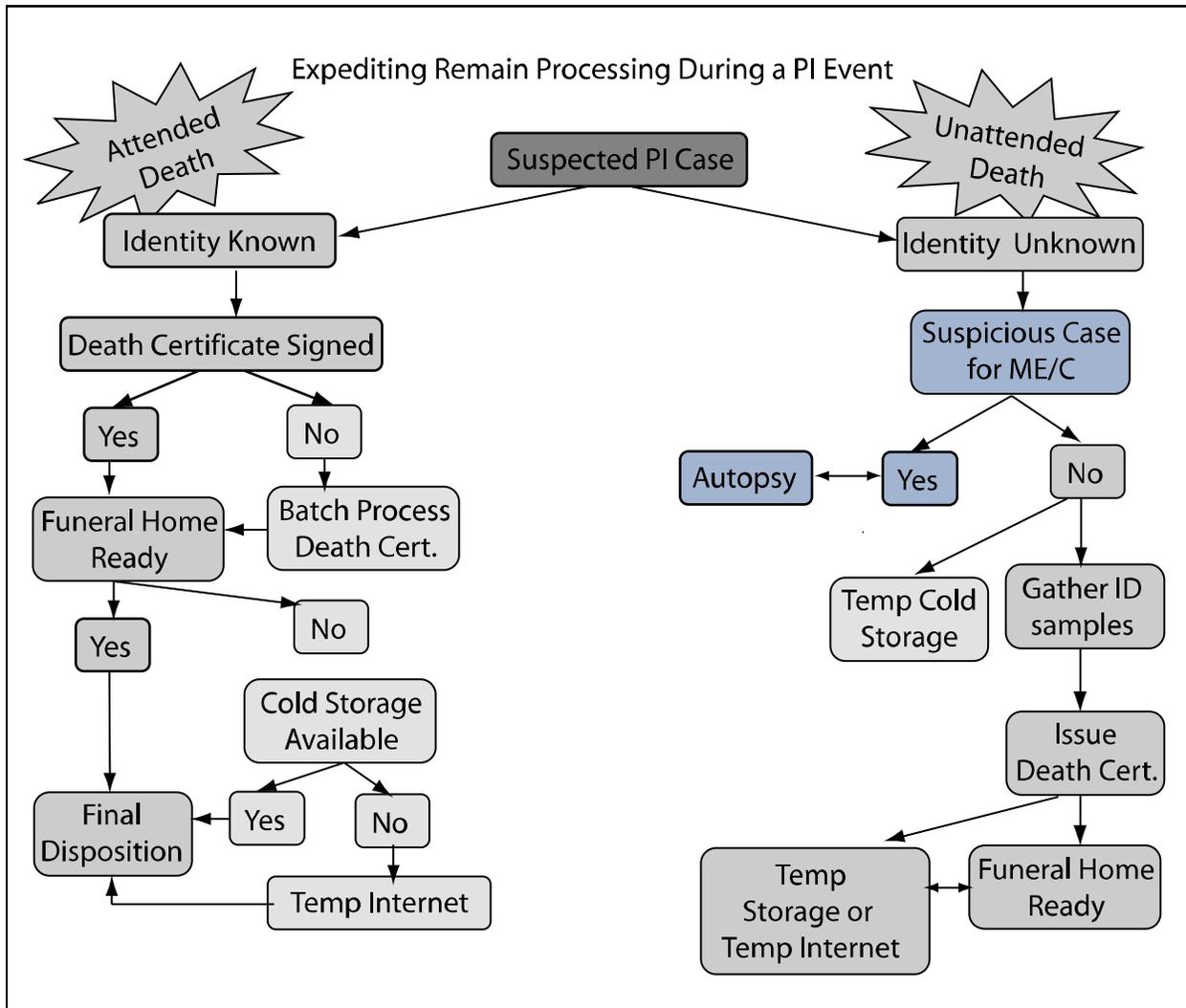
These assumptions are examples of the potential impact of a worst-case scenario pandemic influenza (PI) event.

- Susceptibility to pandemic influenza will be universal.
- There may be a case fatality rate of up to 5% in addition to the average rate of deaths from other causes.
- Up to 40% of the workforce could be absent from work during peak periods.
- Mutual aid resources from state or federal agencies to support local response efforts may not be available.
- It is estimated that 50% to 75% of deaths will occur outside of a hospital or medical treatment facility.
- The death care industry could expect to handle about six months work within a six to eight week period.
- The time to complete fatality management of a PI event may exceed six months to a year.

During a pandemic, local authorities have to be prepared to manage additional deaths due to influenza, over and above the number of fatalities from all causes that are normally expected. Trigger points for different ways of working are likely to vary. For some, it will be the number

of increased deaths that will be the tipping point. Limited storage space at local mortuaries and funeral homes may be the tipping point. For others, absenteeism might be the tipping point. It is likely that a combination of a number of pressure points would see activation of different ways of working. The trigger point at which a jurisdiction activates its mass fatality plan should be part of the pandemic planning process.

The following is a proposed flow chart for handling human remains during peak periods of a pandemic influenza.



Source: *Morgue Operations, Identification, and Command and Control of Mass Fatalities resulting from a Pandemic Influenza Event in the United States*

It is recommended that the ME/C Office, local authorities, funeral directors, private cemeteries, crematoria, and religious groups/authorities be engaged in reviewing the flow chart above and reviewing, discussing and planning for addressing the issues identified in the following table. This planning will augment existing mass fatality management plans, which will be activated during a pandemic.

**General Guidelines:**

*All personnel will wear personal protective equipment as directed by the Health Officer.*

- Protecting employee health and reducing the spread of infection among workers is a priority.
- All personnel handling dead bodies in mass fatality response will also receive proper immunizations as appropriate; training in blood borne pathogens, personal protective equipment (PPE), and proper lifting techniques; and PPE as defined by existing regulations, for example:
  - Disposable, long-sleeved, cuffed gown (waterproof if possibly exposed to body fluids).
  - Single-layer non-sterile ambidextrous gloves which cover the cuffs of the long-sleeve gown.
  - Surgical mask ( a particulate respiratory if handling the body immediately after death).
  - Surgical cap and face shield if splashing of body fluids is anticipated.
  - Waterproof shoe covers if required.

Proper hand washing is *always* recommended when handling remains.

**Family Care Plans.** The ME/C, vital records system, and death care industry should encourage employees to develop “family care plans” knowing that they may not be able to be with their families for extended periods during waves of severe disease during the pandemic period.

<b>Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza</b>
<b>Planning for Possible Solutions</b>
<b>Emergency Operations Center and Public Health Department Actions for Managing Deceased</b>
<p>Consider ME/C Office and death care industry personnel as first responders.</p> <ul style="list-style-type: none"> <li>▪ Classify ME/C Office and death care industry personnel as first responders for priority prophylaxis and antivirals.</li> <li>▪ Ensure the ME/C Office’s and death care industry’s priority access to labor, supplies, personal protective equipment, vaccines, fuel, raw materials, communication bandwidth, transportation, security, temporary housing as needed, and other resources.</li> </ul> <p>Consider involving Public Health, the ME/C, and police in developing specific investigative checklists, which clarify the concepts of medico-legal determination of cause and manner of death, victim identification procedures, scene documentation, overall investigative requirements, and required PPE and personal decontamination, for all call centers and responders to unattended deaths during a PI event.</p>

## Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza

### Planning for Possible Solutions

Train all first responders in the field about the symptoms of PI deaths and the actions to take when a suspected PI event related death is found vs. when non PI event related deaths are found.

Consider establishing a dispatch/tracking system with a centralized database that is separate from emergency medical services and 911 systems to track patients and deaths. Design it so that it can be managed through family assistance and patient tracking centers. Link all first responders/health care centers/collection points/morgues/family assistance/ME/C Office/law enforcement/etc. to this system. Consider facilitating its use by private citizens.

Consider establishing a county voluntary registry of next of kin so families can register information before a disaster.

Implement reciprocal licensing of mortuary services personnel to overcome variations in state licensing of funeral directors, embalmers, cemetery, and crematory operations, and unionized labor.

Educate behavioral health professionals, social service organizations and religious leaders regarding the process for managing human remains to ensure the process is understood and can be properly communicated to the general population in their response activities.

Advise the ME/C Office and death care industry of additional respiratory protection that is needed

- During autopsy procedures performed on the lungs or during procedures that generate small-particle aerosols (e.g., use of power saws and washing intestines) in case the decedent was infectious when he/she died.
- During embalming procedures prior to burial or cremation.

If families will be transporting loved ones who have died from pandemic influenza, provide education on general precautions for handling dead bodies. Special precautions are not required since the “body” is not contagious after death.

Track federal, state, and local laws applicable to the handling of human remains that impact the ME/C, vital records system, and death care industry. Existing laws, such as time requirements for completing death certificates and disposition permits, may need to be amended/waived. Alert all parties to waivers and modifications that impact services.

#### Step: Death Pronounced

**Requirements:** Person legally authorized to

Provide public education on what to do if someone dies, how to access an authorized person to certify death, and where to take the deceased if family or friends must transport them.

<b>Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza</b>	
<b>Planning for Possible Solutions</b>	
<p>perform this task.</p> <p><b>Limiting Factors:</b> If death occurs at home then one of these people will need to be contacted.</p> <p>Availability of people able to do this task.</p>	<ul style="list-style-type: none"> <li>▪ Consider planning an on-call system 24/7 specifically for this task that is separate from the 911 System. Keep 911 focused on calls pertaining to life safety missions.</li> </ul> <p>ALL who interface with decedents should record official personal identification information for patients who enter their systems and maintain this information in the patient’s police report and/or medical record.</p> <ul style="list-style-type: none"> <li>▪ If a deceased patient enters the system without an official photo identification, and identity is never established, healthcare facilities should report this person to the patient’s local police department. There is a possibility the deceased has been reported missing by a family member who can visually identify the decedent.</li> </ul> <p>Consult with Native Americans, Jews, Hindus, Muslims and other religious groups that have special requirements for the treatment of bodies and for funerals and involve them in planning for funeral management, bereavement counseling, and communications with their respective communities in the event of a pandemic. During the pandemic, the wishes of the family will provide guidance, however, if no family is available local religious or ethnic communities can be contacted for information.</p>
<p><b>Step: Death Certified</b> (signing of a death certificate stating the cause of death)</p>	
<p><b>Requirements:</b> Person legally authorized to perform this task.</p> <p><b>Limiting Factors:</b> Legally, may not necessarily be the same person that pronounced the death.</p>	<p>ALL who interface with the deceased should record official personal identification information (first, middle, last name &amp; suffix; race/ethnicity, color of eyes, hair, height, and weight; home address, city, state, zip &amp; telephone number; location of death and place found; place of employment and employer’s address; date of birth, social security number &amp; age; and next of kin—or witness—name, contact number &amp; address).</p> <p>To ensure proper identification of the deceased, consider implementing standardized methodology for collecting samples of deceased such as a right thumbprint, DNA sample (e.g., saliva swab or blood stain card), and a facial photograph. In the case of decomposed bodies, this may also include assistance from the ME/C for identification—anthropological markers, dental impressions, and, if possible, fingerprints, etc.</p> <p>Although these identification samples may not need to be processed, those in authority are able to substantiate the identification of the decedent at a later time should individuals</p>

## Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza

### Planning for Possible Solutions

question the ME/C about a decedent's identity.

Healthcare facilities may want to consider designating a single physician, familiar with patients' records, as responsible for expeditiously signing death certificates.

Consider pre-identifying "collection points" for the deceased to centralize processing and hold remains at the lowest appropriate local level. Have an authorized person certify deaths en masse and batch process death certificates of identified decedents to improve efficiency.

- At the designated collection point, trained personnel should sort bodies by cause and manner of death (identified PI cases vs. ME/C cases) to ease subsequent processing (victim identification and issuing a death certificate).
  - Attended deaths will have a known identity and may have a signed death certificate. Unattended deaths may require the ME/C to further process remains to determine identification, issue the death certificate, track personal effects, and notify next of kin.
- Establish a uniform method for numbering and tracking decedents, such as the state abbreviation, zip code, and a case number (with name if identified).

When moving, storing, and/or releasing remains and personal effects, keep detailed records like that of a chain-of-evidence for each individual body and personal effects bag.

Consider broadening the range of professionals who can certify deaths. Explore strategies that facilitate and provide oversight to the process of pronouncing death, determining cause and manner of death, completing death certificates and establishing victim identity. This may include amending/waiving the Health Insurance Portability and Accountability Act of 1996, other regulations, and codes to allow trained and credentialed non-ME/C personnel (such as police, fire and emergency medical services) and retired physicians to assist with these responsibilities during a large-scale emergency.

Establish a call line for ME/C consultations and physician-patient data to assist in determination of death.

### Step: Body Wrapped

## Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza

### Planning for Possible Solutions

<p><b>Requirements:</b> Person(s) trained to perform this task.</p> <p>Body bags.</p> <p><b>Limiting Factors:</b> Supply of human and physical (body bags) resources.</p> <p>If death occurs in the home: the availability of these requirements.</p>	<p>Clearly tag the body and pouch with the individual decedent’s identifiers such as name, date of birth, SSN, location of origination, medical record number, etc. Complete labeling reduces the number of times mortuary staff needs to open pouches to confirm contents.</p> <p>Consider developing a rotating six months inventory of body bags, given their shelf life.</p> <p>Consider training or expanding the role of current staff to include this task.</p> <p>Consider providing this service in the home in conjunction with pronouncement and transportation to the morgue.</p> <p>If personal effects accompany the remains in the human remains pouches, ensure that the funeral director and family are made aware of this so that effects may be safely retrieved before cremation or burial. Funeral directors and others should sign a receipt for items as well as the body.</p>
---	---

### Step: Transportation

(To “Collection Points” and/or the Morgue and To Temporary Storage or Burial Site)

<p><b>Requirements:</b> In hospital: trained staff and stretcher.</p> <p>Outside hospital: informed person(s), stretcher, and vehicle with driver suitable for this purpose.</p> <p><b>Limiting Factors:</b> Availability of human and physical resources.</p>	<p>Consider amending codes as needed regarding the use of volunteers, family members, etc., to transport the deceased.</p> <p>In hospital:</p> <ul style="list-style-type: none"> <li>▪ Consider training additional staff working within facility.</li> <li>▪ Consider keeping old stretchers in storage instead of discarding.</li> </ul> <p>Look for alternate suppliers of equipment that could be used as stretchers in an emergency e.g., trolley manufactures.</p> <p>Outside hospital:</p> <ul style="list-style-type: none"> <li>▪ Provide public education or specific instructions through a toll-free phone service regarding where to take the deceased if the family must transport.</li> <li>▪ Identify alternate vehicles that could be used for this purpose.</li> <li>▪ Consider use of volunteer drivers.</li> </ul>
--	---

<b>Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza</b>	
<b>Planning for Possible Solutions</b>	
<b>Step: Morgue Storage</b>	
<p><b>Requirements:</b> A suitable facility that can be maintained at 34-37° F, the ideal temperature for storing and preserving human remains. It does not prevent decomposition of the decedent, which continues, albeit at a slow rate for up to six months.</p> <p><b>Limiting Factors:</b> Capacity of such facilities.</p>	<p>Pre-identify and plan for possible temporary morgue storage sites:</p> <ul style="list-style-type: none"> <li>▪ Refrigerated trucks with temporary shelves and ramps.</li> <li>▪ Temporary portable facilities.</li> <li>▪ Cold storage lockers.</li> <li>▪ Conex boxes with diesel or electrical power.</li> <li>▪ Hangars.</li> <li>▪ Warehouses.</li> <li>▪ Refrigerated rail cars.</li> <li>▪ Empty public buildings that lend themselves to cooling and proper security.</li> </ul> <p>An organized, segregated storage system will provide the public a higher level of confidence that government agencies are managing the PI event well.</p> <p>Consider ice skating rinks as a resource when all other resources have been exhausted.</p> <p>Use processes routinely used in mortuaries to track and locate deceased.</p> <p>Consider some facilities maintained at -15°/-25° C or 5°/-13° F, used in forensic institutes, especially for bodies which have not yet been identified. The body is completely frozen and decomposition totally halted.</p>
<b>Step: ME/C Office and Autopsy if Required/Requested</b>	
<p><b>Requirements:</b> Person qualified to perform autopsy and suitable facility with equipment.</p> <p><b>Limiting Factors:</b> Availability of human and physical resources.</p> <p>May be required in some</p>	<p>Ensure that it is public knowledge—that all physicians and families are aware that an autopsy is not required for confirmation of influenza as cause of death.</p> <ul style="list-style-type: none"> <li>▪ However, for the purpose of health surveillance, respiratory tract specimens or lung tissue for culture or direct antigen testing could be collected postmortem to confirm the early cases that start the pandemic.</li> </ul> <p>Examine the capacity, continuity of operations planning, and surge capacity of the ME/C Office in your jurisdiction.</p> <p>Shift ME/C resources to the most vital public health functions, including body recovery, abbreviated</p>

## Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza

### Planning for Possible Solutions

circumstances.

processing, temporary storage, and tracking.

- Employ a phased operation to ensure bodies are properly identified and handled with dignity.

Identify ways to augment staff.

- Break down functions into tasks so that disaster service workers and volunteers are able to provide more effective assistance.
- Consider requesting a volunteer category for death care professionals be added to established organized volunteer Citizen Corps and/or Medical Corps.
- Provide just-in-time training for current staff who will be performing new management/oversight roles, for suitable drivers and handlers to support the human remains recovery and for other positions as practicable.

Keep daily death cases separate from PI event cases and number them using different identifiers.

Ensure that critical morgue supplies are stockpiled or develop a rotating six month inventory of essential equipment/supplies.

Consider putting in place contracts and memoranda of agreement to ensure that the ME/C Office receives priority distribution of water, generators, and gasoline.

If an autopsy is required, usual protocols based on current law will prevail.

- Consider advocating for amending regulations regarding reportable deaths. For example, the ME/C assumes jurisdiction over deaths of persons in correctional custody, deaths in mental institutions, and sometimes in nursing care facilities, regardless of the circumstances. Consider requiring ME/C jurisdiction *only* when the cause of death is of suspicious nature during the pandemic.
- Seek direction from Health Officer re: additional respiratory protection needed during autopsy procedures performed on the lungs or during procedures that generate small-particle aerosols (e.g., use of power saws and washing intestines) in case the decedent was infectious when he/she died.

<b>Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza</b>	
<b>Planning for Possible Solutions</b>	
<b>Step: Cremation</b>	
<p><b>Requirements:</b> Suitable vehicle and driver for transportation from morgue to crematorium.</p> <p><b>Limiting Factors:</b> Capacity of crematorium/speed of process.</p> <p>Availability of authorized official to issue death certificate.</p> <p>Availability of staff and resources in vital records office to certify death certificate and issue permit for disposition of remains.</p>	<p>Identify alternate vehicles that could be used for transport.</p> <p>Examine the capacity, continuity of operations planning, and surge capacity of crematoriums within the jurisdiction.</p> <p>Arrange for maintenance and inspection of equipment—ahead of periods of peak usage—with backup equipment and replacement parts stockpiled.</p> <p>Consider streamlining the completion of required cremation forms.</p> <p>Discuss and plan appropriate storage options if the crematoriums become backlogged.</p> <p>Seek direction from Health Officer re: additional respiratory protection needed during embalming procedures to prepare for cremation for those who die from the pandemic in case the decedent was infectious when he/she died.</p> <p>Examine the capacity, continuity of operations planning, and surge capacity of the vital records office.</p> <p>Consider developing arrangements between crematoriums and the local registrar to expedite the filing of a large number of death certificates and applications for cremation.</p>
<b>Step: Embalming</b>	
	<p>Examine the capacity, continuity of operations planning, and surge capacity of funeral homes in your jurisdiction.</p> <p>Consult with funeral homes regarding availability of equipment/supplies and potential need to stockpile or develop a rotating six month inventory of essential equipment/supplies.</p> <p>Consider “recruiting” workers that would be willing to provide this service in an emergency (e.g., retired workers or students in mortuary training programs).</p>

<b>Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza</b>	
<b>Planning for Possible Solutions</b>	
	<p>Consider providing embalming and casketing services in a temporary morgue.</p> <p>Seek direction from Health Officer re: additional respiratory protection needed during embalming procedures for those who die from the pandemic in case the decedent was infectious when he/she died.</p> <p>Examine the capacity and surge capacity of the vital records office.</p> <p>Consider developing arrangements between funeral directors and local registrar to expedite the filing of a large number of death certificates and applications for disposition permits.</p>
<b>Step: Funeral Service</b>	
<p><b>Requirements:</b> Appropriate location(s), casket or urn, funeral director.</p> <p><b>Limiting Factors:</b> Availability of caskets/urns.</p> <p>Availability of location for service and visitation.</p> <p>Social distancing and/or quarantine measures that may be in effect during pandemic waves.</p>	<p>Examine the capacity, continuity of operations planning, and surge capacity of funeral homes in your jurisdiction.</p> <p>Contact supplier to determine lead time for casket and urn manufacturing and discuss possibilities for rotating six month inventories—with a more that normal supply of low cost caskets and low cost alternatives.</p> <p>Consult with funeral directors to determine surge capacity and possibly the need for additional sites (e.g., use of churches, etc. for visitation).</p> <p>Develop strategies for handling services when social distancing measures and/or quarantine are in effect.</p> <ul style="list-style-type: none"> <li>▪ Consider alternatives such as video-conferences to allow for funerals to occur with relatives of the decedents having the ability to mourn but at a non-public venue.</li> <li>▪ Be prepared to clearly explain why limitations have become necessary.</li> </ul>
<b>Step: Temporary Storage while Awaiting Burial</b>	
<p><b>Requirement:</b> Access to and space in temporary storage.</p>	<p>Expand capacity by increasing temporary storage sites.</p> <p>Expand capacity by increasing temporary vault sites with security features such as covered windows</p>

<b>Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza</b>	
<b>Planning for Possible Solutions</b>	
<p><b>Limiting Factors:</b> Temporary storage capacity and accessibility.</p>	<p>and locks on doors. (Note: A vault is a non-insulated storage facility for remains that have already been embalmed, put into caskets, and are awaiting burials.)</p>
<b>Step: Burial</b>	
<p><b>Requirement:</b> Grave digger and space at cemetery.</p> <p><b>Limiting Factors:</b> Availability of grave diggers and cemetery space.</p> <p>Extreme cold and heavy snowfall.</p>	<p>Examine the capacity, continuity of operations planning, and surge capacity of cemeteries in your jurisdiction.</p> <p>Identify sources of supplementary workers.</p> <p>Consider temporary mass burials where bodies will be temporarily buried in body bags in common graves in cemeteries or at a designated location until they are exhumed at a later time.</p> <p>Be prepared to make public statements regarding storage solutions, particularly the employment of long-term temporary interment.</p>
<b>Step: Family Assistance</b>	
<p><b>Requirement:</b> The ME/C Office is responsible for providing family assistance in the event of a mass fatality.</p> <p><b>Limiting Factors:</b> The catastrophic scope of the disaster and mandated social distancing will prohibit a traditional family assistance center and dictate limitations to the provision of direct services.</p>	<p>Identify a local agency/organization to manage family assistance during a pandemic.</p> <p>Implement a <i>virtual family assistance center model</i> that includes:</p> <ul style="list-style-type: none"> <li>▪ Broadcasting information ‘pushed’ to families through mass media channels. Content may include: coping with death and dying at home, coping with illness and death at work, financial support, health issues, emotional and behavioral health concerns, Social Security questions, and legal issues.</li> <li>▪ “Warm Lines” established and staffed to provide a more direct line of communication with families and track/manage death and missing persons calls. Issues may include: death care guidance, body removal, burial sites, death certificate information, and psychological support. “Warm Lines” may include toll-free telephone lines staffed by behavioral health providers working from their homes and Internet “Counseling Rooms” established for computer-based interactions between behavioral health providers and community members needing assistance. <ul style="list-style-type: none"> <li>○ May want to consider a separate fatality/missing person information telephone number to report fatalities that can incorporate this information into a national patient tracking</li> </ul> </li> </ul>

## Issues Related To Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza

### Planning for Possible Solutions

system. Consider the National Find Family Hotline as a model.

- Face-to-Face Crisis Interventions provided by trained behavioral health services professionals with appropriate PPE for those individuals with acute psychiatric reactions.
- Strategies for providing psychological first aid and educational/informational materials for all response personnel.
- Identify interventions and strategies for assisting at-risk and/or special populations, such as those with mental and behavioral illness or disabilities and/or with general pharmaceutical needs or medication withdrawal issues, homeless, senior citizens, immigrants, and undocumented residents.

## Associated Tools

### Baron County’s Pandemic Influenza Mortuary Planning Guidelines

Barron County, Wisconsin has developed a plan which consolidates and coordinates resources under a single unified mortuary command structure at a single facility known as the Unified Mortuary Preparation Facility (UPMF). In the event of a worst-case scenario pandemic, all funeral directors in the county will temporarily close their facilities and relocate to the UPMF during waves of severe disease—consolidating all resources, including staff, equipment, and supplies. Barron County’s Pandemic Influenza Mortuary Planning Guidelines is included as a resource for your consideration.

This resource is available at: <http://flustrackers.com/forum/showthread.php?t=47605>.

### Chart to Facilitate Local Decision Making in Determining Priorities and Regulations to Amend to Achieve Acceptable Handling of Human Remains during a Pandemic Influenza Event

The following chart was developed to assist jurisdictions in making decisions about how they may want to adapt their own regulations and priorities to achieve acceptable handling of deaths in a PI event. It begins from the moment a death is discovered/reported until the body has been transported to whatever is functioning as a morgue. The columns represent the tasks that should be completed to ensure medico-legal concerns are met regarding documentation of the death scene and transport of the body to the morgue. The rows represent a qualitative division of who may have to perform said tasks as the situation deteriorates and resources are depleted.

Chart to Facilitate Local Decision Making in Determining Priorities and Regulations to Amend to Achieve Acceptable Handling of Human Remains during a Pandemic Influenza Event							
Level of Crisis	Positive or Presumptive Identification	Pronounce (Local Authority)	Collect Death Scene info PI/non-PI/ Violent	Contain	Analysis Reporting	Track (COC) HR&PE	Transport
Tier I (Normal)	LE ME/Coroner Hospital	LE ME/Coroner Funeral Director	LE ME/Coroner Physician	Human Remains Pouch (HRP)	Public Health	Standard Operating Procedures (SOP)	Morgue Funeral Homes EMS
Tier II (Surge)	Above + Funeral Directors	Above + Non-Physician Licensed Medical Professionals	Above + Non-Physician Licensed Medical Professionals	Human Remains Pouch (HRP)	LE Physicians	Bar Code RFID	Refrigerator Trucks Temporary Morgues Private Contractor
Tier III (Crisis)	Above + Family Co-worker Neighbor	Above + Non-Physician Non-Licensed Medical Professionals	Above + Non-Physician Non-Licensed Medical Professionals	Field Exp	Family	Field Exp	Gov Workers National Guard State Militia DOD
Tier IV (Overwhelmed)	Above + Witness	Above + Deputized Volunteer	Above + Deputized Volunteer	Limited	Limited	Field Exp	Non-Gov Workers Family

Source: Scene Operations, to Include Identification, Medico-legal Investigation Protocols and Command and Control of Mass Fatalities Resulting from a Pandemic Influenza (PI) in the United States

This chart is presented as a starting point for discussion so that each jurisdiction can use it to arrive at whatever compromise best suits their own situation and priorities. At the time of a PI event, it will then be up to local officials to make the decision about when which functions have reached which tier.

## Resources

*The Canadian Pandemic Influenza Plan for the Health Sector, Annex I Guidelines for the Management of Mass Fatalities During an Influenza Pandemic*, Public Health Agency of Canada, February 2004 is available at: <http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-i-eng.php>.

*California Mass Fatality Management Guide: A Supplement to the State of California Coroners Mutual Aid Plan*, The State of California Governor's Office of Emergency Services, September 2007 is available at:

<http://www.oes.ca.gov/Operational/OESHome.nsf/Content/A3F586FD13D795C788256B7B0029BBFF?OpenDocument>. Click on Coroner's Mutual Aid.

*Planning for a Possible Influenza Pandemic—A Framework for Planners Preparing to Manage Deaths*, Home Office, Public Order Unit—Mass Fatalities Section, London, England is available at: [http://www.ukresilience.info/news/manage\\_deaths\\_guidance.aspx](http://www.ukresilience.info/news/manage_deaths_guidance.aspx).

*A Working Group Consensus Statement on Mass Fatality Planning for Pandemics and Disaster*, July 2007, Elin A. Gursky on behalf of the Joint Task Force Civil Support Mass Fatality Working Group is available at:

<http://www.homelandsecurity.org/newjournal/Articles/displayArticle2.asp?article=160>.

*The Provision of Family Assistance and Behavioral Health Services in the Management of Mass Fatalities Resulting from a Pandemic Influenza in the United States*, Fatality Management Pandemic Influenza Working Group Conference White Paper, March 2006 is available at: [http://www.icfa.org/docs/white\\_paper2.doc](http://www.icfa.org/docs/white_paper2.doc).

*Scene Operations, to Include Identification, Medico-legal Investigation Protocols and Command and Control of Mass Fatalities resulting from a Pandemic Influenza Event in the United States*, Fatality Management Pandemic Influenza Working Group Conference White Paper, March 2006 is available at: <http://www.pandemicpractices.org/practices/resource.do?resource-id=176&standards-id=4>.

*Morgue Operations, Identification, and Command and Control of Mass Fatalities Resulting from a Pandemic Influenza Event in the United States*, Fatality Management Pandemic Influenza Working Group Conference White Paper, March 2006 is available at: [http://www.icfa.org/pdf/white\\_paperMFM.pdf](http://www.icfa.org/pdf/white_paperMFM.pdf).

*Information for Managing Pandemic Influenza Fatality Events in Virginia*, Virginia Department of Health, 4/06 is available at: <http://www.vdh.virginia.gov/medExam/PandemicFluPlanning.htm>.