

# State of Ohio



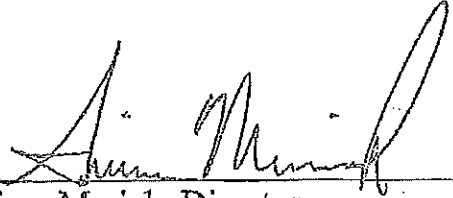
## ACUTE MASS FATALITY MANAGEMENT

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### Local Jurisdiction Guidance


# Ohio Acute Mass Fatality Management Local Jurisdiction Guidance



  
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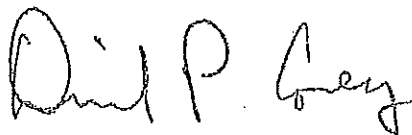
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## 1. INTRODUCTION

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The purpose of this guidance is to assist local jurisdictions including county coroners, emergency management agencies, local health departments and other partners in developing a plan, prior to an incident, which will enable an effective acute mass fatality response. Local agencies should use this document as an information source when developing their own plans based on local resources and conditions.

Additional information can be found in the State Emergency Operations Plan. The two sections that specifically address mass fatality planning are Tabs D and E of the ESF-8 Public Health and Medical Health Annex. Tab D addresses acute mass fatalities and Tab E addresses non-acute mass fatality plans.

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## 2. EXPLANATION OF TERMS

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### 2.1. ACRONYMS

AAR	After Action Review
ADA	Americans with Disabilities Act of 1990
AM	Ante-mortem
ARC	American Red Cross
ATF	Bureau of Alcohol, Tobacco, Firearms, and Explosives
BCP	Body Collection Point
BEHRP	Bureau of Environmental Health and Radiation Protection
CBRNE	Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive
CERT	Community Emergency Response Teams
DEXIS	Digital X-ray Imaging System
DMORT	Disaster Mortuary Operational Response Team
DoD	Department of Defense
DPS	Department of Public Safety
DNA	Deoxyribonucleic Acid
EDRS	Electronic Death Reporting System
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ERT	Evidence Response Team
ESF-8	Emergency Support Function-8
FAC	Family Assistance Center
FBI	Federal Bureau of Investigation
FM	Fatalities Management
FSRT	Fatality Search and Recovery Team

GPS	Global Positioning System
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HR	Human Remains
HVAC	Heating, Ventilation, and Air Conditioning
IAP	Incident Action Plan
IC	Incident Command or Incident Commander
ICE	Immigration and Customs Enforcement
ICS	Incident Command System
ICP	Incident Command Post
IND	Improvised Nuclear Device
IT	Information Technology
JIC	Joint Information Center
JIS	Joint Information System
MA	Mortuary Affairs
MFI	Mass Fatality Incident
MFM	Mass Fatality Management
MOU	Memorandum of Understanding
MRC	Medical Reserve Corp
NIMS	National Incident Management System
NGB	National Guard Bureau
NGO	Non-Governmental Organization
NOK	Next of Kin
NTSB	National Transportation Safety Board
Ohio EMA	Ohio Emergency Management Agency
ODH	Ohio Department of Health
ODOT	Ohio Department of Transportation
OFDA	Ohio Funeral Directors Association
OMORT	Ohio Mortuary Operational Response Team
PD	Police Department
PE	Personal Effects
PIO	Public Information Officer
PM	Postmortem
PPE	Personal Protection Equipment
SME	Subject Matter Experts
SOP	Standard Operating Procedure
UVIS	Universal Victim Identification System
VIP	Victim Identification Program
WinID3	Dental Identification System

## 2.2. DEFINITIONS

Acute Mass Fatality: Acute mass fatality incidents are events that exceed the routine mortuary systems of a locality, and are sudden and short-lived, such as a plane crash. Acute mass fatality incidents do not include deaths due to prolonged, non-acute incidents such as pandemics.

Ante-mortem: Prior to death.

Casualty: A person who is injured or killed in a mass fatality incident.

Cause of Death: A formal, certified opinion by an attending physician or coroner/medical examiner of the internal medical condition and/or external incident or chain of incidents that resulted in death.

Closed Population: A closed population occurs when the names and number of the deceased in a mass fatality event are known. For example, a plane crash in an unpopulated area would likely be a closed population because the number and identity of the victims would be provided by the flight manifest.

Direct Reference: A DNA sample obtained from the deceased or their personal effects used for comparison with other DNA samples in laboratory identification procedures.

Emergency/Disaster Declarations: Official emergency declarations made by specified elected officials at the local, state, or federal level authorizing the use of equipment, supplies, personnel, and resources as may be necessary to cope with a disaster or emergency. Formal declarations are made when the incident requires more assets and resources than exist within the jurisdiction.

Family Assistance Center: The designated location/facility established to exchange accurate, timely information and render support services for family members and friends of mass fatality victims who travel to the incident location.

Family Reference: A DNA sample taken from a biological relative (only one generation removed) used for comparison with other DNA samples in laboratory identification procedures. Also referred to as indirect references.

Fatality: A person who dies as a direct or indirect result of a mass fatality incident (interchangeable with victim, decedent).

Fatality Management: The process of locating, recovering, processing, identifying, and releasing for final disposition deceased victims of a mass fatality incident.

Human Remains: A deceased body or fragmented parts from a deceased body.

Final Disposition of Human Remains: The concluding arrangement for the remains of the decedent, a decision of the next of kin. Options include burial, entombment, cremation, removal from state or donation.

Incident Command System: A prescribed method of command, control, and coordination within the National Incident Management System to provide a common organizational structure designed to aid in the management of facilities, equipment, personnel, supplies, and information.

Just-in-Time Training: Instruction provided to capable individuals enabling them to perform task-specific functions immediately following the instruction.

Manner of Death: A classification of the fashion or circumstances that resulted in death (either: homicide, suicide, accidental, natural, or undetermined).

Mass Fatality Incident: Any incident that results in more fatalities than a local jurisdiction can adequately manage, whether natural or man-made, accidental or intentional.

Medico-legal: Of or pertaining to law as affected by medical facts. A Medico-legal representative is usually a lead investigator for the /Medical Examiner/medical examiner's office who work to protect the legal integrity of the operation.

Missing Person: Those persons whose whereabouts are unknown to family or friends following an incident.

Morgue: The facility location where decedents undergo external and internal physical examinations.

Mortuary Affairs: A term synonymous with fatality management, generally referring to the provision of necessary care and disposition of missing and decedent persons, including their personal effects.

National Incident Management System: The part of the National Response Framework that outlines how the government and private entities at all levels can work together to manage domestic incidents, regardless of their cause, size, location or complexity.

Next-of-Kin: Immediate family members including: spouses, children, parents and siblings. .

Non-Acute Mass Fatality: A sustained mass fatality incident that exceed a locality's routine mortuary capability. A non-acute mass fatality occurs over a prolonged time period, such as an epidemic.

Non-Governmental Organization: Independent organizations free from government control.

Non-Profit Organization: A business or enterprise that does not distribute its surplus funds to owners or shareholders, but instead uses them to help pursue its goals.

Open Population: An open population occurs when the responders to a mass fatality incident do not have a list of victims. This could be caused by a weather event such as a tornado where responders know neither the number of victims nor their identity.

Patrons: Family members and close friends that visit and have access to the Family Assistance Center.

Personal Effects: Belongings of an individual including clothing, clothing accessories, jewelry, and other property on their person or otherwise in their possession.

Postmortem: After death.

Situational Orphan: A child, due to circumstances of a MFI, that has been involuntarily separated or otherwise detached or displaced from their immediate family, relatives, or designated caregivers. The child may, or may not, have actually been orphaned as a result of the MFI.

Spontaneous Unaffiliated Volunteers: An individual, not associated with any recognized disaster response agency, who may or may not have special skills, knowledge, or experience, but who appears, unsolicited, at an incident to render assistance.

Survivor: Anyone who is exposed to or otherwise encounters a mass fatality incident that does not perish as a result of the incident.

Temporary Interment: A location where decedents are interred underground in individually marked spaces that may or may not become their final disposition location.

Temporary Morgue: An ad hoc morgue operation established specifically to process and identify human remains resulting from a mass fatality incident.

Victim: A person who dies as a result of a mass fatality incident (interchangeable with fatality, decedent).

Victim Identification Program: A disaster management computer software program designed to collect personal information of known and unknown individuals, and then conduct comparative analysis to suggest best probable matches or exclusions of ante- and postmortem information to aid in identification processes of unidentified individuals. Developed by federal DMORT teams.

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## 3. SITUATION & ASSUMPTIONS

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### 3.1. SITUATION

An acute mass fatality incident may occur anywhere within a county or multiple counties as the result of a natural, accidental, or intentional incident. An acute mass fatality incident is usually a single event of short duration where more deaths occur than can be handled by local resources (tornado, airplane crash, building collapse). A non-acute mass fatality incident is one where fatalities occur over a prolonged period of time (pandemic). This guidance primarily addresses acute mass fatalities.

Because communities vary in size and resources there is no minimum number of deaths for an incident to be considered a Mass Fatality Incident (MFI). A MFI is not solely defined by the number of fatalities, but includes additional factors such as the condition of remains, accessibility of the scene, complexity of recovery, and resources available for response. The county Coroner/Medical Examiner (C/ME) is the legal authority to conduct victim identification, determine the cause and manner of death, and manage death certification during acute mass fatalities (O.R.C. 313.12).

A MFI may occur as part of a broader disaster. Efforts to conduct MFI response may occur alongside search and recovery operations, sheltering, crime scene investigation and debris removal. Therefore, mass fatality response efforts will almost always operate within a broader incident command structure, and response resources may need to be shared with other disaster recovery efforts.

Proper treatment and care of both human remains and victim's families are vital to successful incident response. Public evaluation of the government's ability to effectively manage the disaster is based on a few key factors, especially the appropriate treatment of victims and their families. This relies on coordination with various non-governmental agencies as well as an effective public information campaign. MFI response and specifically Family Assistance Center operations will likely be one of the final portions of incident management to be completed.

### 3.2 ASSUMPTIONS

This guidance is based upon the following assumptions:

- During a MFI, the C/ME will still experience their normal caseload and must continue to manage both the incident and standard services.
- The C/ME has a limited number of resources – including personnel, supplies, and capacity – to respond to and manage fatalities. Incidents will occur that will surpass the limited resources of the C/ME.

- Response to a MFI may be hindered by second-order impacts from the incident or the failure of critical infrastructure.
- MFI response requires coordination with local agencies and organizations – it cannot be solely managed by the C/ME.
- The C/ME retains control and authority over fatality management, even when the response is supported by regional, state, or federal assets.
- Limitations of remains storage may necessitate mass fatality standards of response, including use of alternate storage systems such as refrigerated containers or dry ice.
- Catastrophic incidents may necessitate the implementation of mass fatality standards of response regarding the processing and identification of victims.
- Incidents resulting from an act of terrorism will involve the Federal Bureau of Investigation (FBI) as the lead investigative agency and will require close cooperation and coordination with local authorities.
- A Joint Information System will be established to manage incident related communication, including information pertaining to MFI management.
- State and regional mass fatality response-related physical resources will be available for use in conducting decedent evaluation and handling the temporary storage of bodies.
- Title 10 Department of Defense (DoD) Mortuary Affairs (MA) assets (i.e. regular military defense forces) are limited, only possessing basic MA capabilities to process victims.
- Title 32 National Guard MA assets possess restricted capability to recover victims from non-contaminated areas and from limited chemical, biological, radiological, nuclear, and high-yield explosive (CBRNE) contaminated areas.
- Family members and friends will make numerous calls and inquiries to authorities regarding their loved ones – as many as one-hundred times the actual number of victims – during the course of the incident.
- Non-governmental agencies will be available to operate and staff FACs.
- Families will press for the quick identification and release of their family members; identification expectations must be managed early in the response.

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## 4. CONCEPT OF OPERATIONS

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### 4.1. ACTIVATION & NOTIFICATION

Activation of a Mass Fatality Management (MFM) Plan is dependent on various criteria presented below. The activation of the plan will allow for the formation of Unified Command or Incident Command, consisting of representatives from the C/ME, local emergency management agency, local public health, law enforcement, fire service, and any other necessary command representatives.

#### 4.1.1. *Mass Fatality Incident Decision Points*

Any incident consistent with one or more of the following criteria may precipitate the activation of a MFM plan:

- An incident involving a protracted or complex decedent recovery operation
- A situation in which the number of decedents exceeds the C/ME's capacity
- An incident or other special circumstance requiring a multi-agency or multi-county response to support MFM operations

#### 4.1.2. *Plan Activation*

The C/ME will be notified of an incident by routine channels of communication: local law enforcement, emergency services or the local EMA. Activation of a MFM plan should follow the illustration on the following page (Fig. 4.1). This can be adjusted depending on local capabilities. The Assessment Team concept is discussed in more detail in Section 5.1., Assessment Team.

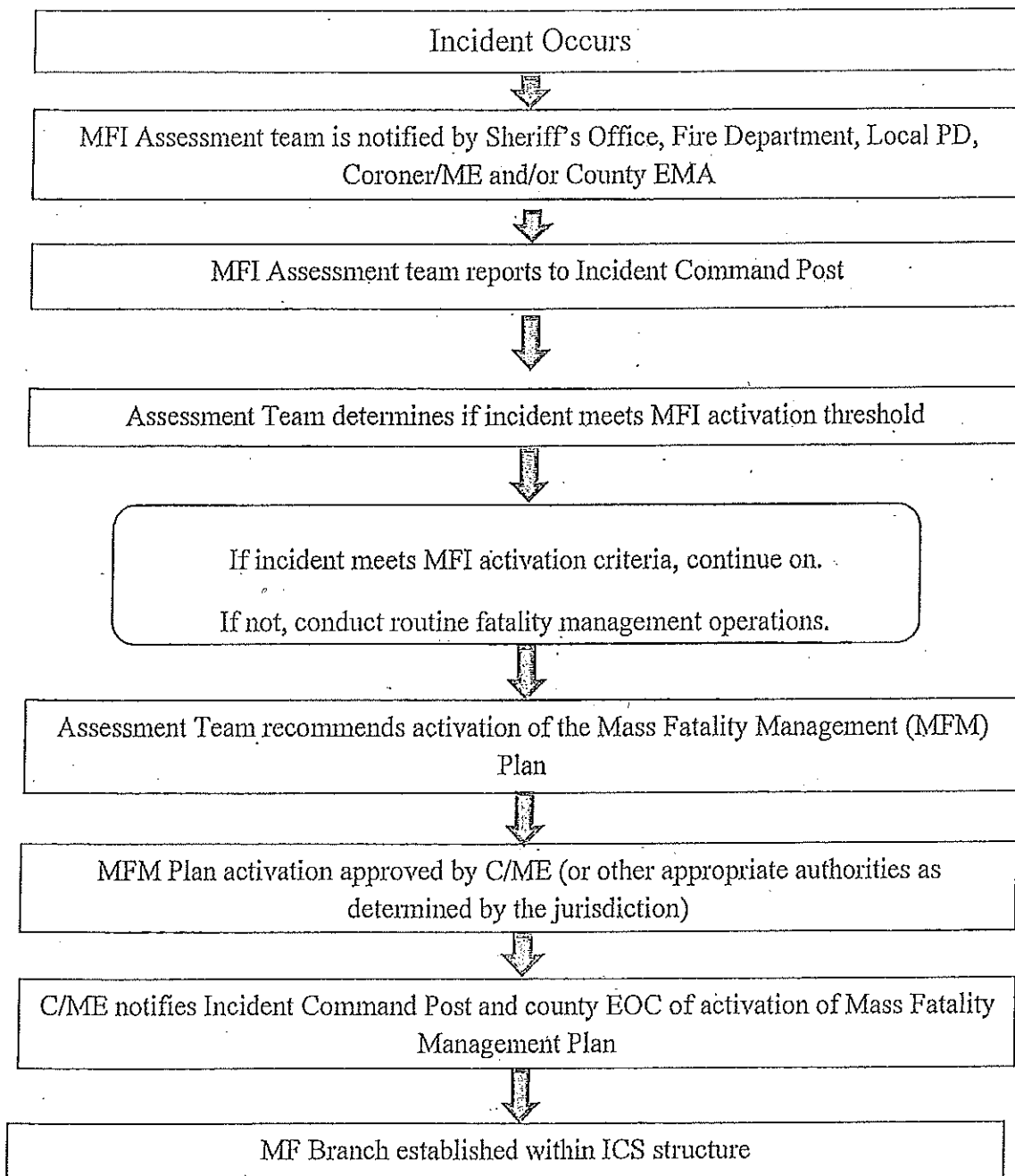


Figure 4.1. MFM Plan Activation Procedure

#### 4.2. AGENCY RESPONSIBILITIES

Responding to a mass fatality incident involves multiple agencies and organizations; no single agency can manage a mass fatality without support from other agencies. Each responding agency has specific activation, operations, and demobilization responsibilities. All agencies involved must work together to ensure the complete recovery and processing of remains, care of the

victims' families, and the maintenance of daily operations. For an example of tasks performed by agencies during a MFI refer to Appendix A (Example Agency Task Matrix).

*Note:* Appendix A is only a guide. Coordination is required with all agencies to determine if they can/will perform these tasks during a MFI. Different jurisdictions may allocate responsibilities differently than depicted. Not all tasks may be necessary in all events.

#### *4.2.1. Activation Phase*

During the activation phase, the mass fatality management needs are assessed, resources are deployed, and facilities established.

#### *4.2.2. Operations Phase*

During the operations phase MFM operations are managed and monitored to ensure provision of services. Participant agencies continue to assess their operational requirements during this phase.

#### *4.2.3. Demobilization Phase*

The demobilization phase involves three areas: (1) recognition and management of decline in MFM operations; (2) continuity of operations as resources depart, and; (3) effective transition to normal operations.

In addition, during the demobilization phase all agencies should:

- Provide After-Action Review (AAR) feedback to the County EMA
- Attend demobilization meeting(s) arranged by the County EMA
- Develop transition plans and timelines for MFM activities
- Identify long-term coordination needs and the responsible agencies

### **4.3. ORGANIZATIONAL STRUCTURE**

#### *4.3.1. National Incident Management System (NIMS)/Incident Command System (ICS)*

Any mass fatality incidents are managed using the NIMS/ICS management guidelines which respond to five functional areas: Command, Operations, Planning, Logistics, and Finance/Administration.

The NIMS is designed to be flexible and scalable to meet incident operational needs. The designated incident commander determines the degree of organization expansion to best combat and resolve the incident. A mass fatality response will most likely be incorporated into the operations section within the overall incident command structure.

#### *4.3.2. Organizational Chart*

The organizational chart on the following page illustrates how a mass fatality incident response may operate according to ICS guidelines (Fig. 4.2). In addition to Operations, fatality management personnel may be represented in Planning, Logistics, and Finance/Administration. This is an example of how Incident/Unified Command would be established; different

jurisdictions may establish themselves differently. Not every operational component of MFI response may be activated depending on the nature of the incident.

*Note:* For ease of discussion throughout this guidance, individual sections (i.e. Pathology, Fingerprints, Call Center, etc.) are referred to as teams although the team may consist of only one person and a single person may serve on more than one team function based on need.

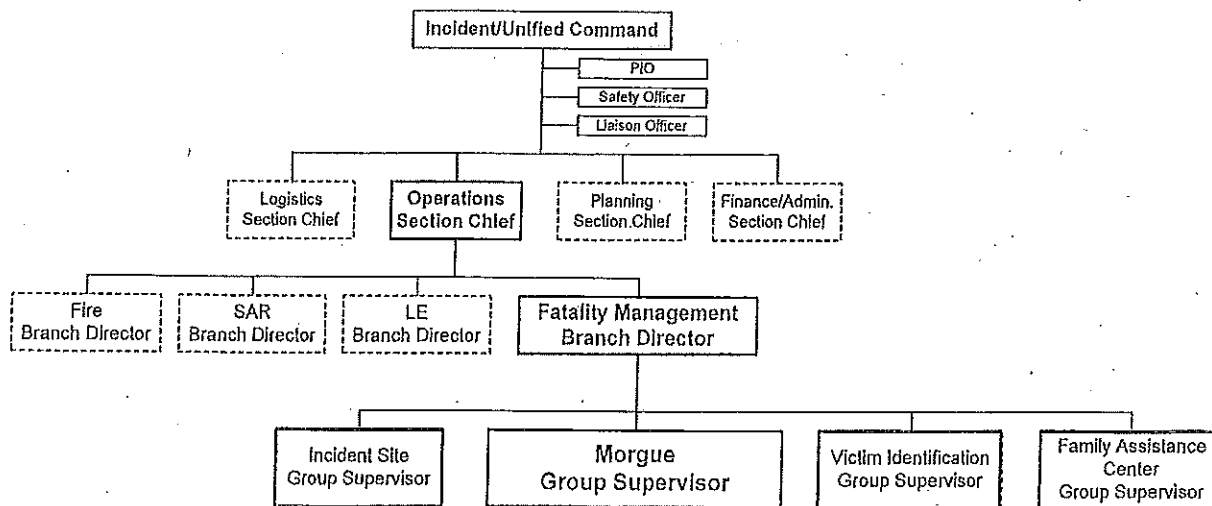


Figure 4.2. Example MFI Response Operations Organizational Chart

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## 5. INCIDENT MANAGEMENT CONSIDERATIONS

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### 5.1. ASSESSMENT TEAM

The function of the Assessment Team is to evaluate the incident site and determine whether the Mass Fatality Plan should be activated, and if so, determine requirements for the temporary morgue, cold storage, transportation, logistics, and the Family Assistance Center.

#### 5.1.1. *Assessment Team Composition*

The Assessment Team may be comprised the following agencies/representatives. Different portions of the assessment may require different attendees. This list can be adjusted as needed.

- County Coroner/Medical Examiner (or designee) and team
- Representative(s) from local first responders
- Representative(s) from supporting outside agencies such as Ohio Mortuary Operations Response Team (OMORT) or United Way

#### 5.1.2. *On-Scene Assessment*

Once the scene has been declared safe by the Incident Commander or safety officer, the on-scene assessment process can begin. If the scene has not been deemed safe for on-scene assessment, members can attempt remote assessment (by video) or other long range visual assets. The Assessment Team evaluates the site for the following information:

- Potential or actual number of fatalities
- Condition of human remains
- Size and accessibility of the incident site
- Level of difficulty in recovery
- Possible CBRNE hazards

#### 5.1.3. *Assessment Results*

Based on the on-scene assessment, the team will determine the following:

- Type and number of personnel and equipment needed for human remains recovery, and transportation needs
- Location of temporary morgue operations (if needed) and type and number of personnel and equipment needed for the processing and identification of human remains
- Site for Family Assistance Center and an estimate of personnel needs (in concert with the FAC Group Supervisor)

### 5.2. LOGISTICS CONSIDERATIONS

A MFI response will require significant logistical resources. The requests, acquisition, delivery, storage, and expenditure of any and all materials, equipment, and facilities used in support of a MFI response must be managed effectively. The responsibility for all aspects of logistical support falls on the Logistics Section within the ICS structure.

### 5.2.1. *Incident Site*

Logistical requirements for supporting incident site operations for a MFI may include, but are not limited to:

- suitable search and recovery vehicles and equipment,
- area lighting (for night recovery),
- personal protection equipment (PPE),
- cadaver dogs,
- communications equipment,
- global positioning systems (GPS),
- body bags,
- vehicles for body transport,
- food and drinking water.

Incidents requiring decontamination of human remains will require additional and specialized resources and personnel.

### 5.2.2. *Morgue Operations*

Logistical requirements for the support of morgue operations for a MFI may include but are not limited to:

- building space,
- life support including electricity, running water, heating, ventilation, and air conditioning,
- cold storage (should not rely upon hospital morgues),
- computers,
- medical equipment, expendable medical supplies, PPE, and biohazard waste containers.

The logistics section will likely need to store and manage morgue supplies at the morgue. Expendable medical supplies will be depleted at varying “burn” rates, and must be monitored closely. Depletion of any given supply item could abruptly halt morgue operations and cause significant delays in the identification process. Morgue operations should routinely communicate logistical requirements to the logistics section. If necessary, OMORT has a mobile morgue that can be deployed to the incident site to facilitate processing. Hospital morgues should not be relied upon for decedent storage due to a potential requirement surge from the incident. Additional storage considerations are listed in Appendix B of this document.

### 5.2.3. *Family Assistance Center*

Logistical requirements supporting FAC operations for a MFI may include (but not limited to):

- communications systems (telephone, radio, public address system, and internet access),
- computers and copy machines
- furniture (desks, chairs, sofas, etc.),

- paper goods (cups, tissues, etc.),
- food (meals and snacks),
- children's activities,
- signage and badging.

In some instances, temporary lodging may need to be arranged for some or all family members. A Family Assistance Center facility must be compliant with the Americans with Disabilities Act (ADA) of 1990.

### 5.3. DEMOBILIZATION CONSIDERATIONS

Demobilization is the orderly, safe, and efficient return of an incident resource to its original location and status. It can begin at any point during an incident, but should begin as soon as possible to facilitate accountability of resources. The demobilization process should be coordinated between the incident command structure and multiagency coordination systems for the re-assignment of resources if necessary, and to prioritize critical resource needs during demobilization. Within the ICS structure the responsibility for demobilization falls upon the Planning Section.

#### 5.3.1. *Incident Site Demobilization Criteria*

Demobilization for the incident site should begin when the following criteria have been met:

- All Human Remains (HR) and Personal Effects (PE) have been located and removed.
- The agencies responsible for investigation have released their control of the site.

#### 5.3.2. *Demobilization Considerations*

Demobilization for the morgue should begin when the following criteria have been met:

- All human remains has been recovered from the site and processed through the morgue.
- Identification processes have concluded.
- Temporary storage issues for human remains have been addressed.
- Release of identifiable human remains to NOK has been accomplished.
- Disposition of unidentified human remains has been addressed.
- Radiation surveys of triage areas to ensure no radiological contamination remains.

#### 5.3.3. *Family Assistance Center Demobilization Criteria*

Demobilization for the Family Assistance Center should begin when the following criteria have been met:

- Daily briefings are no longer needed.
- Rescue, recovery, investigations, and identification issues have decreased to the degree that ongoing operations can take place at the C/ME's office.
- Memorial services have been arranged for family and friends.
- Provision for the return of personal effects has been arranged.
- Ongoing case management and/or a hotline number has been established (if needed).

*Note:* It is important to know that the Family Assistance Center will most likely be the last external process to completely close.

#### 5.4. VITAL STATISTICS CONSIDERATIONS

##### 5.4.1. *Electronic Death Reporting System (EDRS)*

The web based EDRS application has the ability to flag death records associated with a pandemic or mass fatality event. The Vital Statistics (VS) HelpDesk can provide real time instructions to Ohio coroners, deputy coroners and local vital statistics staff on the correct use of the system flags. The “EDRS User Support Document” (Appendix F) may be used to add additional user accounts in EDRS to assist in an emergency. Questions can be directed to the [vs.helpdesk@odh.ohio.gov](mailto:vs.helpdesk@odh.ohio.gov) or 614-466-2531.

##### 5.4.2. *Coroner Personnel Surge*

Due to increased demand on the Coroner’s office during a mass fatality incident, it may be necessary to increase the number of deputy coroners, pathologists and other employees. Ohio Revised Code (O.R.C.) 313.05 and the county’s existing hiring procedures would govern the addition of these personnel.

##### 5.4.3. *Rapid Reporting of Fatalities in an Emergency or Disaster*

Determining the total number of incident-related fatalities during disasters can be challenging. It can also be difficult to determine which deaths were caused by the incident. Additionally, there are many official and unofficial ways to transmit information. This creates the potential for misreporting the number of disaster-related decedents.

For these reasons, ODH may activate the Rapid Reporting of Fatalities Procedure during a disaster to expedite accurate reporting of fatality numbers. This procedure’s activation will be sent out by ODH through the Ohio Public Health Communication System (OPHCS) alert platform. As necessary, ODH may send out specific case definitions, to assist in determining whether a death is event-related. If the Rapid Reporting of Fatalities Procedure is activated, coroners will send death notifications via email to ODH in order to provide more timely information. When no longer needed, ODH will send an additional OPHCS alert to notify Coroner’s to cease this procedure.

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## 6. INCIDENT SITE MANAGEMENT

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### 6.1. INTRODUCTION

Characteristics of mass fatality sites vary greatly from one incident to another based upon type of incident and area impacted. However, all MFI sites have common characteristics as well. The efforts necessary to respond to MFIs are not fundamentally different than those required for day-to-day public safety responses by law enforcement, fire and rescue, and other emergency response resources. Perimeters need to be established, access must be controlled, and subject matter experts (SME) must take charge of processing the site.

Ohio has a valuable resource available for dealing with MFIs. The Ohio Mortuary Operational Response Team (OMORT) is a group of pathologists, forensic anthropologists and funeral directors from across the state that have expertise in dealing with mass fatalities. The team works under the direction of the C/ME to supplement existing county resources and accomplish the processing of remains.

### 6.2. ORGANIZATION

Tasks associated with incident site management fall within the responsibilities of the Operations Section Chief in the ICS structure. Branch Directors with site responsibilities may include Fire, Search and Rescue, Law Enforcement, Fatality Management, and others as required.

### 6.3. HAZARDOUS MATERIALS (HAZMAT)

Mass fatality incidents may involve sites that are contaminated by HAZMAT. HAZMAT may range from mild irritants to highly toxic and lethal substances. Prior to any MFI site processing, the area must be examined by trained HAZMAT personnel to determine if hazardous materials are present and, if so, act to prevent responder exposure or mitigate the threat with appropriate countermeasures. Concerns for evidence, personal effects, and human remains handled at the site or subsequently removed from the site must be addressed to prevent HAZMAT from escaping site containment.

### 6.4. SAFETY

A MFI site has the potential of presenting hazardous environmental issues for responders and the general population affected by the incident. Safety must be a common theme during the entire response process and is the responsibility of all leaders and responders. Responders should never be placed at risk and operations should not commence without properly addressing all potential safety risks.

#### 6.4.1. *Personal Protective Equipment (PPE)*

Appropriate PPE requirements must be identified and responders must be outfitted accordingly before accessing a MFI site. Anyone that is allowed access to the incident site should first be

provided a safety briefing, and identified PPE requirements should be strictly enforced. Responders' health should be monitored throughout the progression of site management.

#### 6.4.2. *Responder Medical Support*

An EMS unit should be on site to monitor the safety environment and working conditions and to provide medical attention to responders as needed.

### 6.5. SECURITY

The initial action at the incident site is to establish security and control access. The law enforcement agency taking charge of the site should establish a security perimeter, create access point(s), and control entry and exit to and from the site. The entire site area should be designated as a "no fly zone" until after site processing and human remains removal has been completed. In the event the site processing efforts continue beyond two days, a badging system should be implemented for access to the site, morgue, and FAC.

### 6.6. SEARCH AND RESCUE

Initial emergency management response is focused on saving lives. However, as time passes in the response efforts, focus shifts from rescuing the living to managing the deceased.

#### 6.6.1. *Resources*

Search and Rescue units from local fire departments and law enforcement agencies may conduct rescue operations to locate casualties and fatalities.

#### 6.6.2. *Discovery of Human Remains*

As rescue units locate human remains, the location should be marked and Global Positioning Systems (GPS) coordinates noted. Human Remains Recovery Teams under the direction of the C/ME will transport human remains from the site to a location designated by C/ME (see Section 6.8., Human Remains Recovery Team below). Human remains should not be removed from the site without permission from the C/ME or his/her designated representative.

### 6.7. EVIDENCE RESPONSE TEAM (ERT) & SCENE INVESTIGATION

The location of the incident will dictate which C/ME has authority for death certification of victims. In a MFI, inquest resources are likely to be immediately overwhelmed and local law enforcement will likely assume responsibility for conducting a preliminary investigation into the circumstances surrounding the MFI when in question. Law enforcement investigators will process death scenes to properly document the site and record, collect, and safeguard evidence. The C/ME will assume responsibility for the victims and associated personal effects (PE). Any PE having potential value as evidence will be collected by law enforcement as part of their investigation. Recovery assets must be mindful of crime scene preservation techniques and exercise caution to protect potential evidence as they conduct their operations. Investigation

efforts take precedence over human remains recovery when those tasks are assigned to separate teams.

## 6.8. HUMAN REMAINS RECOVERY TEAM

The C/ME is the approval authority to move human remains from a MFI site. The recovery of human remains must be managed in an efficient, yet meticulous and respectful manner. As the overall response effort and identification process continues in the MFI response, it may be necessary to review details of where human remains were first located and by whom. That initiative could be impeded without accurate accounts of the body recovery process.

### 6.8.1. *Body Bag Numbering*

Human remains at the incident site will be controlled by the C/ME and removed under his or her direction. The C/ME will be responsible for assigning a human remains numbering system to track the location at the site where the human remains was found. In a MFI, it is not uncommon for different individuals' remains to become mingled during the recovery process. Therefore the numbering technique should be as uncomplicated as possible in order to reduce errors or confusion. Tracking numbers can be as simple as a sequential number from 1 to XXX. If more than one body collection point is established, the number sequence may be modified as follows, each site should be assigned a number or letter (1,2,3 etc., or A, B, C) and that number or letter should precede any numbering sequence. Another method would be to pre-assign unique numbers to each site so that numbers are not reused (site one utilizes numbers 1-25, site two utilizes numbers 26-50, etc.). If a sites numbers get used, then additional sequential numbers will be assigned to that site.

### 6.8.2. *Multiple Sites and Human Remains Transportation Teams*

In the event of a geographically dispersed MFI with multiple locations of fatalities it may be necessary to have two or more human remains Transportation Teams. The situation may also necessitate establishment of one or more designated body collection points (BCP) if fatalities are not in one location but instead randomly scattered across large areas.

## 6.9. PERSONAL EFFECTS TEAM

Items of PE not considered to be investigative evidence will remain at the site for collection by a team(s) designated by the C/ME for that purpose. Clothing found on victims and PE in the clothing will be kept with the victim and transported to the morgue with the body. Disassociated PE from the site should be transported to a location designated by the C/ME.

## 6.10. HUMAN REMAINS TRANSPORTATION TEAM

Local funeral directors under contract with the local jurisdiction will be called upon to transport human remains from the incident site to the morgue. If the local funeral directors become overwhelmed, other options for moving remains should be explored including contacting the funeral directors of neighboring counties. A transportation log should be established to document the removal time, vehicle identification, operator information, and identity of the funeral home/service accepting responsibility for body transport to the morgue. A manifest will be required to document the tracking numbers of those remains being transported.

## 6.11. LARGE-SCALE MASS FATALITY EVENTS

Incidents may occur that produce fatalities of a magnitude sufficient to render an identification process unrealistic at that time. Although not desirable, it may be necessary to alter operations to cope with the number of decedents. Potential ways to increase storage include storing remains side-by-side in a morgue, renting refrigerated containers or rail cars, and transporting remains to less affected areas for processing. Temporary interment (temporary in-ground storage prior to final disposition) is strongly discouraged, should be considered a last-resort option, and must be in compliance with Ohio law. This includes the issuance of disposition permits prior to burial (ORC 3705.17). Refer to Appendix B Remains Storage Surge Guidelines for additional considerations during large-scale mass fatality events.

## 7. MORGUE MANAGEMENT

### 7.1. INTRODUCTION

Oversight of morgue operations is the primary responsibility of the Fatality Management Branch Director under the Operations Section of the ICS command structure. The individual tasked with oversight of morgue management must have considerable knowledge of human identification and forensic sciences in general.

### 7.2. ORGANIZATION

There are a variety of responsibilities within the structure of morgue operations which require varying degrees of expertise. Many of the Subject Matter Expert (SME) positions require highly trained and skilled individuals holding unique certification and licensure. OMORT has individuals with these skill sets. The organizational chart on the following page depicts a possible MFI morgue org chart within ICS guidelines (Fig 7.1).

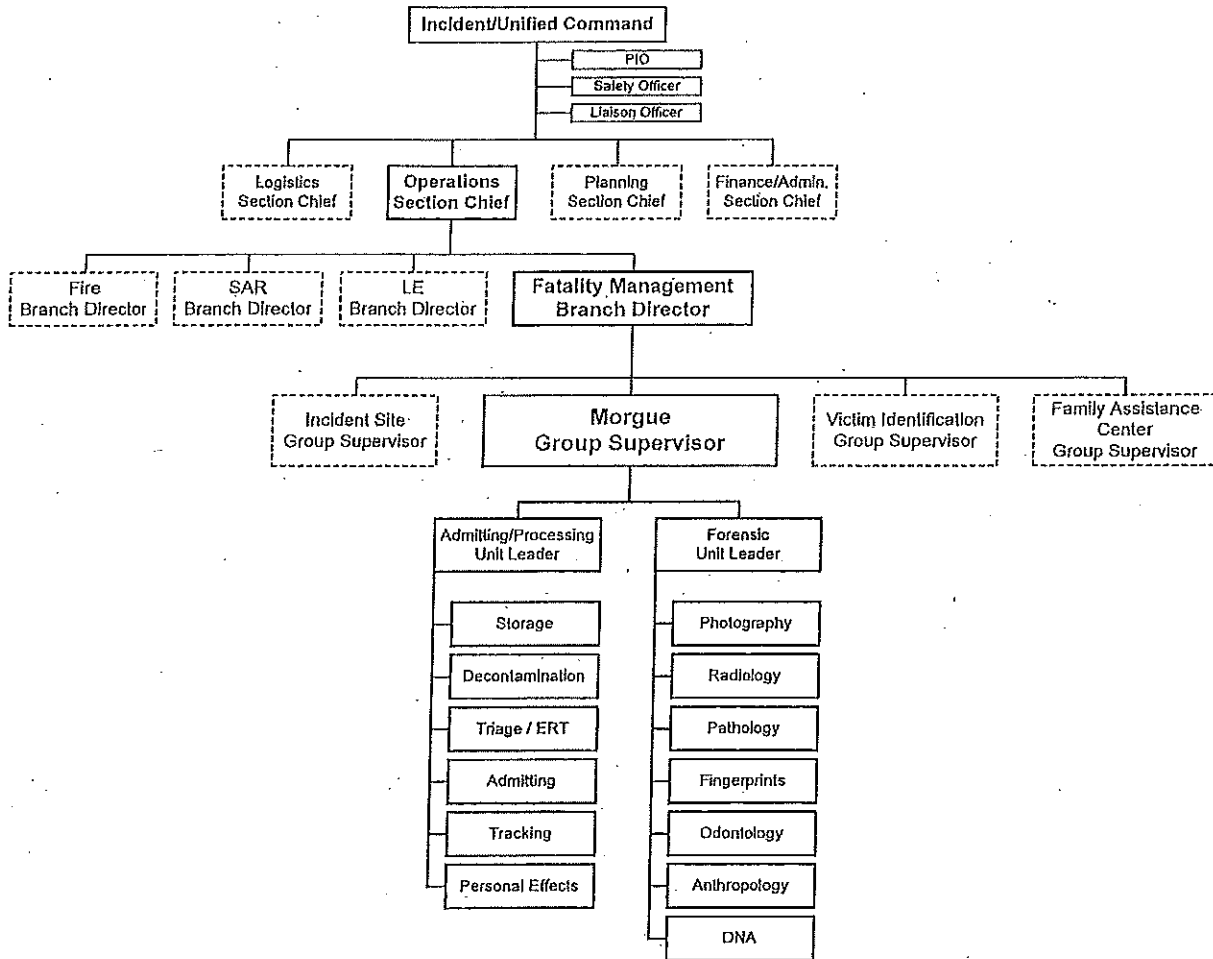


Figure 7.1. Example Morgue Group Operations Organizational Chart

### 7.3. GENERAL CONSIDERATIONS

Although the following discussion about morgue operations encompasses every operational aspect, the concept is designed to be flexible and scalable to meet the demands of each specific incident. Any number of the components discussed below can be included, excluded, or expanded to support the specific needs of the situation. For ease of discussion, the individual sections are referred to as teams although the team may consist of only one person and a single person may serve more than one team function based upon the scale of the operation.

### 7.4. PERSONNEL

Individuals selected to perform functions in morgue operations must have appropriate knowledge, skills, and abilities. Subject matter experts (SMEs) must be approved by the C/ME prior to being assigned to the morgue. However, some of the skill sets necessary to support morgue operations are general in nature. Positions as trackers, scribes, and data entry clerks can be filled by preapproved individuals who receive just-in-time training. Individuals experienced in funeral businesses are frequently called upon to support morgue operations. It should also be noted that the requirements for SMEs have a direct impact on the ability of morgue operations to expand to the needs of the incident and a lack of SMEs may hasten the necessity for regional, state, and/or federal assistance. OMORT can provide assistance with morgue staffing or operate the morgue themselves. Spontaneous, unaffiliated volunteers should not be permitted to work in a MFI morgue.

### 7.5. DOCUMENTATION

A significant amount of documentation is produced in the effort of collecting, classifying, describing, and controlling human remains post incident. All documents created (including photographs and x-rays), collected or otherwise generated during morgue operations for a MFI, fall under the control of the C/ME. Authority over the release of information concerning human remains and morgue operations is the C/ME or that official's designee. Care must be taken to safeguard sensitive personal identifiable information to prevent identity theft.

### 7.6. SAFETY

Safety is the highest priority of any aspect of handling human remains. A safety officer should be identified and appointed to oversee all aspects of MFI morgue operations. Personnel working in the morgue must comply with international safety precautions and wear appropriate PPE. Biohazard waste bags and sharps containers must be available for disposal of all waste generated from human remains processing and disposal of used scalpels, syringes, etc. Personnel assigned to work in morgue operations must have completed blood-borne pathogens training prior to assignment of duties in the morgue.

## 7.7. SECURITY

Processing of human remains from a MFI cannot commence without first establishing security of the facility housing that operation, whether it be the existing County C/ME facilities or an off-site temporary morgue established to support the MFI response. The function of providing security generally belongs to the local law enforcement agency where the morgue or temporary morgue is located. A form of badging of all personnel assigned to the morgue is recommended to facilitate and limit morgue access. Media, family members of the deceased, spontaneous, unsolicited volunteers, and curiosity seekers must be prevented from accessing or viewing the morgue.

## 7.8. TEMPORARY MORGUE FACILITIES

There may be a need for a temporary morgue facility to handle remains surge from a MFI if existing resources are overwhelmed, compromised, or non-existent. A temporary facility can be an existing building or a temporary structure. Either option must have running water, electricity, and heating/air conditioning. The structure footprint should be a single floor configuration with a minimum of 10,000 square feet and arranged in such a manner to facilitate efficient morgue flow processing. It should also be located relatively close to the incident site yet sufficiently distanced to be clear of danger from the site and associated incident aftermath. The facility must also be conducive to security and controlled access. Avoiding highly-trafficked areas is preferable when possible.

## 7.9. MORGUE PROTOCOLS

Standing Operating Procedures (SOPs) should be established to document morgue processing protocols in order to maintain process consistency. The protocols are determined prior to any human remains being sent through the morgue process. Circumstances influencing protocol decisions include but are not limited to: degree of degradation of the remains, number of bodies, availability of medical equipment and facilities, funding constraints, time constraints, and safety issues. All protocols established must be approved for implementation by the C/ME. Once a protocol is adopted the processes should remain consistent.

## 7.10. COMMON TISSUE

In some instances there may be human remains fragments that may not be suitable for morgue processing. Any fragmented remains that cannot be classified as having potential for identification may be declared common tissue. Common tissue most frequently results from incidents such as high-impact airplane crashes where severe fragmentation occurs. Examples include small nondescript pieces of bone and tissue that are unclassifiable and unsuitable for deoxyribonucleic acid (DNA) sampling. These human remains fragments are labeled during triage as common tissue, described to the degree possible, photographed, weighed and returned to temporary storage for safekeeping. Common tissue should be handled respectfully throughout.

### 7.11. KNOWN DECEDENTS

It is not uncommon for MFI victims to die hours, days, or perhaps even weeks after the incident. Their deaths are usually witnessed by family or may occur at a medical facility. However, if their cause of death was a direct result of injury or medical conditions resulting from the MFI, they should be processed as MFI victims, even when their identity is known. The remains of these victims should be transported to the MFI-designated morgue and processed.

### 7.12. WORK FLOW

All human remains entering the morgue for processing should be handled in uniform fashion. The remains pass through various operational phases, categorized into three general functions: Admitting/Processing, Forensic Examination, and Victim Identification. The following illustration depicts the flow process of human remains through the various stations in a morgue (Fig 7.2).

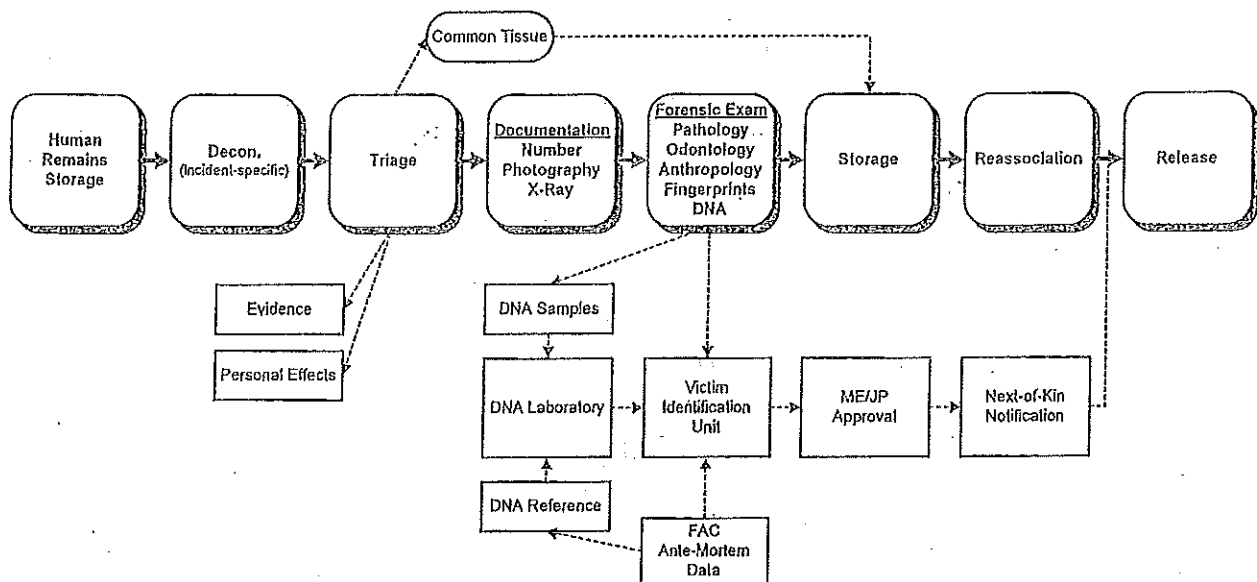


Figure 7.2. Example Morgue Operations Flowchart

### 7.13. CASKET REPATRIATION

Mass fatality management may include repatriation of caskets if an incident impacts a cemetery. Flooding has been known to compromise cemeteries by unearthing caskets and causing them to float away. Recovering caskets, identifying the casketed remains, re-casketing, and returning the remains to their rightful resting place is commonly referred to as casket repatriation. Repatriation efforts are similar in nature to mass fatality responses. Cemetery compromise may be a result of flooding where no fatalities occur or part of a larger scale incident (as was the case with Hurricanes Floyd and Katrina). In either circumstance, casket repatriation will require a non-routine response and should be managed in similar fashion to a MFI response.

### 7.14. ADMITTING/PROCESSING UNIT

Morgue admitting and processing functions are the front end morgue processes and may include: temporary storage, decontamination, triage, evidence, admitting, tracking, photography, and personal effects. These functions are set in place to maintain an orderly process, provide for the safety of individuals working in the morgue, ensure systematic and thorough documentation, and standardize accountability of the remains and PE.

#### 7.14.1. *Storage Team*

Human remains from a MFI must be handled with the utmost dignity and respect throughout the entire process of locating, collecting, identification, and release.

##### 7.14.1. a. Temporary Storage

Temporary remains storage is likely needed when remains from a MFI exceeds the C/ME's in-house capacity. The State of Ohio, along with communities and hospitals, maintain mobile refrigerated body storage trailers which can be requested through county EMAs. If there is a need for additional refrigerated, mobile units, other resources would need to be explored for this purpose. Alternate methods of increasing cold storage capacity include placing remains side-by-side (not stacked) on mortuary shelves, using dry ice, and renting refrigerated containers/trucks/rail cars. The use of shelving of human remains is allowed, but it is unacceptable to stack bodies on one another due to the damage done to the remains. Commercial freezers and ice rinks are not acceptable options for temporary human remains storage. Freezing remains damages tissue, making identification difficult. Ice rinks will freeze the portion of the remains in contact with the surface, while failing to keep the top portion of the remains sufficiently cool. Remains, once processed through the morgue, should be segregated from human remains that have not. Refer to Appendix B Remains Storage Surge Information for a discussion of surge facilities and use considerations for refrigerated trucks.

##### 7.14.1. b. Release of Human Remains

Following the identification of a MFI victim, the Next Of Kin (NOK) is officially notified. Their wishes for disposition are discussed for transfer of the remains from C/ME control. In

the event a Family Assistance Center (FAC) is established to support the MFI, notification of identification and discussion of release instructions are usually conducted at the FAC by a designated representative of the C/ME.

#### 7.14.1.c. Non-Releasable Human Remains

Common tissue that is not associated to any victim, remains that are not identified, and remains identified that are not claimed, are retained under the control of the C/ME until other disposition decisions are reached.

#### 7.14.2. Decontamination

Depending on the type of incident, human remains transported to the morgue may be biologically- or radiologically- contaminated. Both biologically- and radiologically- contaminated remains that are transported to the morgue may need to be decontaminated prior to morgue intake. Radiologically-contaminated remains, or those exposed to radiation, may be transported and processed following appropriate evaluation. In both types of event a system should be established to track and decontaminate valuable personal items for return to the family, when possible. Also, in either type of event personal protective equipment must be properly worn and disposed of correctly. A general rule is to handle all human remains as if they are infectious material.

##### 7.14.2.a. Handling Remains During a Radiological Event

It is recommended to handle radiologically-contaminated remains in accordance with the State of Ohio Emergency Operations Plan, Catastrophic Incident Annex, Tab A, Improvised Nuclear Device (IND) Plan. Management of the deceased resulting from an IND event may be handled generally in accordance with the State Acute and Non-Acute Mass Fatality Tabs within the State Emergency Operations Plan, however, specific considerations need to be made. Due to the hazards involved, locals will rely heavily on DMORTs and the State Emergency Operations Center to assist in the coordination of mutual aid, external resources, and volunteer services.

##### 7.14.2.b. Allowable Radiation Contamination Levels

Allowable radiation contamination levels and handling of the deceased in regard to radiation dose will be advised by the ODH Bureau of Environmental Health and Radiation Protection (BEHRP).

##### 7.14.2.c. Radiation Survey and Uncontaminated Decedents

All decedents should be subject to a complete radiation survey to confirm the absence or presence of contamination. No radiation-specific precautions are needed for deceased persons with exposure to radiation but no contamination; use standard autopsy procedures and transport to an uncontaminated morgue.

#### 7.14.2.d. Decedents with Low Contamination Levels

Decedents with low contamination levels can be processed in a field morgue, along with a forensic examination and victim identification. Prior to release of the body, decontamination should be conducted.

#### 7.14.2.e. Decedents with Significant Contamination

Decedents with significant contamination levels should be moved to refrigerated storage; DMORT or ODH BEHRP will help determine how long to store the body.

#### 7.14.2.f. Autopsies on Decedents with Significant Contamination Levels

If necessary to perform an autopsy on an internally contaminated body, refrigerate decedent and defer the procedure until a health physicist can assist in planning, as the pathologist performing the autopsy may receive significant radiation dose to the hands.

### 7.14.3. *Triage/Evidence Response Team*

Human remains collected from a MFI may represent varying degrees of intactness. The possibilities range from fully articulated bodies to minute, highly fragmented pieces. A cursory review of human remains presented to the morgue is accomplished prior to being admitted.

#### 7.14.3.a. Triage Station

A Triage Station, operated by a pathologist, an anthropologist, or both, conducts an examination of the contents of each body bag to verify anatomical articulation, search for potentially comingled body parts, and segregates accordingly. Body bags discovered to represent multiple victims must be sorted, re-bagged as separate human remains and issued a new human remains number for processing. Records must reflect this sorting process and be annotated with the associated human remains number(s). Any fragmented remains that cannot be classified as having potential for identification may be declared common tissue, culled from the process and stored as human remains material unsuitable for identification. The Triage Team can determine whether or not a specific human remain needs to be processed through every station. For example, a body bag containing only a flap of skin does not need to be examined by the dental or fingerprint sections.

#### 7.14.3.b. Evidence Response Team (ERT)

In the event of a MFI resulting from a criminal act or suspected criminal act there may be a requirement to have evidence collection capability in the morgue operation. The responsibility for evidence processing rests with law enforcement agencies. Evidence technicians may have the need to examine all human remains and PE submitted to the morgue to ensure items were not collected from the site(s) without first being examined for potential evidence. This procedure should also occur at the front end of morgue processing and may be conducted in concert with triage. Items identified as having potential evidentiary value may be collected by the ERT and removed from the morgue. Other items of evidence

discovered during the stages of morgue processing (such as a bullet discovered at autopsy) can also be seized as evidence by the ERT at the morgue. Any item(s) taken from a numbered human remains body bag should be annotated by the ERT on human remains administrative tracking forms. Items that have potential for identification should be processed through the morgue stations prior to release to the ERT and removal from the morgue.

#### *7.14.4. Admitting Team*

There must be a formal admitting procedure set in place to properly account for each set of human remains submitted to the morgue and create a record of each step throughout the process by the various forensic disciplines to document procedures, classify, and identify the remains. The Admitting Team creates a folder of pre-printed forms for use by each morgue station along with a tracking log to verify each set of remains has been examined at each station. The Admitting Team also assigns an escort, referred to as a “tracker”, for each set of remains to direct the remains from station to station.

#### *7.14.5. Tracking Team*

The tracking of remains through the morgue process is accomplished by individuals assigned as the trackers. The tracker escorts a set of remains from station to station, ensuring each required discipline has the opportunity to examine the human remains. Trackers use a one-page form listing each morgue station where the human remains is presented for examination. A station representative must check and initial the tracking form to verify each set of human remains has been presented for examination. The tracker also collects the station’s documents generated from the exam or evaluation conducted of the human remains. In the event the human remains are presented to a station but is determined to be unsuitable for examination by that particular station (i.e. a fragmented body with no hands or feet that does not require fingerprinting) that station representative must initial the tracking document as verification that no examination is required by that station. After the tracker has completed the entire morgue circuit the human remains is returned to storage and the documents generated from station examinations are returned to the Admitting Team for subsequent release to the Victim Identification Unit.

#### *7.14.6. Personal Effects Team*

Subsequent to any MFI, Personal Effects (PE) must be managed effectively. Belongings associated with human remains or disassociated from human remains at the site must be collected, safeguarded, examined for evidence, documented, cataloged, associated back to its rightful owner, and eventually relinquished to next-of-kin when possible. The amount of PE generated from a MFI and the complexity of managing the PE will vary greatly from incident to incident. For example, a fatality from a flood is likely to have just the clothing worn and the items held in clothing pockets. Conversely, a fatality of an airplane crash will likely have clothing and belongings on their person as well as carry-on and checked luggage that is disassociated from the owner and possibly dispersed across a huge debris field.

#### 7.14.6.a. Processing Personal Effects at the Morgue

Items of PE collected at the incident site should be transported to the County C/ME or temporary morgue. Even when PE is evaluated for evidence prior to collection at the site, it should be re-evaluated upon receipt by the County C/ME staff. Any items of PE having potential value as evidence should be treated as evidence, separated from other PE, and released to investigators. Some items of PE may require processing for latent fingerprints in an effort to establish ownership and further aid in identification processes. Personal effects are removed from bodies during forensic examination but are not separated from the human remains for PE processing until the remains have passed through all of the identification stations. After the remains complete the examination circuit, the PE is segregated from the remains and either stored for safekeeping or transferred to another location for dissemination to the NOK.

#### 7.14.6.b. Return of Personal Effects to Family Members

Personal effects become an important aspect of providing support to surviving family members as they struggle with the grieving process over the loss of loved ones. Return of PE to NOK is just one of the key elements of helping them cope and accept the tragic death of a family member.

### 7.15. FORENSIC UNIT

The second operational phase of the morgue relates to the technical examination of remains by SMEs.

#### 7.15.1. *Photography Team*

Photographing each set of human remains is essential to morgue processing. The contents of every human remains bag must be photographed whether it is an intact body or a small fragment. Photographs serve as a frame of reference for human remains returned to storage, as these photographs can be examined from the filed documents associated with a particular human remains number and may negate the requirement to retrieve the human remains from storage for visual examination. Photography support may also be required by other morgue sections if unique or unusual findings are encountered and require visual documentation. Additional photographers may be required to support MFI morgue operations and may be available from local law enforcement forensic assets.

#### 7.15.2. *Radiology Team*

Any human remains bag entering the morgue process must be x-rayed. If the remains are intact a full-body x-ray is required to adequately document the remains. Radiographs expose important biological information (such as previous bone fractures, surgical intervention and implants, etc.). Detection of these anomalies frequently provides means for positive identification, as is the case when a serial numbered implant is revealed and its origin successfully traced. Viewing x-rays can also aid in detection of comingled remains.

#### *7.15.3. Pathology Team*

The decision to perform a complete, partial or no autopsy on human remains from a MFI rests with the C/ME. The number of remains, condition of remains, and complexity of identification will influence that decision process. At a minimum, a gross description of the remains must be recorded. Any evidence discovered during autopsy is photographed, recovered and released to law enforcement officials. In smaller incidents the pathology station may also serve as the DNA collection station. Assigning a scribe to each pathologist can expedite the examination process.

#### *7.15.4. Fingerprints Team*

Inked postmortem fingerprints present on any remains are recorded from any human remains bag presented to the morgue. Record fingerprints collected at the morgue are released to the lead investigative agency for classification, comparison, and analysis. Matches to local or national fingerprint databases are reported to the C/ME for identification consideration. The fingerprint cards of MFI victims are returned to C/ME for filing with other human remains documentation.

#### *7.15.5. Odontology Team*

Dentists conduct exams of each set of dentition presented in a human remains bag and the dental x-rays taken by either the Radiology Team or the Odontology Team. The dentition is charted using DEXIS computer software and the resulting postmortem charts are used by the Data Analysis Team for comparison with retrieved ante-mortem records. Dental identification software, WinID3 (<http://winid.com/>), is necessary to aid dentists in the task of ante- and postmortem dentition comparisons. Disassociated partial dentition receives separate human remains numbers and are examined and classified as well. Odontology teams are most efficient when staffed by three members: a dentist, a dental assistant, and a scribe.

#### *7.15.6. Anthropology Team*

This team serves primarily to classify unidentified decomposed, mummified, and skeletal remains and articulate disarticulated remains. Estimations of age, height, sex, and race are useful as well as uncovering skeletal anomalies and unique identifies such as bone fractures, surgical plates, and screws. Anthropology SMEs may also be needed on site for human remains recovery efforts and at the Triage Station to sort comingled remains.

#### *7.15.7. DNA Team*

This team may be a separate operation or combined with the Pathology Team if it is a modest undertaking. It is the last section in the sequence of morgue stations because DNA sample collection alters the condition of the human remains, however slight. Sample collection consists of either a buccal swab, whole blood, tissue, bone, or teeth. Sample medium and quantity is dictated by the DNA laboratory selected to receive the items for testing. DNA sampling is documented using both the DMORT tracking form and a separate evidence chain of custody document prescribed by the servicing DNA laboratory. Human remains records must also be annotated to document what sample was collected and from where. The method and timing of transfer of DNA samples from the morgue is coordinated between the DNA Team and the

servicing DNA laboratory. Laboratory results are reported back to the Victim Identification Group.

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## 8. FAMILY ASSISTANCE CENTER

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### 8.1. INTRODUCTION

The Family Assistance Center (FAC) is the designated location established to exchange accurate, timely information and render support services for victim family members of mass fatalities and friends who contact or travel to the incident location seeking help. In the aftermath of a MFI, family members and close friends (hereafter referred to as patrons) will struggle to cope with the tragic, unexpected loss of family, friends, and co-workers. Attending to those needs and providing assistance is fundamental to an adequate response to any MFI. It is important to understand the significant and critical role of the FAC. No other aspect of fatality management may have as much human emotion, grief, and anger exhibited within the confines of a FAC. The FAC is a “safe place” for these emotions to be expressed. Furthermore, the FAC provides the opportunity to collect personal information about the victim, allowing authorities to obtain vital information for victim identification. Note that this will possibly be one of many services being offered to survivors of a disaster, which may reduce the pool of potential FAC staff and resources.

### 8.2. ORGANIZATION

The county where the MFI is located will need to determine who will lead and staff the FAC. Staffing may be found in a variety of human services agencies and Non-Government Organizations (NGOs). While scalable to the size and scope of the incident and flexible to meet the needs of the situation and community, the FAC is structured to include three units: Victim Identification, Family Management, and Health and Human Services. The organizational chart on the following page suggests how that structure might appear within the guidelines of the ICS (Fig. 8.1).

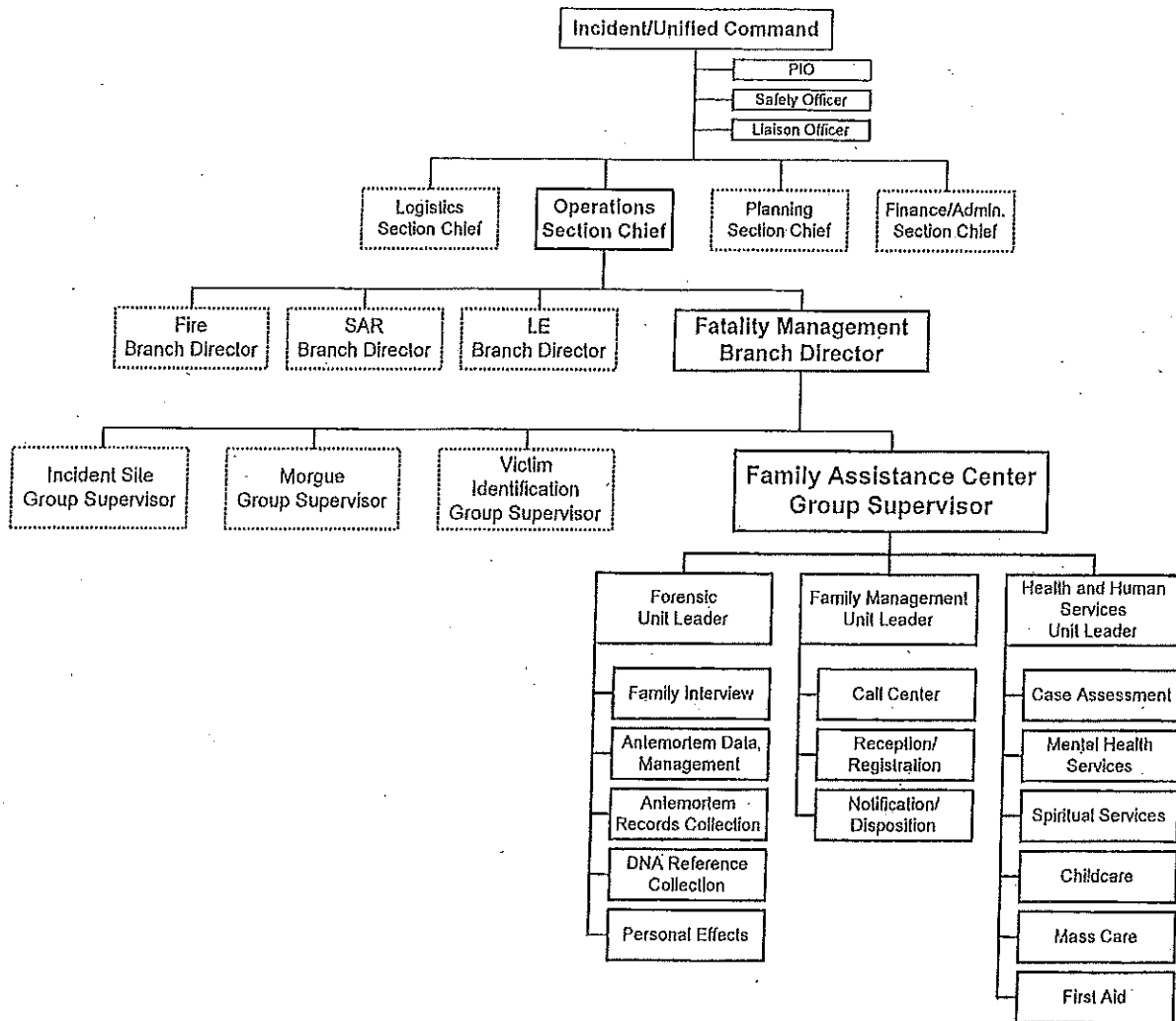


Figure 8.1. Example Family Assistance Center Group Operations Organizational Chart

### 8.3. GENERAL CONSIDERATIONS

It should be noted that the following discussion about Family Assistance Center operations encompasses every operational aspect in a full-scale incident. The concept, however, is designed to be flexible and scalable to meet the demands of each specific incident. Any number of the components discussed below can be included, excluded, or expanded to support the specific needs of the situation. For ease of discussion, the individual sections are referred to as teams although the team may consist of only one person and a single person may serve more than one team function based upon the scale of the operation.

*Note:* Family Assistance Center operations for disasters involving aviation (but not military- or intelligence agency-related), selected rail, highway, marine, pipeline, or hazardous materials (Hazmat) accidents will be the responsibility of the National Transportation Safety Board

(NTSB) to coordinate. Local responders will still be necessary for staffing and operation of the FAC.

#### 8.4. SITE SELECTION AND REQUIREMENTS

At the time of an incident, the Assessment Team (previously discussed in Section 7.1., Assessment Team) should select a site for the Family Assistance Center. This site is based on the type, size, and location of the incident. Ease of access to the facility and availability of internet, information technology (IT) services, etc. are also determining factors. A FAC facility must be ADA compliant. Once the FAC site selection is made and the C/ME approves the site, the FAC Supervisor requests needed supplies, equipment, and technical support through the Logistics Chief. The illustration below suggests how a FAC may be configured (Fig. 8.2).

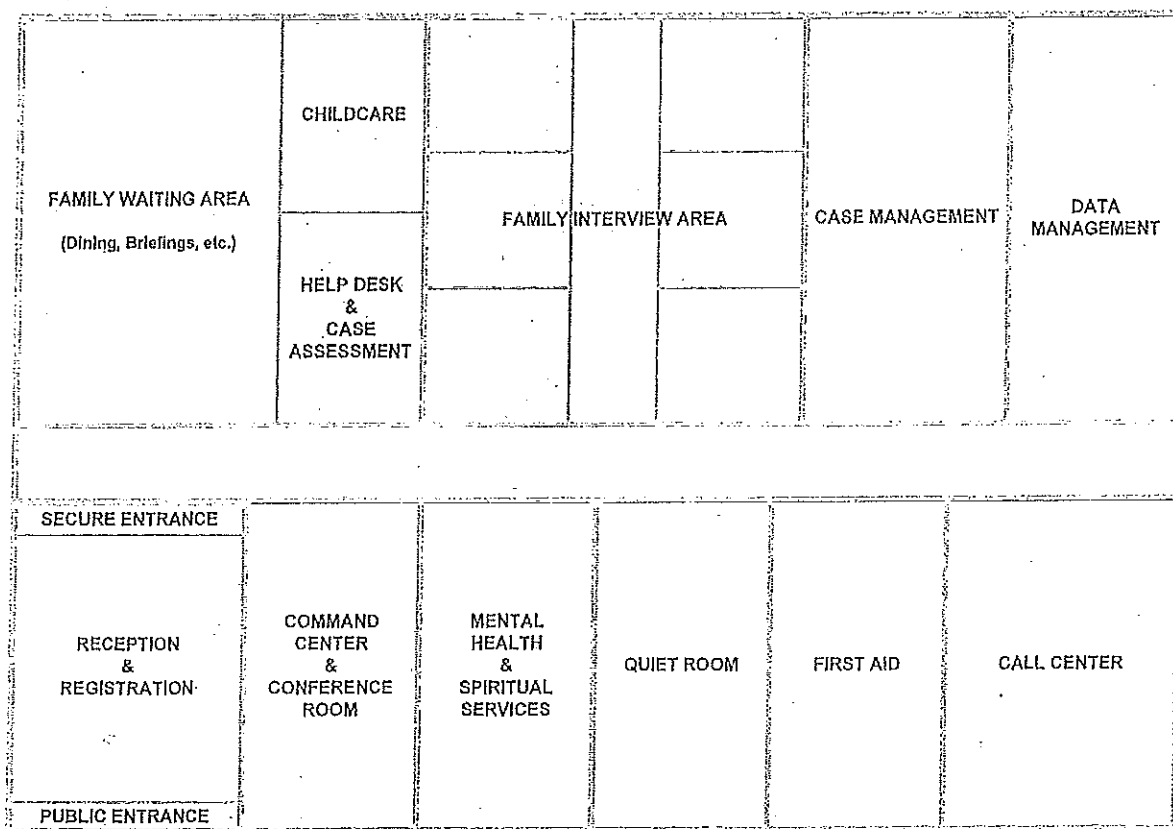


Figure 8.2. Sample Family Assistance Center Layout

##### 8.4.1. Security

The FAC should be a safe and secure facility that protects family members from unwanted intrusion from media, curious onlookers, and the general public. There should be a constant security presence on-site at the FAC. Access to the FAC should be monitored at all times.

#### 8.4.2. *Availability*

Quickly following the result of the Assessment Team, authorization should be given by the C/ME to setup the FAC. The FAC should remain open on a continual basis for as long as required.

#### 8.5. FAC PATRON INTAKE PROCESS

Patrons entering the FAC should be managed in an orderly fashion. Coordination with the American Red Cross Safe and Well Website (<http://www.redcross.org/find-help/contact-family/register-safe-listing>), will assist in distributing information to NOK. The illustration below depicts the flow process of patrons through the FAC (Fig. 8.3).

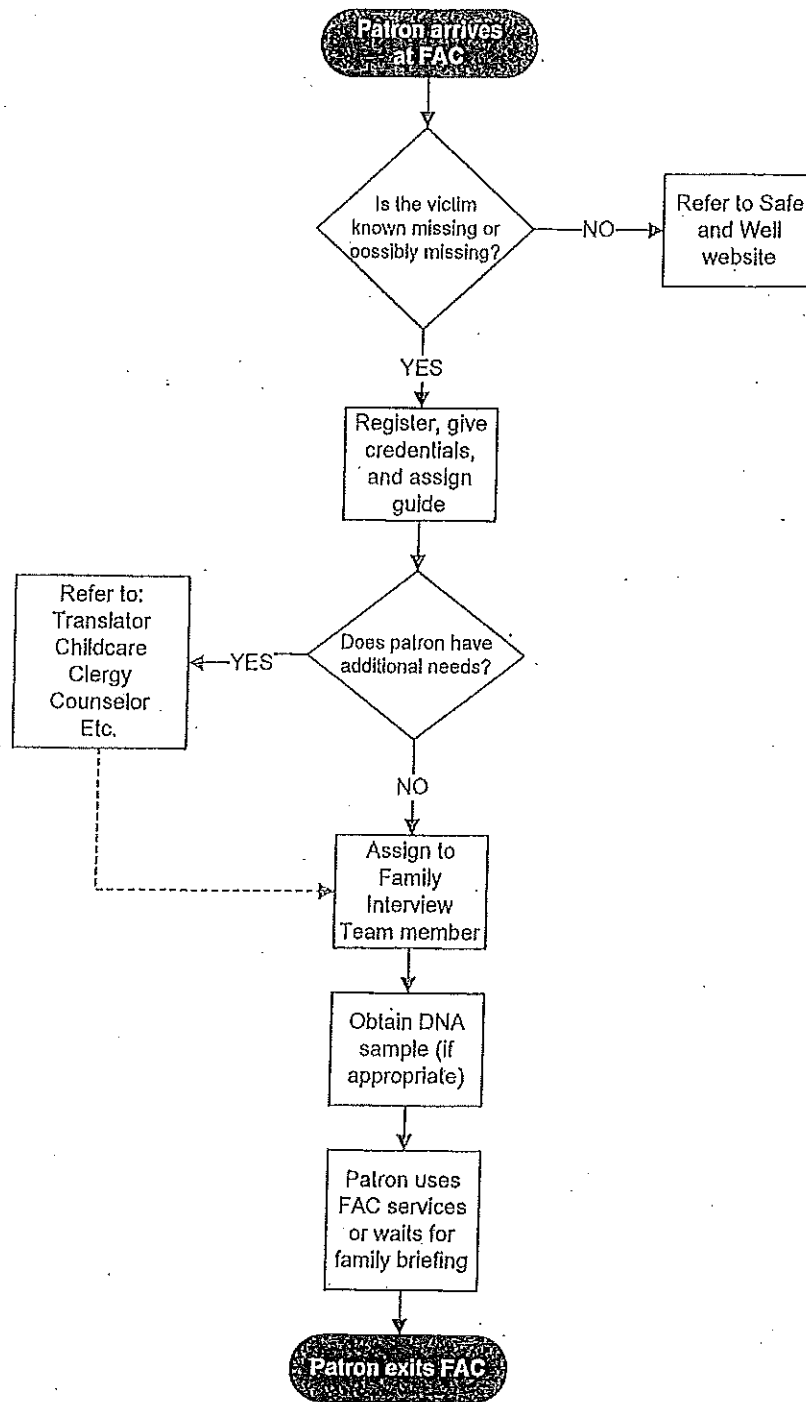


Figure 8.3. Patron Intake Process.

## 8.6. FAMILY BRIEFINGS

It is critically important that patrons receive a continuous flow of information and understand the identification process. Family briefings help to meet this need. It is imperative that information is provided to the families as soon as possible and before being released to the media. The Public Information Officer (PIO) or designated representative should lead family briefings and brings patrons up to date on the latest developments. A conference call bridge may be set up in the briefing room to connect to family members who are not on site. The Family Management Unit Leader should coordinate the family briefings making sure that families are aware of the briefings and are notified of any changes of location and/or time. The Family Management Unit Leader should work with the Logistics Section to ensure that facility needs in the briefing room are met and functional. Family briefings should be conducted at least once daily, ideally at a uniform time. In order for families to feel they are being kept fully informed, briefings should be held even if there is no significant news to report. The briefing location and times should be posted throughout the FAC.

## 8.7. FORENSIC UNIT

The Forensic Unit coordinates all identification operations among different units and teams associated with the FAC (i.e. Family Interview, Data Management, Notification/ Disposition Teams).

### 8.7.1. *Family Interview Team*

After initial intake by the Reception/Registration Team, patrons are escorted to a family interview room. A team member conducts an in-depth and confidential interview using the Ante-mortem Interview Form which collects detailed information about the victim. This interview normally takes two to three hours to complete. Team members are specifically trained to interview families or friends of MFI victims such that the interview does not have the feel of an interrogation. If technology permits, a member of the Data Management Team sits in on the interview and enters information received into the VIP database. The interviewer establishes the relationship (kinship) of the interviewee to the victim by completing a kinship diagram. Appropriate family members are identified for reference DNA sample collection, sign a consent form, and are directed to the DNA Reference Collection Team where a DNA sample is taken that will aid in victim identification. Also discussed in the interview is the family's initial preference for death notification. When the interview is completed, the team member notifies the Ante-mortem Team of ante-mortem information that must be obtained from the victim's medical records.

### 8.7.2. *Ante-mortem Data Management Team*

The Data Management Team provides clerical support for all aspects of the FAC, ensures that information from the Ante-mortem interview form is entered into the database and manages all hard-copy files. In addition, this team scans victim photographs and other pertinent documents

into the database. Information is exchanged with the morgue to ensure that there is a complete file on each victim.

#### *8.7.3. Ante-mortem Records Collection Team*

The Ante-mortem Team works in tandem with morgue operations to gather and manage ante-mortem data through various collection and distribution methods. During the interview process families are asked to provide victim medical history including details of previous surgeries and dental restorations. The Ante-mortem Team then obtains medical records of this nature for postmortem comparison in the identification process using the Requested Records Log.

#### *8.7.4. DNA Reference Collection Team*

Frequently MFI identifications depend on DNA testing. DNA results from human remains must be compared to reference samples in order to make DNA identifications. Reference samples can be from one of two sources, either direct or indirect. Direct references are samples obtained that can yield the DNA profile of a particular missing/unidentified person. Indirect references are DNA samples of biologically related family members that can be used in varying combinations to match to human remains DNA profiles. Therefore, the FAC must serve as the DNA collection point for family members.

##### *8.7.4.a. Direct References*

Family members are solicited to locate and provide personal items of their missing/unidentified loved one that may hold that individual's DNA. Items of clothing, toothbrushes, and used shaving razors are but a few examples. These items are surrendered by the families and must be documented on a chain of custody evidence form for subsequent transmittal to the DNA laboratory conducting the DNA testing.

##### *8.7.4.b. Family References*

The type of sample collected (buccal swab [cheek] or whole blood) is determined by the laboratory selected to process the reference samples. Buccal swabs are preferred as they are the least invasive and painless collection method. All family reference samples are documented on a chain of custody evidence form and released to the individual responsible for transferring the samples to the laboratory conducting testing. Specific consent forms and evidence forms vary from agency to agency and are obtained from the laboratory processing the samples.

#### *8.7.5. Personal Effects Team*

The Personal Effects Team supports PE recovery at the site and PE recovery at the morgue. This team collects, inventories, refurbishes (but does not restore), and catalogues the deceased's personal effects for return to family members. In some incidents, the families are required to identify the PE of loved ones. Creating a photographic catalogue of recovered PE allows each family to sit in private and view the catalogue to identify PE. This serves a dual purpose: first, it facilitates the return of PE to the family; second, associating a particular item of PE may aid in

the circumstantial identification of a victim based upon details of the PE recovery (location, possession, association, etc.). Personal effects recovered must be made acceptable for viewing prior to photographing or release to family members to prevent further traumatizing the family. Some of the recovered PE may not be suitable for viewing or release if it cannot be restored. Recovered PE frequently invokes extreme family emotions and must be considered when managing this aspect of MFI response.

## 8.8. FAMILY MANAGEMENT UNIT

The Family Management Unit manages the flow of patrons calling or coming to the FAC. This unit collects timely, regularly updated, and accurate lists of identified victims, individuals receiving medical treatment, missing persons, and family members waiting for information.

### 8.8.1. *Call Center Team*

The Call Center Team receives over-the-phone initial missing persons intake information as well as information calls regarding volunteers and donations. Generally there are up to 100 calls for every one victim of a MFI. For example, the Louisiana Family Assistance Center handled 52,000 incoming and 164,000 outbound calls following Hurricane Katrina in 2005.

#### 8.8.1.a. Call Intake Process

At the Call Center, incoming calls are answered on dedicated, toll-free lines (an alternate line will also be maintained for the hearing impaired) by a team member who electronically fills out a Call Center Intake Form using the VIP database. This form records the caller's name and contact information, relationship to the victim, and initial family member/victim information. Using this information, the team member prioritizes the call using the following categories:

- "Known missing" – i.e. my son and daughter-in-law had tickets to the concert at the local venue and called us from the concert, and now I cannot reach them
- "Possible missing" – i.e. my son had said he was going to the concert tonight and now I cannot reach him
- "Not known" - i.e. my son his family live in the impacted area and frequently attend concerts at the local venue and I cannot reach them

If the call meets the "known missing" or "possible missing" thresholds, the caller is advised that they will receive a return phone call from law enforcement or other personnel handling missing persons cases. After the return phone call, if the potential victim is still determined to be in the "known missing" or "possible missing" categories, the family member is encouraged to travel to the FAC for a family interview. If the caller cannot travel to the FAC, the caller may be transferred to a Family Interview Team member who conducts the interview over the phone and electronically enters the ante-mortem interview information into the VIP database. If the caller is in crises, he/she is connected to a chaplain or a counselor from the Mental Health Services or Spiritual Services Team at the FAC. If the caller meets the "not known" threshold, a referral is made to the Safe and Well website

(administered by the American Red Cross). Workers at the call center need to be provided with instructions to respond to offers of donations or volunteer services. For other MFI-related questions, the caller is transferred to the Help Desk managed by the Case Assessment Team. The described call intake procedure is illustrated in the flowchart below (Fig. 8.4).

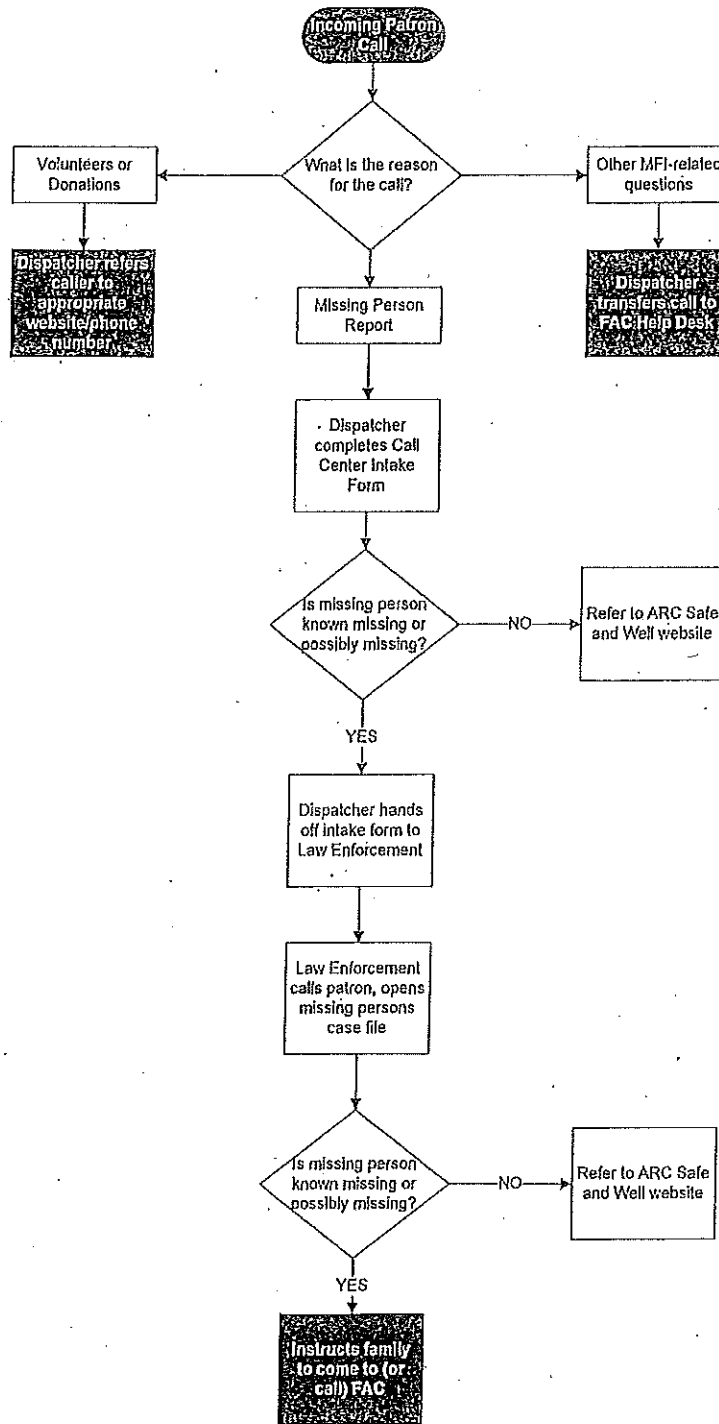


Figure 8.4. Call Intake Process

#### 8.8.1.b. Found Persons

If a person calls to advise that a “missing person” – either self or another person – is found, the Call Center Team member takes the caller’s contact information along with the name, address, and telephone number of the person who has been located and passes that information to the on-duty Call Center Team Leader.

#### 8.8.1.c. Call Center Scripts

Scripts are developed and a resource binder is prepared by the Call Center Team Leader so that each Call Center Team member receives and gives uniform and accurate messages. These resources should be updated daily by Call Center personnel to ensure that all information is current.

### 8.8.2. *Reception/Registration Team*

The Reception/Registration Team receives initial intake information from patrons who present themselves at the FAC. When patrons arrive, the staff warmly greets them, ensuring that they are treated with respect, consideration, and sensitivity.

#### 8.8.2.a. Patron Entry/Registration

Patrons whose loved ones do not meet the “known missing” or “possible missing” criteria are referred to the Safe and Well website, and may use one of the computers set up at the FAC. Patrons whose friend or family member falls into the “known missing” or “possible missing” categories sign the FAC Family/Friend Daily Sign-In Sheet. The Reception/Registration Team member then completes a Family/Friend Registration Form which provides initial information about the patron and his/her relationship to the victim. Patrons are provided with FAC identification badges.

#### 8.8.2.b. Guides

A team member is assigned to guide patrons through the FAC, first taking them to a waiting area where they are informed of available FAC services, provided with pertinent written information, given the family briefings schedule, and assisted in navigating the FAC. When the next interviewer is available, family members are escorted from the waiting area to an interview room.

#### 8.8.2.c. Patron Exit/Re-Entry

When patrons leave the FAC, they check out and leave their contact information at the Registration Desk so they can be contacted when more information is either needed or available. Each day when families and friends return to the FAC, the Reception/Registration Team checks their identification.

### 8.8.3. *Notification/Disposition Team*

The Notification/Disposition Team notifies family members of the confirmed identification of their deceased loved one and releases the body in accordance with their wishes. Preliminary information received during the family interview as to the family’s wishes for the disposition of

the remains will be followed. Discussion is also held with the family as to any preferences the FAC may have for funeral home services, as such an arrangement may dictate the timing for release of the body. The Notification/Disposition Team will have the victim's authorized family member sign a Remains Release Authorization, which directs the family's wishes for further notification and disposition.

#### 8.8.3.a. Notification Options

The Remains Release Authorization Form provides the family with several options for notification upon additional identification of their deceased family member. These choices include:

- Do not notify (families are content not knowing specific details of the identification)
- Notify one time (i.e. when the first remains are identified)
- Notify each time remains are identified
- Wait to notify until all known remains are identified
- Notify through a third party (clergy, funeral director, etc.)

#### 8.8.3.b. Notification Process

The process of notification is determined by the size of the incident and the proximity of patrons to the incident site. If families live within a close proximity, notification is made either at the Family Assistance Center or by a personal visit by a team of authorized representatives (law enforcement, clergy, funeral directors, mental health professionals, etc.) to the family member's home. If the family member lives outside the immediate area, notification may be made by telephone.

### 8.9. HEALTH AND HUMAN SERVICES UNIT

The Health and Human Services Unit cares for the physical, emotional, and spiritual needs of patrons.

#### 8.9.1. Case Assessment Team

The Case Assessment Team provides support to patrons as needed (i.e. interpreters, translators, referrals to support agencies, resources, etc.). The Case Assessment Team maintains a Help Desk to answer questions from people calling via telephone or in person. It assists patrons at the FAC in securing such services as: benefits counseling and assistance, financial assistance and planning, laundry services, physical health services, interpreters/translators, and web access. The team also helps FAC patrons in identifying governmental, corporate, and non-profit support services. Referrals are made using the Secondary Services Referral Form.

##### 8.9.1.a. Interpreters/Translators

In the FAC, it is likely there will be patrons who cannot read, write, or understand the English language. In these instances, the Case Assessment Team will provide interpreter and translator services for:

- Individual and family meetings

- Family briefings
- Translation of FAC materials and ante-mortem records

#### 8.9.1.b. Situational Orphans

Representatives from Child Protective Services are present or on-call for the Case Assessment Team to arrange for the care of minors who are either separated from family members or have become “situational orphans” as a result of the MFI.

#### 8.9.2. *Mental Health Services Team*

The Mental Health Services Team provides Psychological First Aid and/or mental health services to family members and also to those who staff the site, morgue, and FAC. Mental Health Services assists families and friends of victims in understanding and managing the full range of grief reactions.

##### 8.9.2.a. Patron Support

An appropriate mix of professionals – social workers, marriage, family and child therapists, psychologists, psychiatrists, and grief counselors are either on-call or on-duty at all times. The Mental Health Services Team maintains visibility by circulating through the FAC, visiting and talking to patrons to gauge how they are coping over time. When needed, the team also guides family members to private rooms for counseling, reflection, and rest. The Mental Health Services Team monitors patrons reaction to information received at family briefings (particularly the number of positive identifications), assists with ante-mortem interviews and death notifications as needed, and attends all special events (i.e. incident site visits) to monitor behavioral health reactions during activities.

##### 8.9.2.b. Collaborative Services

The team provides consultation to FAC leadership and leaders of other teams and works closely with clergy and chaplains on the Spiritual Services Team to maximize assets and minimize functional overlap. This team also provides crisis intervention, mediation, and management of ‘at risk’ patrons by providing referrals, as necessary, to mental health professionals and support groups located in the family member’s local area for adult, adolescent, and child counseling.

#### 8.9.3. *Spiritual Services Team*

The Spiritual Services Team provides pastoral counseling and spiritual care for people of all faiths who request it. The Spiritual Services Team is accessible to families, friends, and co-workers of victims, particularly during large group meetings and events. This team will also provide emotional support/crisis intervention and assist mental health staff as needed. In addition, a representative of the Spiritual Services Team may be present when death notifications are made.

#### 8.9.3.a. Patron Support

Clergy and chaplains who serve on the Spiritual Services Team reach across faith group boundaries, do not proselytize, and protect families and friends from being confronted by unwelcome forms of spiritual intrusion. The team is available throughout the FAC, gauging the emotional reactions of those around them and, when appropriate, guiding patrons to a private room where they can talk about their loss and pray. Team members share meals at the FAC with patrons to provide support. Clergy and chaplains assist the Call Center when needed by talking with callers in distress. They may arrange and conduct an interfaith memorial service when appropriate. In addition, Spiritual Services Team members should attend family briefings and all special events (i.e. visits to the incident site) to monitor family reactions during activities and provide support.

#### 8.9.3.b. Responder Support

The Spiritual Services Team also tends to the spiritual needs of the staff, volunteers, and responders. This may include offering and conducting regular interfaith worship services.

#### 8.9.4. *Childcare Team*

The Childcare Team should provide temporary care for children while their parents or guardians are at the FAC involved in interviews, briefings, and meetings.

##### 8.9.4.a. Credentialing

The childcare area is prepared to provide support and activities for children representing a range of ages and is structured and staffed to provide appropriate monitoring and support for children's needs. Only licensed childcare providers and staff who have passed a criminal background check should be used for these services, which should be identified pre-incident.

##### 8.9.4.b. Accountability

Appropriate documentation of children should be maintained through sign-in and sign-out and badging or tagging procedures. Parents or guardians should provide staff with special instructions, such as medical conditions or dietary needs and requirements, when registering their children.

#### 8.9.5. *Mass Care Team*

The Mass Care Team should provide feeding for patrons and staff and limited lodging for out-of-town family members. The Mass Care Team should arrange for a dining area where three meals each day are served and where snacks and drinks are available during all hours of operation. This team also gives attention to the cultural and ethnic composition of patrons and ensures appropriate foods are available to meet their needs. Staff and patrons should have separate areas to dine, and Spiritual Services and Mental Health Services should be present and available during meal times to meet with and bring comfort to patrons and staff.

#### 8.9.6. *First Aid Team*

Depending on the size of the FAC, a First Aid Team may provide basic first aid or medical care for patrons and staff at the FAC. Staff may consist of qualified nurses, EMTs, or Medical Reserve Corps personnel. Team members are positioned throughout the facility during family briefings and other events when large numbers of families and friends are gathered for activities. The First Aid Team arranges for transport to a hospital as needed. If DNA family reference collection is required the First Aid Team could potentially be assigned that responsibility in lieu of a separate DNA Reference Collection Team.

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## 9. VICTIM IDENTIFICATION GROUP

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The Victim Identification Group is responsible for document housekeeping, collecting victim ante-mortem records, and conducting analysis of ante- and postmortem data to identify human remains. This group analyzes data to reach scientific conclusions upon which to base probable identifications. Their findings are formally documented in an identification report that is presented to the Coroner /Medical Examiner who, in turn, either accepts or rejects the findings. Accepted findings become identifications by the C/ME, not the Victim Identification Group. The C/ME is responsible for signing the death certificate during most acute mass fatalities. The death certificate is then finalized with the local registrar using EDRS.

### 9.1. SCIENTIFIC vs. PRESUMPTIVE IDENTIFICATION

The task of identifying MFI victims ranges from relatively simple to highly complex processes depending on the incident. Caution must be exercised to ensure identification procedures are based on sound evidence and reliable information. Results should be based on scientific findings rather than circumstantial evidence. It is most likely that legal issues of identification associated with victims of MFIs will come under scrutiny (by next-of-kin [NOK], media, and others) and findings may be contested.

### 9.2. IDENTIFICATION PROCESS

The identification process of MFI victims is heavily dependent upon collecting ante-mortem and postmortem information for comparison and matching details of each in order to reach a conclusion of positive identification. The task of data comparison is aided by the use of computer software designed specifically for that purpose. The Disaster Mortuary Operational Response Team (DMORT) software program used for this purpose is titled Victim Identification Program (VIP) and the other notable program (used by New York Office of the Chief Medical Examiner [NY OCME]) is the Unified Victim Identification System (UVIS).

### 9.3. OPEN vs. CLOSED VICTIM POPULATIONS

Identification processes start by creating a closed population for victims. Closing MFI populations reduces the number of possibilities for identification. For example, obtaining and verifying the flight crew and passenger list of a manifest creates a closed population of victims who die in an airplane crash. Conversely, attempting to close the incident population from a tornado requires a significant investigative effort and relies on family and friends to report missing persons to proper authorities.

## 9.4. VICTIM IDENTIFICATION TEAMS

The organizational chart on the following page depicts a typical Victim Identification Group operating under the Fatality Management Branch Director.

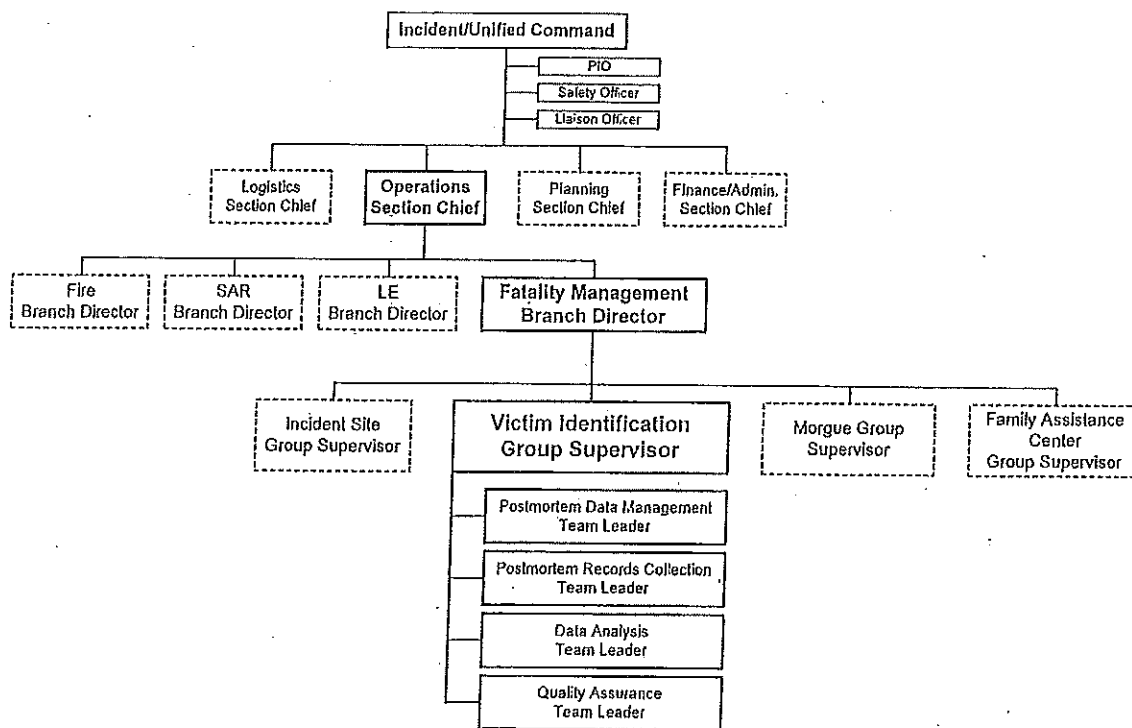


Figure 9.1. Victim Identification Group

### 9.4.1. Postmortem Data Management Team

Records management ensures the systematic, orderly, and retrievable manner in which document filing takes place. Management of records also carries the responsibility of tracking files that are released internally to the various units and teams for reconciliation. The Records Management Team also maintains a records sign-out log and records the release of any and all documents within the morgue to various units and teams.

### 9.4.2. Postmortem Records Collection Team

The Records Collection Team receives postmortem information from the examinations conducted by the morgue teams. This team also seeks to obtain ante-mortem records of potential victims from sources such as family doctors, dentists, and hospitals. Details provided by NOK and friends of suspected MFI victims are used to identify sources of ante-mortem records and subsequently retrieve those records. Ante-mortem records that exist in personal belongings are solicited from family members and received at the FAC. The FAC Ante-mortem Records Collection Team relinquishes the records they obtain to the Postmortem Data Management Team

for correlation and safekeeping. These information pieces are used for inclusion and exclusion purposes in the identification process.

*Note:* The SMEs working in this team are typically pathologists, dentists, and anthropologists.

#### *9.4.3. Data Analysis Team*

The analysis of the ante- and postmortem information is conducted by a team of SMEs. Matching characteristics of pre-existing MFI victim information with that of postmortem examinations frequently result in positive identification of MFI victims. It also facilitates re-association of dismembered, unassociated body parts. Software programs aid the comparison process. Laboratory DNA analysis reports generated from human remains samples, direct references of victims, and family references that produce identifications are returned from the laboratory to this unit. When compelling identification information is gathered, a written summary of facts is prepared to explain the details and circumstances of the identification.

#### *9.4.4. Quality Assurance Team*

Findings leading to matching information and subsequent positive identification of human remains must be verified by a second SME and the written findings of the analysis endorsed. The identification findings are presented to the C/ME for approval. Conclusive findings resulting in victim identification are presented by the C/ME with death certification authority for the MFI. The C/ME has responsibility for completing death certificates in most mass fatality events.

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## 10. COMMUNICATIONS

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### 10.1. PUBLIC INFORMATION AND MESSAGING

In a MFI, it is imperative that public information and messaging be timely, accurate, and regularly updated. Doing so will support response and recovery efforts and bring a sense of security and understanding of incident response to the public. Failure to provide timely, accurate, and updated information can result in mixed and inaccurate messages, unreasonable expectations, and public disapproval. Refer to the county EOP for specific instructions on responsibilities when communicating with the public.

#### 10.1.1. *Public Information*

Information will be reported to the general public that will not only give verified details as to what has taken place at an incident, but will also manage expectations as to how long the search and recovery effort will take and why. These messages should not undermine the response efforts of the local jurisdiction. Information should be delivered via a variety of communication methods, including internet, social media, telephone, and media outlets. Potential items that need to be addressed during a MFI include:

- How to report missing persons
- An information line for family members and friends outside the area who wish to obtain information on recovery and identification effort, incident investigation, and other concerns
- Volunteer opportunities
- Donations management

#### 10.1.2. *Interagency Communication*

Information must be provided to designated public officials (Commissioners, Executive, Mayor, etc).

These officials may desire to be making the public announcements or be involved, which must be coordinated out of the Joint Information Center (JIC) (if activated).

#### 10.1.3. *Family Briefings*

Private briefings for families and friends will be held on a regularly-scheduled basis to report on the progress of recovery efforts, identification of victims, the investigation, site visits and memorial services (if appropriate), return of personal effects, and a description of services available at the FAC. These briefings should commence within 24 hours of the FAC operations activation. Briefings should be held even if there is no new information to report. Greater detail regarding family briefing procedures can be found in Section 8.6., Family Briefings.

#### 10.1.4. *Messaging Order*

It is imperative that critical information (i.e. details of the investigation, progress of recovery efforts, identification of victims, etc.) is shared in a controlled manner. Below is a suggested order of notification:

1. Fatality management responders
2. Designated public officials
3. Victim family members and friends (i.e. FAC patrons) at briefings
4. General public and media

It is essential to the success of the response that families receive information from responders prior to being contacted by the media.

### 10.2. COMMUNICATION ROLES AND RESPONSIBILITIES

Communication typically causes the most challenges during incident response. It is essential for cohesive and efficient mass fatality management to appropriately control communication inflow and outflow. The Mass Fatality Branch must provide accurate and timely information to communications personnel for these personnel to succeed.

#### 10.2.1. *Public Information Officer (PIO)*

The PIO representing the Incident Commander serves as the single point of contact for the incident, conducts press briefings, and presides over family briefings.

#### 10.2.2. *Joint Information System (JIS)*

The JIS establishes parameters of how the public information function will operate at an incident, and serves as a mean for multiple agencies to coordinate messaging.

#### 10.2.3. *Joint Information Center (JIC)*

The JIC is a physical or virtual location that serves as a single point of incident-related information dissemination.

### 10.3. COMMUNICATION HARDWARE AND TECHNOLOGY

The Logistics Section is usually tasked with providing the necessary communications hardware and technology needed to effectively manage a MFI. These items include:

- Telephonic and computer connectivity to support MFM operations
- Technical component operators of MFI-related call centers
- Computer servers support at MFI locations
- IT infrastructure to support ante-mortem and post-mortem data collection systems
- Interoperability between MFI branches and other first responders

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## 11. FEDERAL, STATE, AND LOCAL INTERFACE

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Regional, state, and/or federal assistance may be required to provide adequate resources to manage a MFI. Request for these resources should be coordinated through the Incident Commander to the County EOC. The C/ME retains operational control over any assets deployed to support a MFI response.

### 11.1. REGIONAL ASSETS

Planners must research their region to become familiar with available assets for mass fatality response. The plan should account for regional SMEs, MEs, forensic pathology services, and other resources that may be available during incident response.

### 11.2. STATE ASSETS

Requests for state assistance for local mass fatality incident response should be sent through the Incident Commander to the County EOC. Resource requests that cannot be fulfilled by the County EOC are forwarded to the State DOC for assistance. Specific resources by category, kind, and type, including size, capacity, capability, skill, and other characteristics should be requested using an ICS-213RR form.

#### 11.2.1. Ohio Emergency Management Agency (Ohio EMA),

The Ohio EMA, within the Ohio Department of Public Safety, is responsible for coordinating and facilitating state-level emergency management operations; including planning, training, mitigation, preparedness, response, and recovery. The State Emergency Operations Center (SEOC) manages state-level disaster response and aids in the appropriation of federal and state resources during disasters.

#### 11.2.2. Ohio Department of Health (ODH)

ODH assure an effective statewide health response through planning and collaboration. ODH is the lead agency for planning for MFIs in the State of Ohio. ODH also maintains four temporary storage trailers for cold storage of remains that can be deployed throughout the state.

#### 11.2.4. Ohio Mortuary Operational Response Team (OMORT)

OMORT can provide assistance with body processing, victim identification and family assistance centers at the direction of the C/ME. OMORT members have experience with Federal DMORT deployments and have been trained in the handling of mass fatalities.

### 11.3. FEDERAL ASSETS

Federal entities may have direct or indirect responsibilities for mass fatality incidents that occur locally. Their response role may be direct management and coordination of the response or a supporting role to local authorities. Federal assistance may be predicated upon a federal emergency declaration.

#### 11.3.1. *National Transportation Safety Board*

The National Transportation Safety Board has authority for investigating all public transportation fatalities including civil aviation, railroad, highway, marine, and pipeline accidents in the United States. In the absence of suspected criminal activity, NTSB is the lead investigative agency for transportation incidents. The Aviation Disaster Family Assistance Act of 1996 mandates transportation carriers meet the needs of aviation disaster victims and their families. These needs include victim identification, providing a Family Assistance Center, and crisis counseling.

#### 11.3.2. *U.S. Department of Health and Human Services*

Federal resources for MFI response are within the control of the U.S. Department of Health and Human Services (HHS). Their resources, both equipment and manpower, are contained by the Disaster Mortuary Operational Response Team (DMORT). Equipment resources include three portable morgues, and are located throughout the U.S. and each team has SME for every discipline of morgue operations.

#### 11.3.3. *National Guard Bureau (Title 32 Forces)*

The National Guard Bureau maintains a 12-man Fatality Search and Recovery Teams (FSRT) capable of limited decedent recovery from contaminated field settings under the authority, direction, and supervision of coroners /medical examiners. This capability is part of the NGB CBRNE Enhanced Response Force Package and can be activated as either a state (Title 32) or federal (Title 10) asset and can be used to support civilian MFI response.

#### 11.3.4. *Department of Defense (DoD) (Title 10 Forces)*

Title 10 Forces refers to Active Component soldiers, sailors, airmen, and marines. Under routine circumstances these resources *cannot* be used for civil support. However, Title 10 Forces may be called upon as part of a DoD activation of its Joint Task Force-Civil Support in response to a CBRNE incident due to weapons of mass destruction. DoD Directive 1300.22, Mortuary Affairs Policy, requires a Title 10 mortuary affairs force structure capable of providing support for search, recovery identification, evacuation, and, when required, temporary interment, disinferment, decontamination, and re-interment of (among others) U.S. noncombatants.

#### 11.3.5. *Federal Bureau of Investigation (FBI)*

The FBI is the lead federal investigative agency for any mass fatality incident resulting from or suspected of resulting from domestic terrorism or other criminal acts.

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## 12. AFTER ACTION REVIEW

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### 12.1. RESPONSIBLE AGENCIES

An after action review (AAR) should be conducted upon completion of a MFI response. The AAR is generally initiated by the local jurisdiction EMA, and should convene within a few weeks after completion of the incident response. Often individual teams/agencies will conduct internal AARs. The responsible agency may request that another agency facilitate the AAR process. Representatives from each of the agencies involved in the response should participate in the AAR process. The AAR is an opportunity to discuss what went well and should be repeated in future incident responses, and to pinpoint areas that need improvement. The focus of an AAR is on overarching multi-agency issues. Action items which address the areas for improvement should be identified before concluding the AAR. An individual/agency should be assigned to follow up on each of the actions items that are discussed to ensure they are addressed to completion. A formal report detailing the AAR findings should be completed and dispersed to all agencies that participated in the response (see Section 12.3 below). Individual agencies may also choose to conduct their own independent AARs to discuss internal plans and procedures that may need to be revised within the agency.

### 12.2. LONG-TERM CONSIDERATIONS

The AAR process should include addressing long-term considerations. These considerations may include environmental damage, economic impact, grief counseling for FAC patrons and critical stress debriefing for staff. The agencies responsible for managing the long-term impacts will depend on the particular issue. It is useful to discuss the anticipated long-term considerations at the AAR in order to identify the responsible agency and to ensure that all relevant issues are addressed.

### 12.3. WRITTEN FINDINGS

The AAR findings should be formally documented in a written report. The written findings should be maintained by the local jurisdiction EMA and made available for local jurisdiction officials to review. A copy of the full report should be provided to each agency participating in the AAR process as determined by the C/ME. The specific format of the written report is optional and may be constructed in a format dictated by the agency responsible for conducting the AAR. Often, at the conclusion of the MFI, the IC Operations Section Chief/local jurisdiction EMA may assemble representatives from the Fire, Search and Rescue, Law Enforcement, and Fatality Management branches to write an After Action Report which summarizes the strengths of and lessons learned from the MFI response. This report will then be given to Incident Command/local jurisdiction EMA for inclusion in its after action review. The AAR will also be shared with Ohio EMA and ODH in order to share lessons learned with others.

## Appendix A - Example Agency Task Matrix

NOTE: Appendix A is only a guide. Coordination is required with all agencies to determine if they can/will perform these tasks during a MFI. Different jurisdictions may allocate responsibilities differently than is depicted. Not all tasks may be necessary in all events.

Agency	Activation Phase	Operations Phase	Demobilization Phase
Local Jurisdiction Emergency Management Agency	<ul style="list-style-type: none"> <li>- Activate the jurisdiction's EOC when requested</li> <li>- Request personnel and/or equipment assets as needed</li> <li>- Initiate and coordinate press releases regarding MFM operations</li> <li>- Communicate MFM operational activities to local officials</li> <li>- Respond to requests from local/state/federal officials to attend community forums</li> <li>- Establish a Joint Information Center</li> </ul>	<ul style="list-style-type: none"> <li>- Staff EOC</li> <li>- Coordinate resource and information support for MFM operations</li> <li>- Develop daily situational reports for use by responder personnel, local officials, family briefings</li> <li>- Work with other agencies to staff a JIC</li> <li>- Manage asset requests</li> <li>- Begin planning outside asset demobilization</li> </ul>	<ul style="list-style-type: none"> <li>- Terminate EOC operations, when appropriate</li> <li>- Continue coordination with city, county, state, federal agencies</li> <li>- Notify PIC/JIC of demobilization timeline as soon as possible</li> <li>- Notify all response agencies of demobilization timeline and strategy via meeting</li> <li>- Conduct transition meeting with federal support agencies</li> <li>- Coordinate After Action Review (AAR) process with all necessary participants</li> <li>- Arrange facility and asset demobilization</li> <li>- Monitor change in MFM operational requirements</li> <li>- Coordinate long-term operations for identification and storage</li> <li>- Continue to serve as the Facility Management Branch Director</li> <li>- Monitor change in MFM operational requirements</li> <li>- Identify declining operational tasks</li> <li>- Assess operations that can be accomplished with routine procedures in house</li> <li>- Identify appropriate demobilization timeline in concert MFM Planning representative</li> <li>- Coordinate long-term operations for identification and storage</li> <li>- Inform IC of demobilization timeline and process</li> <li>- Organize staff debriefings with mental health provider</li> </ul>
Coroner/Medical Examiner's Office	<ul style="list-style-type: none"> <li>- Serve on Incident Assessment Team</li> <li>- Assign County EMA liaison</li> <li>- Develop messaging for Public Information Officer (PIO) regarding MFM operations</li> <li>- Identify MFM response needs, potentially including temporary assistance teams such as OMORT</li> <li>- Communicate asset requests to Logistics Section</li> <li>- Activate on-site MFM response</li> <li>- Formulate investigative approach in concert with local law enforcement (if needed)</li> <li>- Formulate MFM incident objectives and transmit them to the Incident Commander (IC)</li> <li>- Coordinate victim recovery process in concert with first responders</li> </ul>	<ul style="list-style-type: none"> <li>- Serve as the Facility Management Branch Director</li> <li>- Update Incident Command/Planning Section Chief daily with a situational report</li> <li>- Integrate additional mass facility assets into the ICS structure</li> <li>- Provide oversight of body removal from the site</li> <li>- Provide oversight of temporary storage</li> <li>- Manage and perform postmortem operations for victim identification</li> <li>- Approve victim identification protocols</li> <li>- Monitor asset needs and communicate changes to County EMA</li> <li>- Manage expectations of the next-of-kin</li> <li>- Participate in family briefings when requested</li> <li>- Manage personal effects recovery and refurbishing process</li> <li>- Perform autopsies as needed</li> <li>- Present preliminary identifications to Medicine-Legal Authority for certification</li> <li>- Lead medico-legal investigation</li> <li>- Attend and speak at community forums</li> <li>- Certify victim identifications</li> <li>- Sign death certifications</li> <li>- Provide oversight of body release</li> </ul>	<ul style="list-style-type: none"> <li>- Release site/morgue/FAC security</li> <li>- Organize staff debriefings with mental health provider</li> </ul>
Law Enforcement Agency (ies)	<ul style="list-style-type: none"> <li>- Serve as Incident Commander, if applicable</li> <li>- Serve on Incident Assessment Team</li> <li>- Establish security protocols and perimeters for site, morgue, and Family Assistance Center</li> <li>- Formulate investigative approach in concert with local law enforcement</li> <li>- County Coroner/Medical Examiner</li> </ul>	<ul style="list-style-type: none"> <li>- Update Incident Command/Planning Section Chief daily with a situational report</li> <li>- Preserve site and control access</li> <li>- Secure morgue from media, bystanders, general public, families, etc.</li> <li>- Secure FAC from media, bystanders, general public, etc.</li> <li>- Collect evidence from site and morgue intake station</li> <li>- Preserve evidence and establish chain of custody</li> <li>- Conduct incident investigation in concert with Coroner/Medical Examiner, other agencies, FBI, as applicable</li> <li>- Staff fingerprint station and conduct fingerprint identifications</li> <li>- Manage FAC Victim Identification Unit</li> <li>- Participate in family briefings when requested</li> </ul>	<ul style="list-style-type: none"> <li>- Disposition of Hazmat waste</li> <li>- Organize staff debriefings with mental health provider</li> </ul>
Local Fire Department(s)	<ul style="list-style-type: none"> <li>- Serve as Incident Commander, if applicable</li> <li>- Serve on Incident Assessment Team</li> <li>- Identify Hazmat issues, if any</li> <li>- Implement Hazmat procedures, if applicable</li> <li>- Activate Search and Rescue operations</li> <li>- Transition to Search and Recovery after Search and Rescue mission is complete</li> </ul>	<ul style="list-style-type: none"> <li>- Manage search and rescue operations</li> <li>- Manage decom/Hazmat operations, if applicable</li> <li>- Update Incident Command/Planning Section Chief daily with a situational report</li> <li>- Participate in family briefings when requested</li> </ul>	
Local EMS Provider(s)		<ul style="list-style-type: none"> <li>- Perform search and rescue operations in concert with other first responders</li> <li>- Provide medical support for responders</li> </ul>	
Local Funeral Directors		<ul style="list-style-type: none"> <li>- Transport human remains from site to body collection point/temporary morgue/County Coroner/Medical Examiner</li> <li>- Develop final interment plans for each victim with family members and friends</li> </ul>	
Local Public Health Department	<ul style="list-style-type: none"> <li>- Serve as Incident Commander or in Unified Command (if appropriate)</li> </ul>	<ul style="list-style-type: none"> <li>- Register deaths in EDRS and issue Disposition certificates</li> <li>- Serve as Incident Commander or in Unified Command (if appropriate)</li> <li>- Coordinate with hospitals to manage fatalities, if applicable</li> <li>- Utilize Medical Reserve Corps volunteers as appropriate</li> </ul>	

Agency	Activation Phase	Operations Phase	Demobilization Phase
Red Cross / United Way / Salvation Army (Jurisdiction dependent)	<ul style="list-style-type: none"> <li>- Work with Incident Assessment Team for the determination of Family Assistance Center (FAC) location and needs</li> <li>- Communicate asset requests to Logistics Section</li> <li>- Set-up FAC</li> </ul>	<ul style="list-style-type: none"> <li>- Serve as the FAC Group Supervisor</li> <li>- Update Incident Command/Planning Section Chief daily with a situational report</li> <li>- Coordinate all non-governmental agencies involved in FAC response</li> <li>- Serve as the Family Management Unit Leader</li> <li>- Serve as the Data Entry Team Leader with CERT support, if available</li> <li>- Meet and register FAC patrons</li> <li>- Coordinate family briefings</li> <li>- Provide primary call center through 2-1-1 or other available means</li> <li>- Staff call center, if needed</li> <li>- Feed FAC patrons and staff</li> <li>- Coordinate lodging for patrons, if applicable</li> <li>- Secure appropriate outside services for FAC patrons</li> <li>- Provide temporary childcare services to FAC patrons</li> <li>- Secure translation/interpreter services</li> <li>- Coordinate other volunteer services as needed</li> <li>- Provide mental health/counseling services to FAC staff and patrons as well as first responders</li> <li>- Attend family briefings and site visits</li> <li>- Accompany law enforcement on death notifications, if applicable</li> <li>- Provide spiritual services to FAC patrons and staff</li> <li>- Support law enforcement for security, as necessary</li> <li>- Coordinate mass fatality events in their facility</li> <li>- Coordinate the transfer of decedents to collection site(s)</li> </ul>	<ul style="list-style-type: none"> <li>- Monitor change in FAC operational requirements</li> <li>- Identify declining operational tasks</li> <li>- Assess operations that can be accomplished with routine procedures in house</li> <li>- Identify appropriate demobilization timeline (will be different from merge timeline)</li> <li>- Inform local jurisdiction EMA of demobilization timeline and process</li> </ul>
Mental Health Services (Community/State Mental Health Agencies)			
Local Clergy			
Ohio National Guard			
Local/Regional Hospitals			

## Appendix B - Remains Storage Surge Information

This appendix provides additional information on ways to increase capacity to store remains during a mass fatality event. Increasing storage capacity adds additional time to allow processing and identification to occur. It is important to note that temporary internment is a strongly discouraged, last resort and must comply with Ohio Revised Code (ORC 3705.17).

### Do's and Don'ts

#### *Why Refrigeration is Highly Recommended*

- Most hospital morgues' refrigeration capacity will be exceeded during a disaster, especially if there are many unidentified decedents or remains recovered in the first hours of the event.
- Refrigeration between 38° and 42° Fahrenheit is the best option.
- Large refrigerated transport containers used by commercial shipping companies can be used to store up to 30 bodies. (Laying flat on the floor with walkway between).
  - Enough containers are seldom available at the disaster site.
  - Consider lightweight temporary racking systems. These can increase each container or room's capacity by 3 times.
- Refrigeration does not halt decomposition, it only delays it.
  - Will preserve a decedent for 1-3 months.
  - Humidity also plays a role in decomposition. Refrigeration units should be maintained at low humidity.
- Mold can become a problem on refrigerated bodies making visual identification impossible and interfering with medicolegal processes.

#### *Why Dry Ice is an Acceptable Recommendation*

- Dry ice (carbon dioxide (CO<sub>2</sub>) frozen at -78.5° Celsius) may be suitable for short-term storage.
- Use by building a low wall of dry ice around groups of about 20 decedents and then covering with a plastic sheet.
- About 22 lbs of dry ice per remains, per day is needed, depending on the outside temperature.
- Dry ice should not be placed on top of remains, even when wrapped, because it damages the decedent.
- Expensive, difficult to obtain during an emergency.
- Dry ice requires handling with gloves to avoid "cold burns."
- When dry ice melts, it produces carbon dioxide gas, which is an asphyxiant. The area needs good ventilation.

#### *Why Stacking is not recommended*

- Demonstrates a lack of respect for individuals.

- The placement of one body on top of another in cold or freezing temperatures can distort the faces of the victims, a condition which is difficult to reverse and impedes visual identification.
- Decedents are difficult to manage if stacked. Individual tags are difficult to read and decedents on the bottom cannot be easily removed.

#### *Why Freezing is not recommended*

- Freezing causes tissues to dehydrate, which changes their color; this can have a negative impact on the interpretation of injuries, as well as on attempts at visual recognition by family members.
- Rapid freezing of bodies can cause post-mortem injury, including cranial fracture.
- Handling decedents when they are frozen can also cause fracture, which will negatively influence the investigation and make the medicolegal interpretation of the examination results difficult.
- The process of freezing and thawing will accelerate decomposition of the remains.

#### *Why Ice Rinks are not recommended*

- Ice rinks are frequently brought up as possible storage sites. As previously mentioned, freezing has several undesirable consequences.
- A body laid on ice is only partially frozen. It eventually will stick to the ice making movement of the decedent difficult.
- Management and movement of decedents on solid ground is challenging in good circumstances. Workers having to negotiate ice walkways would pose an unacceptable safety risk.

#### *Why Packing in Ice is not recommended*

- Difficult to manage due to ice weight and transport issues.
- Large amounts are necessary to preserve a decedent even for a short time.
- Difficult to resource or obtain during an emergency.
- Ice is often a priority for emergency medical units.
- Results in large areas of run-off water.

#### *Why Temporary Interment is not recommended*

- Ohio law requires the issuance of disposition permits prior to burial (ORC 3705.17). This makes temporary interment impractical in most situations.
- Not in accordance with societal norms. Could result in significant damage loss in public trust.
- Should only be considered as a last resort when no other method is available and longer-term temporary storage is needed.
- Bodies should be interred in a manner that facilitates later recovery.
- Decedents should be labeled with an identification tag, buried at least 5 feet deep, and 600 feet from the nearest water source.
- Remains should not be stacked.
- Land designated for temporary interment will likely not be reused for another purpose.

## Potential Storage Surge Courses of Action

### ODH Trailers:

ODH possesses four Morgue Response trailers capable of handling 18x sets of remains each. This asset can be requested through the Ohio EMA from the county EMA using WebEOC. Requestor is responsible for restocking the trailer and providing fuel for the generator. Refer to the ODH Mobile Asset SOP for additional information.

Each trailer includes:

- North 7140 N95 respirators (500)
- North 5130 N-95 respirators (3,000)
- 3M 8511 N-95 respirators (480)
- 3M 8210 Plus N-95 respirators (1,920)
- Fluid-resistant suits (75 each XL and 2XL)
- Nitrile gloves (850 pair XL, 200 XXL)
- Adult body bags (125)
- Pediatric body bags (50)
- Bariatric body bags (48)
- Winch (1)
- Shoreline power cord (1)
- Pentax Optio camera (2)
- 8,000 kW generator (1)
- Dell Latitude laptop with case (1)

### Refrigerated Trucks/Containers:

Refrigerated trucks and containers provide a way to surge cold storage during a mass fatality event. The refrigeration trucks should be unmarked (e.g., provider names/logos should not be displayed); remove and or cover as necessary.

#### *Capacity requirements*

Diesel refrigerated trucks generally come in two widths, 96 and 102 inches (8 and 8.5 feet respectively). Lengths of truck boxes(storage areas) varies from 9 to 53 feet. Larger commercial vehicles may provide optimal storage however those facilities that do not readily have commercial drivers may opt for smaller vehicles due to the reduced license requirements.

Decedents would be placed next to each other perpendicular to the truck length, with a narrow walk space at head and foot. On average approximately 30 inches (2.5 feet) of truck interior width would be required for each body.

- 53' refrigerated trailer can store 21 decedents in pouches without shelving
- 40' refrigerated trailer can store 18 decedents in pouches without shelving
- Can double/triple/quadruple capacity with shelving

#### *Other Considerations*

Cleaning- Ensure that the vehicle has cleanable inside surfaces. Preferably metal.

Fueling- Diesel refrigerator trucks must run continuously at idle to power the refrigeration units, using approximately 1 gallon of diesel fuel per hour. Fuel tank capacities vary based on the vehicle. Refueling will be required periodically to keep the unit operational.

Health Considerations- Diesel exhaust contains several chemicals and compounds that may be hazardous to human health from concentrated or long term exposure. Therefore careful

consideration should be given to locating the unit in an area away from regular human activity and air circulation intakes.

### Crypt Bed usage:

Examine the use of crypt beds. Determine whether two decedents can occupy a single crypt bed without stacking and without exceeding the manufacturer's weight limit. Move decedents as appropriate.

### Dry Ice:

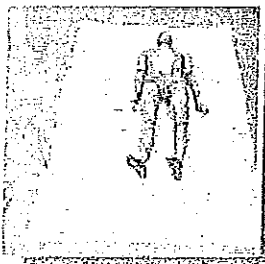
Dry ice (carbon dioxide frozen at  $-78.5^{\circ}$  Celsius) may be suitable for short-term storage. Dry ice precautions and considerations include:

- Use by building a low wall of dry ice around groups of about 20 decedents, and then cover with a plastic sheet.
- About 22 lbs of dry ice per remains, per day, is needed, depending on the outside temperature.
- Dry ice should not be placed on top of remains, even when wrapped, because it damages the body.
- Dry ice requires handling with gloves to avoid "cold burns."
- When dry ice melts it produces carbon dioxide gas, which is an asphyxiant. The area needs good ventilation.

### Body Bags

ODH has purchased a supply of body bags for county corners across the state for use during a mass fatality. ODH also has a central supply of body bags that deploy with the Morgue Response trailers. In the event body bags are unavailable, below is an alternate method of packaging remains.

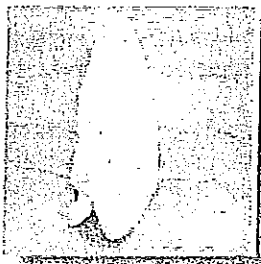
A mass fatality incident/event may facilitate the need for expedited decedent handling, and a streamlined use of decedent storage supplies. For example, the Los Angeles County Department of Coroner uses simple plastic sheeting and cotton rope (see next page for detail) to store decedents. Determine decedent handling and storage strategies for your facility and plan for decedent surge accordingly. The following images depict the Coroner's use of plastic and cotton rope for mass decedent storage.



A. Place plastic under decedent.



B. Wrap decedent in plastic.



C. Wrap decedent with sheet. Tie ends.



D. Tie rope. Attach identification tag.

## Appendix C - Local EMA Checklist

### I. Planning (with Coroner/Medical Examiner)

- Determine how the Mass Fatality Plan will relate to the County EOP.
- Work with other agencies to determine the responsibilities assigned to each organization. Include local departments and agencies (coroner/medical examiner, fire, law enforcement, EMS, public health, EMA, social services, etc.), state agencies (ODH, OEMA, OSHP etc.), federal agencies, regional organizations, volunteer resources (CERT, MRC), VOADs), and private sector businesses and groups.
- Communicate final fatality management responsibilities to other relevant partners.
- Identify and describe mutual aid agreements that are in place. Identify and briefly summarize who is covered by the agreement, for what goods or services, and what limitations apply if any.

### II. Activation

- Describe who has the authority to activate the plan
- Ensure the EMA has the ability to contact the county coroner/ medical examiner.
- Work with the coroner to identify what agencies would participate in an initial assessment to determine what aspects of the mass fatality plan need to be activated and whether any additional resources are required.

### III. Command and Control

- Discuss with local health, first responders and disaster management officials where/how mass fatality management integrates with other response elements on-scene. Provide an organizational chart for chain of command, including operations, logistics, planning, and finance/administration.
- Ensure agencies are aware of their responsibilities in a mass fatality incident.

### IV. Site Clearance and Recovery of Deceased Victims

- Determine what agencies will be involved in remains recovery. Identify any training gaps that may need to be addressed during a mass fatality incident.
- In certain situations such as criminal and/or terrorist attacks the disaster site must be preserved for investigative purposes – whose responsibility will this be and how will it be done.

### V. Mortuary

- Identify available local resources to assist with identification and notification.
- Arrangements for external assistance and/or local arrangements to facilitate identification at the local level should be considered.
- For storage and body preparation local morgue facilities and funeral homes – location, capacity, resources etc., should be listed in the plan with relevant contact details. Transportation to these facilities must be considered. MOUs can be developed with private morgue/funeral homes and included as part of the plan.
- Consider arrangements for handling the media and for security at these facilities.
- A general principle should be applied – hospital mortuaries should NOT be used unless numbers are manageable especially in the case where there is only one available hospital. Temporary mortuary facilities should also be considered.

- o Describe the process and agencies that will document the actions taken during response and recovery operations (incident and damage assessment, incident command logs, cost recovery). Include copies of the reports/forms that are required

## VI. Family Assistance Centers (FAC)

- o With County Coroner, identify what organization or agency will take the lead planning and operating the FAC.
- o Consider what additional organizations and agencies will offer assistance to victims during a mass fatality incident.
- o With County Coroner, determine call center hotline number, staffing, location and resources.
- o Determine potential FAC locations. Develop MOUs with owners as needed.
- o Ensure that provisions are made in the plan for addressing local cultural and religious needs of the community. Identify any communities which may require special outreach support (interpreters, etc.)
- o Include linkages with local psycho-social support teams and define procedures for their activation based on level of assistance that they can provide.

## VII. Logistics

- o Consider arrangements for providing transportation for the movement of the deceased/remains/personal effects.
- o Determine available local facilities, personnel, and organizations that may assist in a MFI.
- o Discuss ways to expand cold storage for remains. Options may include refrigerated containers and dry ice.
- o Discuss how emergency communications will be maintained.
- o Provision of resources -- are there stocks available that can be used i.e. coffins, body bags, waterproof labels, dry ice etc.
- o There may be the need for provision of portable electrical supply and water to field sites.

## XIII. Public Information and Media Policy

- o Identify the lead PIO for mass fatality management.
- o Determine the means and frequency of information flow to the Joint Information System from various elements of the Mass Fatality Incident.
- o Put measures in place to ensure families are notified of sensitive information prior to the media.
- o Identify appropriate messages for various communications platforms (both traditional and social media).
- o Media should be restricted from entering mortuary facilities or crisis intervention centers/family viewing areas -- include procedures for securing these areas and for channelling information to the joint information center.

## IX. Health and Safety

- o Consider provisions for the welfare and psychological needs of responders -- local mental health services may be able to lend support in this area.
- o There may be a need to identify and equip rest areas -- whose responsibility will this be and how will the resources be acquired should be established locally.
- o Provision should also be made to determine how responders who have lost family members and friends will be handled and by whom.

## Appendix D - Mass Fatality Coroner's Considerations Checklist

### I. Planning (with local EMA)

- o Describe who has the authority to activate the plan
- o Work with the local EMA to determine how the Mass Fatality Plan will relate to the Emergency Operations Plan.
- o Work with other agencies to determine the responsibilities assigned to each organization. Include local departments and agencies (coroner/medical examiner, fire, law enforcement, EMS, public health, EMA, social services, etc.), state agencies (ODOT, SHP, EPA, DOH, etc.), federal agencies, regional organizations, volunteer resources (CERT, MRC, VOADs), and private sector businesses and groups.
- o Communicate final fatality management responsibilities to other relevant partners.
- o Identify and describe mutual aid agreements that are in place. Identify and briefly summarize who is covered by the agreement, for what goods or services, and what limitations apply if any.

### II. Activation

- o Describe the activation process and identify who or what agency will be responsible for activating the plan.
- o Include a call out chart and attach roles and responsibilities to each individual for this phase of the plan.
- o With EMA, identify what agencies would participate in an initial assessment to determine what aspects of the mass fatality plan need to be activated and whether additional resources are required.
- o Assessment Team should identify mass fatality management demand, and additional resources required. The assessment should include all phases of fatality management including recovery, storage, identification, and the family assistance center.

### III. Command and Control

- o Discuss with local EMA where/how mass fatality management fits in into the EOP and the broader response. Outline the local incident command structure and how mass fatality management would integrate.
- o Work with other agencies and specifically the local EMA to determine the role of local government agencies, NGOs and other partners such as hospitals and funeral homes during mass fatalities.
- o Reference all hazards/emergency operations plan as appropriate.

### IV. Site Clearance and Recovery of Deceased Victims

- o Determine what agencies will be involved in remains recovery. Identify any training gaps that may need to be addressed during a mass fatality incident.
- o Clearly define what tagging system will be used and who will be responsible for keeping accurate records. Also consider where these procedures will take place (collection point) and provision of adequate site security measures.
- o Procedures for photographing, labelling and securing personal effects should be included in the plan.
- o Note that in certain situations such as criminal and/or terrorist attacks, the disaster site must be preserved for investigative purposes.

## V. Mortuary

- Determine available local resources to assist with identification and notification. Develop Standard Operating Procedures (SOPs) for how to facilitate identification during a recovery.
- Arrangements for external assistance and/or local arrangements to facilitate identification should be considered.
- For storage and body preparation local morgue facilities and funeral homes – location, capacity, resources etc., should be listed in the plan with relevant contact details. Transportation to these facilities must be considered. MOUs can be developed with private morgue/funeral homes and included as part of the plan.
- Consider arrangements for handling the media and for security at these facilities.
- A general principle should be applied – hospital mortuaries should NOT be used unless numbers are manageable especially in the case where there is only one available hospital. Temporary mortuary facilities should also be considered.
- Include as part of this element the mortuary procedures to be followed: Registration and arrival, storage, examination and photographing, cleaning of body, radiography, fingerprints, Odontology, re-bagging, embalming, viewing, release of body, bodies not claimed, repatriated bodies, DNA and toxicology, documentation, securing of property, equipment list, waste disposal, staffing, visitors, health, safety and welfare.

## VI. Family Assistance Centers (FAC)

- Identify what organization or agency will take the lead planning and operating the FAC.
- Consider what additional organizations and agencies will offer assistance to victims during a mass fatality incident.
- Determine call center hotline number, staffing, location and resources. Develop response trees for call center personnel.
- Develop just-in-time training sheets for FAC volunteers and staff.
- Mention provisions that will be made for handling the welfare needs of family and friends (potentially including food, lodging, licensed childcare).
- Ensure that provisions are made in the plan for addressing local cultural and religious needs of the community. Identify any communities which may require special outreach support (interpreters, etc.)
- Include linkages with local psycho-social support teams and define procedures for their activation based on level of assistance that they can provide.
- Procedures for returning the deceased to families must be clearly defined. The wishes of the family for returning partial remains must also be considered.

## VII. Logistics

- Consider arrangements for providing transportation for the movement of the deceased/remains/personal effects.
- Discuss ways to expand cold storage for remains. Options may include refrigerated containers and dry ice.
- Discuss how emergency communications will be maintained.
- Provision of resources – are there stocks available that can be used i.e. coffins, body bags, waterproof labels, dry ice etc.
- There may be the need for provision of portable electrical supply and water to field sites.

## XIII. Public Information and Media Policy

- Determine the means and frequency of information flow to the Joint Information System from various elements of the Mass Fatality Incident.
- Put measures in place to ensure families are notified of sensitive information prior to the media.

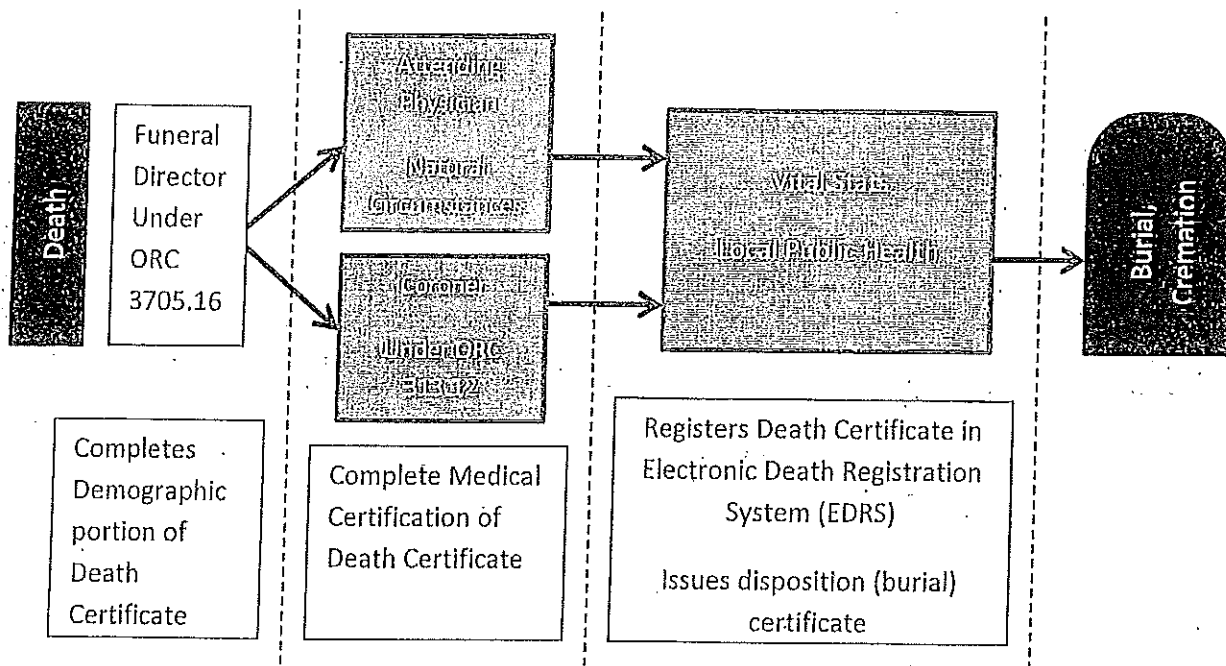
- o Identify appropriate messages for various communications platforms (both traditional and social media).
- o Media should be restricted from entering mortuary facilities or crisis intervention centers/family viewing areas -- include procedures for securing these areas and for channelling information to the joint information center.

## IX. Health and Safety

- o Consider provisions for the welfare and psychological needs of responders -- local mental health services may be able to lend support in this area.
- o Determine what Personal Protective Equipment (PPE) requirements are needed in different areas (on-site, morgue, etc.).
- o There may be a need to identify and equip rest areas -- whose responsibility will this be and how will the resources be acquired should be established locally.
- o Provision should also be made to determine how responders who have lost family members and friends will be handled and by whom.

## Appendix E - Ohio Legal Considerations during a Mass Fatality

### Ohio Death Registration Process in Normal Circumstances



- Funeral Director or other person in charge of final disposition is responsible for moving documentation between parties.
- Coroner may appoint deputy coroners who must be licensed physicians or pathologists
- A burial (but not a cremation) may occur before a death certificate has been completed.

### Relevant Ohio Legal Code

NOTE: This list is not all-inclusive; other laws may apply depending on the incident. This is current as of March 2015.

Ohio Revised Code (ORC)  
Ohio Administrative Code (OAC)

ORC 313.12 Notice to coroner of violent, suspicious, unusual or sudden death. – Defines when a coroner/medical examiner must be notified to investigate a death.

ORC 313.05 Appointment of deputy coroners and other personnel. – Defines the appointment process and powers of deputy coroners.

ORC 2105.35 Determination and evidence of death. – Defines under what circumstances a person may be declared dead when missing.

ORC 3705.16 Statement of facts in certificates - death certificate. – “Each death or fetal death that occurs in this state shall be registered with the local registrar of vital statistics of the district in which the death or fetal death occurred, by the funeral director or other person in charge of the final disposition of the remains.” “The funeral director or other person in charge of the final disposition of the remains shall present the death or fetal death certificate to the attending physician of the decedent, the coroner, or the medical examiner, as appropriate for certification of the cause of death.”

ORC 3705.17 Burial permit required - records to be kept. – describes procedure for issuing a disposition (burial) permit. “The body of a person whose death occurs in this state shall not be interred, deposited in a vault or tomb, cremated, or otherwise disposed of by a funeral director until a burial permit is issued by a local registrar or sub-registrar of vital statistics.”

ORC 3705.29 Prohibited acts. – List of prohibited activities concerning death reporting.

ORC 3707.19 Disposal of body of person who died of communicable disease. – “The body of a person who has died of a communicable disease declared by the department of health to require immediate disposal for the protection of others shall be buried or cremated within twenty-four hours after death. No public or church funeral shall be held in connection with the burial of such person, and the body shall not be taken into any church, chapel, or other public place. Only adult members of the immediate family of the deceased and such other persons as are actually necessary may be present at the burial or cremation.”

OAC 3701-5-06 Medical certification of cause of death; sufficient cause for filing provisional certificate of death or fetal death. – Describes the timeline and procedure for death and disposition certificates

OAC 4731-14-01 Pronouncement of death. – Defines who can pronounce an individual deceased and under what circumstances