Mass Fatality Plan

{insert county name} County, Georgia

{Put county/municipality logo here}

May 2011
Why was this Mass Fatality Plan Template developed?

Federal plans list Mass Fatality Management under Emergency Support Function (ESF) #8: Public Health and Medical Services. Prior to 2010, the Georgia Emergency Operations Plan (GEOP) listed fatality management as the responsibility of ESF-13, with Public Health assisting. The 2010 GEOP now has Mass Fatality Management as the responsibility of ESF-8, and GEMA is looking to Public Health for coordinating this effort. As a result, Public Health has taken the lead in coordinating the creation of this Mass Fatality Plan template for local use.

Why did Public Health Coordinate this Effort?

Public Health is the coordinating agency for ESF-8: Public Health and Medical Services. Public Health has many partners in the community and has a track record of taking the lead in coordinating planning efforts. Public Health also has experience in reaching out to community agencies and organizations through emergency planning, i.e., pandemic planning, as well as having partnerships with Medical Examiners/Coroners (ME/Cs).

How to Use the Plan Template

This plan template was written with the intent that it be adopted and adapted at the local level to reflect the community and its responding agencies’ support capabilities. The template is an all-inclusive document written to be short, so as not to overwhelm planners and responders and for easy reference; therefore, a separate appendix supports each of the ten sections.

The local planning team (see Section I: Roles and Responsibilities) is encouraged to add or delete information as it deems appropriate. It is expected that modifications will be made to supporting forms and reference materials contained in this plan template.

Throughout the plan, there are Notes and Suggestions to Planners that are highlighted in light orange (see examples below).

**Suggestion to Planners:** Identify the medical/legal death investigation system in your jurisdiction as it is critical to initiating MF management planning.

**Note to Planners:** No attempt has been made to create a one-size fits all set of procedures for MF management. Rather, this operational template attempts to list the major categories all jurisdictions should attempt to address in their local planning efforts.

Generally, these are notes pointing planners to supporting material in the corresponding appendix or are suggestions for planners to consider. When adapting this plan to meet your local needs, it is expected that these orange highlighted notes or suggestions would be deleted from your plan, unless the planning team determines they should be kept with appropriate modifications.

Also, there are several places throughout the plan indicating prompted information be filled in, i.e., {insert county name}. While this prompt is bolded to get planners’ attention, it is expected that local planners unbold the content once entered.
Acknowledgements

The Georgia Department of Community Health, Division of Public Health would like to sincerely thank the members of the Mass Fatality Planning Committee for their dedication and contribution leading to the creation of this 2011 Mass Fatality Plan Template. The multidisciplinary Committee was comprised of the following members and affiliated organizations:

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Introduction

Mass Fatality Definition

A mass fatality (MF) incident, by definition, is any situation where more deaths occur than can be handled by local medical examiner/coroner resources. There is no minimum number of deaths for an incident to be considered a MF incident because communities vary in size and resources. Mortuary capacity may be significantly exceeded and in many communities, there is no mortuary capacity. Regardless of the size of the MF incident, the local ME/C is the legal authority to conduct victim identification (or augment with the Georgia Bureau of Investigation (GBI)), determine the cause and manner of death, and manage death certification. The ME/C is also responsible for other medical/legal activities, such as notification of next of kin. Under the direction of the GEOP and the ESF-8, Public Health and Medical Services, the state-level response to a mass fatality event would primarily involve coordination of the response and resources among the Public Health regions and arranging for support from state and federal assets as requested.

ME/Cs make up the investigation system in the United States and are the lead in MF management. Both MEs and Cs are public officials who investigate any death not due to natural causes. MEs are qualified physicians who often have advanced training in forensic pathology (the application of medical knowledge to questions of the law). The medical/legal death investigation system in the United States has coroner-only systems; medical examiner systems; mixed systems (some counties are served by coroners; others by medical examiners); and referral systems, in which a coroner refers cases to a GBI state crime lab.

Suggestion for Planners: Identify the medical/legal death investigation system in your jurisdiction as it is critical to initiating MF management planning.

An MF incident may be caused by natural hazards (e.g., fires, tornadoes, earthquakes, floods and hurricanes) or man-made hazards (e.g., motor vehicle crashes, airline accidents, bridge or tunnel collapses, and terrorist acts). A pandemic influenza has the potential to rapidly spread among the population, last for many weeks and cause fatalities in such large numbers that the current capacity of our medical and coroner infrastructures could be overwhelmed. In this scenario, State, District, and local Public Health officials will work closely with the ME/C and other response partners to coordinate the response.

Note to Planners: While this plan is meant to be an all-hazards approach to MF planning, pandemic influenza will overwhelm local, regional, and state resources rapidly. A separate section titled, “Pandemic Influenza Planning” is provided for Public Health and its partners to consider when developing their local MF plan.

Several MF incidents have occurred in recent years. Natural disasters include such incidents as multiple Southeastern Tornadoes in April 2011 (~320 deaths); Hurricane Katrina on August 29, 2005 (1,464 deaths); the Indian Ocean Tsunami on December 6, 2004 (~250,000 deaths); and the often overlooked Chicago heat wave in 1995 (750 heat-related deaths over 5 days). Man-made disasters include such incidents as the Graniteville, South Carolina, chlorine spill in 2005 (9 dead; 5,400 displaced); US Airways Express accident in Charlotte, North Carolina, in 2003 (21 deaths); the September 11 the terrorist attacks in 2001 (~3,000 deaths); the bombing in Oklahoma City, Oklahoma, on April 19, 1995 (169 deaths); and Airways accident in New Hope, Georgia, on April 4, 1977 (72 deaths). In the United States, during a 5-year period (2000-2005), there were 27 fires and explosions with an average fatality of 18.

Both natural and human-related disasters have demonstrated that the fatality management infrastructure is vulnerable to overwhelming events. The need to recognize and strengthen
fatality management planning and response is critical if we are to be prepared for the possibility of incidents like these, as well as for a worst-case scenario pandemic influenza, a hazard from which no community will be immune.

The 2010 GEOP lists MF management under ESF-8, Public Health and Medical services annex. The coordinating agency for ESF-8 is the Georgia Department of Community Health (GDCH) and services include: public health, medical, mental health services, and mortuary services via the ME/C, all of which have a role in MF management. Public Health has key roles in mass-fatality management that include, at a minimum, plan coordination, allocation of medical resources, health surveillance; worker health/safety; radiological/chemical/biological hazards consultation; burial requirement consultation; public health information; vital records and vector control.

**Purpose**
The purpose of a MF plan is to provide a framework to facilitate an organized and effective response to MF incidents that treats the dead and their loved ones with dignity and respect. This plan will define authority and procedures for notification and activation of the plan; recovery and identification of decedents and their property; morgue services; family assistance and notification; public communication; death certificate processing; tracking; storage; and final disposition.

**Note to Planners:** No attempt has been made to create a one-size fits all set of procedures for MF management. Rather, this operational template attempts to list the major categories all jurisdictions should attempt to address in their local planning efforts.

In {insert county name} County, the {insert Medical Examiner or Coroner} is in charge of local MF management. The Official Code of Georgia (OCGA) 45-16 specifies the ME/C responsibilities.

Per OCGA 45-16-20, the Georgia Death Investigation Act outlines the ME/C’s responsibility and authority. The ME/C function is critical in the area of incident site human remains recovery, morgue services, and coordinating family assistance. Public communication, the vital records system, and death care services operations are also important to effective MF management. If any one of these operational areas is not able to carry out its critical function, the entire MF infrastructure will be impacted. Cooperation and collaboration among all MF response organizations is critical to effective MF management.

This plan is compatible with the Georgia Emergency Operations Plan 2010 and serves as an annex to the {insert county name} County emergency operations plan. This plan is intended to be utilized within the National Incident Management System (NIMS).

**Plan Objectives**
The primary objectives for the MF plan are: (re-order later, once plan is complete)

- To facilitate {insert county name} County’s management of a MF incident
- To identify the stakeholders and organizations responsible for management and coordination of operational activities
- To delineate the command and control structure, who is responsible for activating the plan, and the criteria for levels of activation, utilizing the Incident Command System (ICS)
- To outline a means for obtaining the following support functions with scalability:
  - Supplies and equipment
  - Staffing requirements
  - Facility requirements
  - Support services
• To provide information regarding health and safety threats when handling decedents, infectious diseases, security requirements; family, cultural and religious considerations; and staff and volunteer management.
• To identify potential decedent processing areas
• To describe the method with which human remains will be recovered and identified
• To outline a method for the preservation and storage of human remains on a temporary basis when normal capacity has been exceeded
• To detail local morgue capacity and operations and average death rate
• To delineate a method for assisting families during a MF incident
• To outline the process for obtaining death certificates and permits for disposition of remains
• To describe how the plan will be exercised, updated and maintained

Scope
This plan recognizes the need to organize local and state agencies and resources to plan for and respond to an incident resulting in catastrophic loss of life. Fatalities related to an incident may be located at the scene of the emergency incident, at patient staging areas, at medical facilities or in one’s residence. The {insert county name} County Mass Fatality Plan will be applicable to any incident that results in fatality cases that overwhelm the local capability and will outline the necessary procedures to responding to the event and requesting outside assistance.

This plan seeks to provide guidance, definitions, and relevant laws and delineation of organizational responsibilities pertaining to a response to a MF incident. Additionally, this plan is intended to incorporate local, state, federal, private and volunteer organization resources into a coordinated system for responding to a MF incident.

Emergency Operations Center (EOC) Operations
The county’s EOC may be activated in response to a MF incident. It will provide overall coordination of resources for the multiple agencies and departments involved in the incident response (local, regional, state and federal resources) that support and work with the lead agencies and organizations. When the county EOC is activated, a local ESF-8 representative may be assigned. The Public Health District Operations Center (DOC) will be activated when:

1) There has been a biological-chemical-radiological incident;
2) A pandemic influenza and/or infectious disease of similar seriousness is threatening the general populace of the county;
3) Surge capacity is needed in the Vital Records System to register deaths and issue final disposition permits;
4) The need for multiple patient management is evident for the injured survivors; or
5) The local hospital and long-term care facility resources are exhausted and assistance is needed.

This plan will operate alongside other emergency plans that are activated to respond to the incident.
Planning Assumptions

- The ultimate purpose in a mass fatality response is to recover, identify and effect final disposition of the remains in a timely, safe, and respectful manner while reasonably accommodating religious, cultural and societal expectations. A mass fatality event will be challenging and require support and leadership from all levels of government.

- The Medical Examiner/Coroner (ME/C) is responsible for managing mass fatalities; however, there are many other agencies/organizations that are involved in a mass fatality response.

- A mass fatality plan will be activated in concert with a mass casualty plan (to ensure care for survivors), and normally be activated in concert with jurisdictional emergency operations center(s) and the Public Health department emergency operations center. Coordination of EMS or other healthcare assets will be handled by the local EOC ESF-8 section with support from District and/or State Public Health.

- A diverse pool of public and private resources at regional, state and federal levels may be necessary to effectively manage and/or support mass fatality decedent operations.

- The National Incident Management System (NIMS) will be used in a mass fatality response.

- Unless caused by a natural disaster, i.e., tornado, the incident site will be treated like a crime scene until authorities having jurisdiction over the incident have determined otherwise.

- Incident site operations will be performed according to professional protocols to ensure accurate identification of human remains and, depending on the nature of the event (e.g., commercial airline accident and criminal or terrorist act), to preserve the scene and collect evidence.

- Contaminated deceased victims may require decontamination on scene prior to admittance to a temporary morgue. Local assistance or mutual aid from the fire department, hazardous materials (hazmat) unit, Disaster Mortuary Operational Response Team (DMORT), military, or other non-ME/C discipline may be needed.

- The collection, inventory, and return of personal effects to the decedent’s family must be inventoried and returned. Family members, the general public, government officials, and the media have high expectations concerning the identification of victims and morgue services.

- Family members, the general public, government officials, and the media have high expectations concerning the identification of victims and morgue services.

- Support is essential to managing the short- and long-term emotional impact of responders.

- If the incident is suspected to be an infectious disease outbreak, the Georgia Division of Public Health and its public health partners will coordinate with and provide guidance on the communicable disease investigation to the medico-legal authority.

It is important for the user of this document to recognize that this is a template for emergency responders, including public and private entities, to prepare for a Mass Fatality Incident. It is not meant to provide legal advice and those laws, regulations and policies that appear in this document may change as federal and state laws and initiatives develop. Therefore, it is important that the user of this manual review the status of the current laws since this document was prepared in May 2011, and the laws and regulations may have changed since that time.
Authorities and References

The ME/C in the State of Georgia has the legal authority to determine the cause and manner of death, and manage death certification for a mass fatality. The ME/C and LE share legal authority in victim identification. This mass fatality plan derives its authority from that legal responsibility as detailed in the Death Investigation Act of Georgia.

This plan is consistent with:

- The U.S. Department of Homeland Security's National Response Framework, which states that the primary management of an incident should occur at the lowest possible geographic, organizational, and jurisdictional level.
- Official Code of Georgia Death Investigation Act, Title 45
- The Georgia Emergency Operations Plan
- The {insert county name} County Local Emergency Operations Plan
- The National Incident Management System (NIMS)
- The Emergency Management Assistance Compact
- O.C.G.A. 38-3-57

**Definition of a Mass Fatality Incident.** A mass fatality incident is “an incident where more deaths occur than can be handled by local ME/C resources.”

**ME/C Responsibilities.** The ME/C share responsibility for fatality management with law enforcement (LE) — the recovery, identification, and disposition of mass fatality incident victims. It is the duty of the coroner to inquire into and determine the circumstances of death for suspicious or unusual deaths. (O.C.G.A. 45-16-24)

Suspicious or unusual deaths are when any person dies in any county in this state:

1. As a result of violence;
2. By suicide or casualty;
3. Suddenly with in apparent good health;
4. When unattended by a physician; or
5. In any suspicious or unusual manner.

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

**Mutual Aid.** The Emergency Management Assistance Compact (EMAC) is the mutual aid agreement and partnership between member states (Public Law 104-32, 1996) and the Georgia Statewide Mutual Aid agreement.

**Public Health Responsibilities.** Public Health is a first responder in medical disasters (Presidential Directive HSPD 8) and is charged with providing leadership and coordination with regard to biological-chemical-radiological incidents as outlined in ESF-8 of the Georgia Emergency Operations Plan and {insert county name} County Emergency Operations Plan.

**Law Enforcement Responsibilities.** ESF-13 of the GEOP and the {insert county name} County Emergency Operations Plan.
Section I: Roles and Responsibilities

Below is a suggested list of agencies/organizations that should be at the planning table for your local mass fatality plan.

<table>
<thead>
<tr>
<th>MASS FATALITY PLAN SECTION</th>
<th>EMERGENCY SUPPORT FUNCTION</th>
<th>ASSISTING ORGANIZATIONS (NOT AN ALL-INCLUSIVE LIST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Command and Control</td>
<td>ESF-5</td>
<td>ME/C, local EMA, Public Health, fire and emergency services, law enforcement</td>
</tr>
<tr>
<td>Human Remains Recovery</td>
<td>ESF-13</td>
<td>Law enforcement agencies</td>
</tr>
<tr>
<td>Morgue Services</td>
<td>ESF-8</td>
<td>ME/C Office</td>
</tr>
<tr>
<td>Family Assistance</td>
<td>ESF-6</td>
<td>American Red Cross, mental health representatives</td>
</tr>
<tr>
<td>Public Communications</td>
<td>ESF-15</td>
<td>ME/C Office, Public Health, local EMA (Joint Information Center)</td>
</tr>
<tr>
<td>Vital Records System</td>
<td>ESF-8</td>
<td>ME/C, death care services, Public Health</td>
</tr>
<tr>
<td>Mortuary Industry</td>
<td>ESF-8</td>
<td>Local funeral directors, funeral homes, cemeteries, cremation services, Georgia Funeral Directors Association, Independent Funeral Directors Association</td>
</tr>
<tr>
<td>Mass Fatality Plan Maintenance</td>
<td>ESF-5</td>
<td>Local EMA, ME/C, Public Health</td>
</tr>
<tr>
<td>Security</td>
<td>ESF-13</td>
<td>Local law enforcement agencies</td>
</tr>
<tr>
<td>Staff/Volunteer Processing Center</td>
<td>ESF-5</td>
<td>Local EMA</td>
</tr>
<tr>
<td>Family Concerns and Religious/Cultural Considerations</td>
<td>ESF-6</td>
<td>ME/C Office with assistance from local spiritual care community</td>
</tr>
<tr>
<td>Infection and Other Health and Safety Threats</td>
<td>ESF-8</td>
<td>Public Health, local hospitals</td>
</tr>
<tr>
<td>Infectious Disease Considerations</td>
<td>ESF-8</td>
<td>Public Health, local hospitals</td>
</tr>
</tbody>
</table>

**Note to Planners:** Check with your local EMA as that organization may have a MF Plan that would be a starting point to adopt and/or adapt. It is expected to have the organizations mentioned in this plan come together to plan for their respective county. See *Sample Invitation to Community Members* in Appendix I.

The following highlights the roles and responsibilities of those who may be involved in a mass fatality incident:

**Medical Examiner/Coroner (ME/C)** is the legal authority to conduct victim identification (or augmented with the Georgia Bureau of Investigation (GBI)), determine the cause and manner of death, coordinate transportation of bodies, and manage death certification process. In addition, the ME/C is responsible for other medical/legal activities, such as notification of next of kin. The ME/C is responsible for developing the best approach to managing personnel, equipment, and resources to affect recovery, identification and disposition of mass fatality victims. In small incidents, the EOC is not typically activated, and the Coroner will likely be the Incident Commander. In large scale events, the EOC is activated to manage the various agencies and multiple missions that are involved. In these events, the Coroner may be assigned as the Director of the Coroner’s Service Branch.

**Local Law Enforcement** is responsible for assisting the Coroner with scene security, investigation, and search and recovery.
**Georgia Bureau of Investigation (GBI)**, upon request of the ME/C, may request the GBI Body Recovery Team, which by executive order of the Governor of the State of Georgia, is responsible for the recovery and identification of human remains in the incident of a natural or man-made disaster.

**{Insert county name} County Emergency Management Agency** is responsible for protecting the lives and property from the threat of all types of major emergencies and disasters, both natural and man-made. This is accomplished by providing community-wide leadership, guidance, and support and coordination in the areas of mitigation, preparedness, response and recovery.

**Note to Planners:** The County EMA is the lead agency for coordination of local emergency mitigation, preparedness, response and recovery activities. Mass Fatality planners should contact their local EMA for assistance with coordination of this planning effort.

**Georgia Emergency Management Agency (GEMA)** is the lead state agency in Georgia for statewide coordination of emergency mitigation, preparedness, and response and recovery activities. GEMA accomplishes this through statewide multi-agency coordination in support of local emergency management agencies.

**Public Health** is the lead agency for coordination of ESF-8, Public Health and Medical Services activities. At a minimum, key roles in mass-fatality management include: MF plan coordination; medical resources allocations; health surveillance; worker health/safety; radiological/chemical/biological hazards consultation; burial requirement consultation; public health information; vital records; vector control; and coordination of medical assets, such as post-mortem kits and mobile morgues. Should the mass fatality event be the result of an infectious disease, such as pandemic influenza, the District Health Director would:

- Communicate and coordinate directly with county and city/town leaders, county emergency managers, local boards of health and other health care partners regarding pandemic preparedness and response activities.
- Coordinate directly with county and district healthcare partners and **assist, if requested**, in making decisions regarding strategies, thresholds and methods for re-allocating resources and temporarily restructuring health system operations in response to a pandemic.
- Authorize and communicate public health **recommendations** or directives regarding social distancing strategies and other protective actions to elected/appointed leaders, the business community, schools, and Healthcare Coalition partners.
- Provide leadership for county health departments and **{insert District name}** Health District staff in planning for and responding to a pandemic, including assignment of staff responsibilities.
- Ensure continuity of operations for county health departments and the **{insert District name}** Health District, ensuring performance of critical functions during a pandemic.
- Direct isolation and quarantine, **if indicated**, of individuals and groups in accordance with OCGA 31.2.1.

**American Red Cross (ARC)** disaster relief focuses on meeting immediate emergency disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter,
food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently.

**Death Care Services** is the profession that provides products and services for the burial or cremation of the deceased. This industry is important in planning efforts to ensure the disposition of human remains is handled in an efficient and dignified manner. Additional roles during a mass fatality incident may include:

- Transportation of bodies
- Storage of bodies in Morgue
- Off-site Mortuary services
- Consultation and expertise

**Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)** is the lead agency for coordination of mental health services in the state. If local mental health capacity is exceeded during a mass fatality event, Public Health or local EMA can contact DBHDD for coordination of additional mental health responders from other areas within that DBHDD region or the state.
Section II: Concept of Operations

- Activation of this plan will occur when a mass-fatality producing incident occurs within the jurisdiction of {insert county name} County. Depending on the nature of the incident, demand on response resources may increase gradually, or it may be such that certain local and state resources are quickly overwhelmed.

**Note to Planners:** Each community will need to determine its own triggers to activating the Mass Fatality Plan.

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

- The {insert county name} County Emergency Operations Center (EOC) may be activated and the Public Health District Operations Center (DOC), depending on the type of incident, may be activated in response to a mass fatality incident. Public Health may oversee the coordination of the multiple local, regional, state and federal agencies and departments involved in the management of the incident. This plan may operate concurrent with other emergency plans activated in response to the incident. It should be noted that a mass fatality plan does not address the needs of injured survivors.

- The magnitude of a mass fatality incident may exceed the local capabilities and resources. If this happens, the county ME/C should immediately begin contacting the {insert county name} County Emergency Management Director for additional support and resources.
  - In the instance of a mass fatality event that exceeds the capacity of the county, additional assistance may be requested from the {insert county name} EMA, for state level assistance through the State Operations Center.
  - In the instance of a mass fatality event that exceeds the capacity of state assets, assistance may be sought from other states through the Emergency Management Assistance Compact (EMAC), or from federal resources through HHS Region 4.
  - Mass fatality incidents that exceed local, regional and state resources may result in requests for Federal DMORT. DMORT does not establish command and control over the fatality management operation, but will be integrated into the local ICS structure.
  - Depending on the nature of the incident, other federal agencies will respond immediately to the scene of the incident (e.g., the National Transportation Safety Board for an airplane accident or the Federal Bureau of Investigation for a terrorist activity).

- Operations will be coordinated by the ME/C working with the {insert county name} County EMA who may serve as the Incident Commander.

- In a mass fatality incident, the standard process for managing human remains will be used. The following Figure 1 presents the standard process.
FIGURE 1: The Processing Flow of ME/C Management of Remains


7. Transportation  8. Final Disposition

Source: The California Mass Fatality Management Guide

**Note to Planners:** The order of this chart may be changed depending on the scene evaluation.

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

**Notes to Planners:**

Key local, state and federal resources that may be requested are:
- Coroners Mutual Aid
- Law Enforcement
- Vital Records Processing
- Spiritual Care Providers
- Mental Health Professionals
- Mortuary, Crematory, and Burial Services

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

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

Federal resources, including the Disaster Mortuary Operational Response Team (DMORT), may be requested through FEMA by GEMA at any time during the emergency when resources are depleted. DMORT operations require a federal declaration.

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

If a suspected terrorist activity, local law enforcement may request assistance from the GBI, which may call in the FBI.

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

*Local Resources:* Local Law Enforcement, Fire/Hazmat, Facilities/Public Works, Public Health, The Salvation Army, American Red Cross, local mental health providers, etc.
**State Resources:** GEMA - Office of Homeland Security, Georgia Division of Public Health, Georgia Bureau of Investigation, Department of Motor Vehicles, Georgia Coroners Association, Georgia Sheriff’s Association, Georgia Funeral Directors Association, Independent Funeral Directors of Georgia, etc.

**Federal Resources:** Department of Homeland Security Disaster Medical Assistance Team, Nuclear Incident Support Teams, Department of Health and Human Services Center for Disease Control and Prevention, Environmental Protection Agency, Department of Transportation, Urban Search and Rescue Response System, Department of Defense, National Transportation Safety Board’s Office of Transportation Disaster Assistance, etc.

**Suggestion for Planners:** Add to your Appendix a table of local, state and federal resources that includes specific resources available and contact information.
Section III: Command and Control

The National Incident Management System (NIMS) will be utilized in managing the response and recovery of all emergency incidents in {insert county name} County and the State of Georgia, including multi-agency and multi-jurisdiction emergencies.

NIMS incorporates the use of the Incident Command System (ICS). NIMS is established to provide effective response to multi-agency and multi-jurisdiction emergencies in Georgia. The use of NIMS will improve the mobilization, deployment, utilization, tracking and demobilization of resources and will reduce the incidence of poor coordination and communications and reduce the resource ordering duplication during the response to incidents.

Unified Command

The unified command structure of ICS will be utilized to bring all response agencies together to determine a plan of action to facilitate mass fatality management. The nature and scope of the event causing the fatalities will determine which jurisdictions and agencies are involved. The unified command structure utilizes a single integrated incident organization, shared facilities (command post and EOC), single planning process and incident action plan. Unified command also allows for shared operations, planning, logistics, finance/administration sections and a coordinated process for resource ordering.

Unified command enables all responders to use one set of objectives for the entire incident. A collective approach for developing strategies is utilized. Information flows between participating agencies without comprising any agency authority. Each agency will know the plans and actions of other agencies. Performing under a single action plan optimizes all agencies’ efforts. Functional command is easily shifted as incident priorities are addressed.

Chain of Command

The following diagram highlights {insert county name} County's ICS Organization Chart for key emergency personnel at the EOC. Positions and responsibilities may be added or deleted from this diagram based on the nature and scope of the event. Because the chain of command is linked to the ICS system, flexibility and modification may occur at any time.

Note to Planners: Local jurisdictions should consider placing their organizational chart in this area of the plan. (See Sample EOC Organization Chart in Appendix III)
Section IV: Morgue Services

Under ESF-8, Morgue Services is a division of the {insert county name} County ME/C Services Branch of the County Emergency Operations Center. Local authorities will coordinate search and recovery efforts. Morgue Services are organized to support morgue operations, decedent identification, and data management. This is critical to ensuring the efficient, accurate, and timely identification of the deceased. As with the ICS, morgue services may be scaled to fit the situation by expanding or collapsing its services and resources.

**Note to Planners:** See Appendix IV for *Field Organization for Mass Fatality Morgue Services Sample.*

The ultimate goal of all disaster operations is to accurately establish the identification of every victim. This is essential to surviving family members. To accomplish decedent identification, ante-mortem and post-mortem data will be compared and match. Performed carefully and accurately, these processes will expedite disposition of the deceased and prevent insurance fraud and wrongful death cases.

For management purposes, the morgue services division is divided into two groups:

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

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

**Note to Planners:** Refer to *Morgue Operations/Examination* in Appendix IV.

**Public Health** may be consulted on issues related to infection control from human bodies. In general, Infection Control Procedures indicate that measures should be taken to reduce the risk of transmission of disease or Hazardous Materials associated with handling human remains.

**Note to Planners:** Refer to *Fact Sheet on Health Risk from Dead Bodies* and *Biological Contamination Safety and Handling Recommendations* in Appendix IV.

**Human Remains Storage**

By pre-planning for resources, {insert county name} County has identified the capabilities for the storage of victims and remains. A mass fatality incident will undoubtedly overload the existing capacity; therefore, it will be necessary to sequentially:

1) Utilize existing surge capacity (i.e., hospitals, ME/C, funeral homes, other refrigerated assets, such as trucks);

2) Request Public Health mortuary trailers through mutual aid; and

3) Construct temporary morgue facilities using tents or trailers.

The latter two actions will take place at pre-identified temporary morgue sites.

**Note to Planners:** In some instances, it may be necessary to store remains for a period of time until the examination and identification process are able to occur. Guidelines for examination sites and short-term preservation are delineated below. The primary goal is to store and preserve human remains in a dignified and respectful manner as they await final disposition. See *Human Remains Storage* in Appendix IV for more information. MOUs should be established with organizations for temporary use of refrigerated assets identified.
Existing Surge Capacity (Morgue Facilities – Permanent or Mobile)
Appendix {insert Appendix name/number} delineates the current storage capacity of local morgues, hospitals, funeral homes and refrigerated trucks in {insert county name} County.

Note to Planners: See Local Hospital, Morgue, Funeral Home, and Refrigerated Truck Capacity in Appendix IV for charts and tables to use in your plan.

When the need for additional capacity becomes evident, the {insert county name} County ME/C will activate temporary morgue facilities.

Morgue Facilities - Temporary

Note to Planners: The refrigeration capacity of most county and hospital morgues and local mortuaries will likely be exceeded during a disaster, especially if there are many unidentified bodies or remains recovered in the first hours of the event. This will engender the need for temporary morgue facilities. (See Recommendations for Temporary Storage of Human Remains in Appendix IV for more information.)

Appendix {insert Appendix name/number} identifies supplies to be utilized for a temporary morgue in {insert county name} County.

Note to Planners: See Morgue Supply List Sample Chart in Appendix IV for use in your plan.

Temporary Holding Morgue Requirements
The temporary holding morgue is where remains are held until transported to the incident morgue.

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

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

Temporary Morgue Sites Identified
Appendix {insert Appendix name/number} identifies sites that have been identified as potential Temporary Morgue sites in {insert county name} County.

Note to Planners: See Temporary Morgue Sites Identified in Appendix IV for use in your plan.

Long-Term Examination Center/Sifting Site
A Long-Term Examination Center may be needed when there is extensive property destruction with the commingling of human remains. Examination and identification of human remains will need to continue after the temporary incident morgue closes. Many the requirements for the incident morgue will also be requirements for the long-term examination center/sifting site. If the incident requires a long-term examination center/sifting site, the ME/C Office will work with local {insert county name} County authorities to determine location and requirements at the time based on the incident.
Coordination
Disaster victim identification is normally the responsibility of the ME/C and local law enforcement. During an MFI, this difficult and demanding process must be well organized and allow for the inclusion and coordination with other agencies.

*At the discretion of the county ME/C, the GBI Body Recovery Team may be requested for assistance early in the process or later after the local resources have been exhausted. The number of victims should not be the determining factor for requesting assistance.*
Section V: Recovery

When local resources have been exhausted, the (insert county name) County ME/C, through the local EMA, may request from the GBI/Chief Medical Examiner the activation of the Body Recovery Team. The GBI, by executive order of the Governor of the State of Georgia, is responsible for the recovery and identification of human remains in the incident of a natural or man-made disaster.

ME/C human remains recovery operations are:

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

The GBI has identified, trained and equipped personnel to be immediately deployed in the event of a mass fatality incident. These personnel will act as the core recovery team and can be supplemented by personnel from Department of Corrections and Department of Natural Resources, which have also received the training.

The Director of the Georgia Bureau of Investigation or his designee will authorize the activation and deployment of the team.

The GBI Deputy Director for Investigations or his designee will assume command and control over the operational response of the Mass Fatality Team while maintaining consultation with the local ME/C and while maintaining structure and liaison with the Unified Command. The team will be notified to report to a staging location where a team supervisor will meet and assign responsibilities for the recovery mission. Team members will not report directly to the scene unless directed to do so by Command personnel. Upon notification of a qualifying event, a decision will be made by the Deputy Director for Investigations whether a full or limited response is necessary.

The teams are currently divided geographically into North Georgia, South Georgia and Metro Atlanta areas. A primary and secondary team response is anticipated with the non-affected team serving as the relief team.

If possible, a work unit supervisor in the affected area will respond to the site and provide a timely situation report to the Deputy Director for Investigations or his designee. The GBI Work Unit Supervisor will coordinate with the initial responding Mass Fatality Team to secure and prepare a staging area.

If the scene has been linked to a criminal event, the Mass Fatality Response Team will support evidence gathering initiatives of the investigative agency with jurisdiction over the crime (If an act of terrorism has occurred, the Federal Bureau of Investigation will be the lead agency).

Incident Evaluation

An evaluation group designated by the GBI Deputy Director for Investigations or his designee (while in consort with the (insert county name) County ME/C and within the Unified Command system) will travel to the scene and make an assessment of equipment, personnel and safety needs prior to the deployment of a team into the site. The evaluation team will, at a minimum, report estimates of:
- Number of victims;
- Condition of the remains;
- Environmental or geographical considerations;
- Weather conditions;
- Level of PPE (Personal Protective Equipment) required; and
- Specialized equipment needs.

An evaluation will be made whether to process the site as a crime scene or if it is evident that the event is an accident. Absent a definitive determination, all scenes will be treated as crime scenes.

The GBI supervisor designated to direct the on-site operations of the Body Recovery Team will report to the GBI Deputy Director for Investigations who will be in command and control of the mass fatality operations and all other GBI assets while maintaining consultation with the {insert county name} County ME/C within the Unified Command structure.

Once a command post location has been established, the GBI on-site supervisor or his designee will travel to that location and coordinate the recovery process with the {insert county name} County authorities. The GBI Director, in consultation with the Chief Medical Examiner, coroner and others as indicated, will decide if/when to request Federal DMORT assets.

**Operations**

- A single numbering system will be used to record the number of fatalities/human remains recovered. In the case of an extremely large scale incident the Veri-chip numbering system currently used by the Body Recovery Team will be used. A smaller scale incident may require only issued numbers. A daily count will be provided to the GBI Deputy Director or his designee and the {insert county name} County ME/C.

- All remains will be located, collected, marked and packaged in accordance with accepted procedures. A chain of custody will follow all collected remains and security will be provided for the site and the remains.

- Every effort will be made to collect the remains in as intact form as possible. The condition of the remains and environmental considerations will provide the basis for the approach to the scene.

- Access to the recovery site will be restricted to personnel necessary for operations.

- All operations will be conducted in accordance with standard crime scene and evidentiary procedures, if a crime has been committed or suspected.

**Victims**

- All victims will be treated with reverence and respect.

- No family members will be allowed into the scene while recovery operations are under way. In consultation with the county EMA, an appropriate place for a Family Assistance Center (FAC) will be identified and provided to allow family members to be close to the scene without interfering in the operation.

- Whether intact or fragmented, all recovered remains will be catalogued for future consolidation.
Evidence and Personal Effects

- All non-human remains and personal effects recovered from the scene will be catalogued and accounted for in accordance with evidence handling procedures. All items will be photographed and further catalogued for possible identification by family members.

- Personal effects will only be released to family members after a positive identification of the item is made and the right to ownership is established. All items of evidentiary nature will continue to remain property of the investigation until such time as the items are released by legal authority.

- Upon completion of the operation, a decision will be made by the GBI Director in conjunction with (insert county name) County ME/C and the other proper local authorities as to the final housing and security of the items of personal effects. As required by law, all evidentiary items will be turned over to the agency with jurisdiction over the investigation.

Reporting

- Recovery efforts will be recorded photographically and videotaped (discretionary). A written record will also be made. These will be performed by the recovery team.

- There will be one GBI report of the recovery efforts with a primary and a secondary case agent assigned to manage the report. A tracking system will be utilized to ensure all efforts involved in the recovery are documented. This report will be separate from any criminal case opened. At such time as is warranted, this report will be turned over to the prosecutorial authority with jurisdiction over the matter.

Identification of Human Remains

- The identification of victims of a disaster is a considerable technical challenge for any death investigation system. Mass fatality incidents involving commercial transportation carriers (e.g., an airline crash, which is the prototypical scenario) may be of extreme complexity due to the large number of fatalities coupled with the probable dismembered, fragmented and incinerated nature of the remains. Additionally, international terrorism has reached the level of possible biological, chemical, and nuclear attacks against large unprotected civilian populations in this country.

- The Georgia Bureau of Investigation is charged with the identification of victims of a mass fatality incident in the State of Georgia. This mission will be completed by the combined efforts of the Investigative Division, the Division of Forensic Sciences, and the Medical Examiner’s Office of the GBI. Additional resources may be provided by other local, state, and federal agencies.

- The identification of unknown human remains is based on the comparison of records of a missing person with data obtained by examination of the unidentified decedent.

- The standard means of achieving positive identification of human remains are:
  - Fingerprints/Footprints
  - Dental Records
  - DNA

- Other accepted means of identification include:
  - Matching of unique anthropological features utilizing ante-mortem x-rays or medical records
Identification

- Matching of unique prosthetic devices (pacemakers, orthopedic appliances, etc.) from ante-mortem medical records.

- Personal effects (e.g., jewelry, pocket contents), clothing, marks, scars, tattoos and visual appearance of the body are not a reliable means of identification and are not to be used as the sole means of securing a positive identification.

- All potential identification information should be gathered into an ante-mortem file.

Identification Process

- Early in the response, the [insert county name] County ME/C with jurisdiction over the mass fatality incident will establish policy concerning identification of fragmented remains and re-association of fragmented remains.

  **Note to Planners:** This policy is best established prior to commencement of mortuary operations.

- The victims of the mass disaster will be identified by standard and accepted scientific techniques. As previously described, this will occur by examination of fingerprints, dentition, by documentation of unique physical features and in consultation with family members, or by DNA analysis. The remains will be processed and examined according to established policy and procedures.

- In a mass disaster scenario, the GBI may enlist the aid of multiple other organizations (DMORT, Kenyon International, the Federal Bureau of Investigation, the Armed Forces Institute of Pathology, etc.) in the processing and identification of human remains.

- The Georgia Bureau of Investigation will designate an employee as a technical leader in each of the disciplines utilized in the processing and identification of the remains to review and oversee the technical aspects and to ensure that the processes utilized are scientifically and/or medically reliable and valid. This quality assurance management tool will provide for operational control of every facet of the mass fatality identification process and will insure the quality and accuracy of the work product and documentation of each discipline.

- Once the unidentified remains have been processed and identification secured via one or more of the methods described above, the GBI leader(s) for the discipline(s) involved will review and closely scrutinize the evidence that resulted in the identification. When possible, this review should be performed with the individual(s) whose work product is being examined. The GBI discipline leader will then either accept or reject the identification evidence.

- Upon acceptance of the identification by the GBI section discipline leader, the ante-mortem file and the post-mortem files will be brought together to form a single completed file.
  - This intact file (both ante-mortem and post-mortem records) is to be inspected by a file review team. This review will insure that the file is complete and that all essential ante-mortem and post-mortem information has been properly documented.
  - The reviewers will closely examine the ante-mortem and post-mortem information looking for obvious inconsistencies in the identification.
• Upon successful completion of this records review, the completed file will proceed to the Identification Review Board for certification of the identification.

• Identification Review Board

  – An Identification Review Board will be established to certify the identifications, sign death certificates, and to authorize the notification of next-of-kin and the release of the remains.

  – The purpose of the Board is to continually supervise the identification process, to monitor progress of the overall identification response and to closely scrutinize all evidence related to identification.

  – The Board will meet formally as often as is necessary to certify identifications during the course of the disaster response.

  – The Identification Review Board will consist of the following members:
    ✓ The Chief Medical Examiner (or his designee);
    ✓ A second forensic pathologist appointed by the Chief Medical Examiner;
    ✓ The GBI section discipline leader for the section securing the identification;
    ✓ Representative from assisting mortuary operations organization (DMORT, Kenyon International), if applicable;
    ✓ [Insert county name] County ME/C having jurisdiction for the purposes of signing death certificates and releasing remains to family;
    ✓ Other individuals as authorized by the GBI Deputy Director for Investigations or Chief Medical Examiner.

  – At the Identification Review Board, the evidence securing the identification of the remains will be presented and accepted or rejected by the medical and/or scientific board members. Once the identification has been certified, authorization will be given for the next-of-kin to be notified by the established procedure, and authorization will also be given for the remains to be re-labeled and released according to established policy and procedure.

  – Initially, all identifications should be made by fingerprints, dental records or DNA. Identifications secured via anthropological analysis of the remains or via other unique identifiers (prosthesis, pacemakers, etc.) should not be certified until the primary methods of identification (fingerprints, dental, DNA) have been unsuccessfully attempted, unless the method of identification relies on an extraordinarily unique feature.

  – Remains shall not be released until the formal identification process has been completed. The release of remains prior to the certification of the identification by the Identification Review Board jeopardizes the integrity of the entire process and significantly increases the risk of wrongful identification and release of remains.

  – In true catastrophic events, the overwhelming number of victims and the enormity and complexity of the situation may preclude identification of some of the deceased by the usual scientific methods. In such instances, the Director of the GBI and the Chief Medical Examiner, at the direction of appropriate state and/or federal elected officials, may authorize identification of the victims by any reasonable means.
**Release of Remains**

- The release of any remains will be handled by the {insert county name} County ME/C only after positive identification is made.

- Release of the remains will only be made to a licensed funeral director from an active state licensed funeral home. If the remains are to be removed from the state, it will be necessary for the arrangements to be made through a state licensed facility.

- If DMORT has been involved in the identification process, a decision by the Chief Medical Examiner and {insert county name} County ME/C will be made as to whether the remains will be embalmed prior to release. The Chief Medical Examiner and {insert county name} County ME/C will also decide as to casketing of the remains, but at a minimum, the remains will be in a sealed disaster pouch. If the remains represent a consolidation of two or more fragmented remains, then the remains will be placed in a single container and further placed in a sealed disaster pouch. A complete record of all releases will be maintained in the recovery report.
Section VI: Death Care Services

Overview
Death Care is the profession that provides products and services for the burial or cremation of the deceased. Their services are divided into three main segments: ceremony and tribute (funeral or memorial service); disposition of remains through cremation or burial (internment); and, memorialization in the form of monuments, marker inscriptions or memorial art.

Funeral directors oversee all burial logistics, such as transporting the deceased to a mortuary, preparing the remains, performing a ceremony consistent with the grieving family’s religious and cultural beliefs, filing the death certificate with the local registrar within 72 hours of death, and working with families and legal authorities to implement final disposition of the deceased.

Appendix {insert Appendix name/number} identifies death care service providers within {insert county name} County.

Notes to Planners:
• See the Funeral Home Survey in Appendix VI that may be used to obtain critical information from your local death care service providers.
• Federal, state and local laws govern the death care services as it pertains to the disposition of human remains. There is no single agency or organization in charge of individual funeral homes, mortuary, cemetery, and cremation services. In Georgia, the Secretary of State’s Office handles the state licensing boards for funeral homes, crematories and cemeteries, currently located in Macon, GA. The licensing boards have the contact information for all licensed funeral homes, crematories and cemeteries in the state. In addition, various associations within the profession have created a triage function for members to respond to disasters.
• Georgia Funeral Directors Association (300 funeral home members in Georgia). This association has a permanent office in Roswell, GA. (770.592.8002)
• Independent Funeral Directors of Georgia. This association has a permanent office in Dallas, GA. (770.445.3180)
• Georgia Funeral Service and Practitioners Association, Inc. (GFSPA). This association, which has approximately 150 funeral home members in Georgia and primarily serves the African American community, has a rotating board of directors and officers. This association has a permanent office at 342 S. Alexander Street, PO Box 422, Toccoa, GA 30577. (706.866.3944)
• Funeral homes are licensed businesses that are privately owned. Thus, they have the right to refuse assistance or limit their level of assistance during a Mass Fatality. However, the membership associations have pledged support within a mass fatality situation.

When the local capacity of the services is surpassed, or when an MFI is anticipated, the County EOC may be activated. The EOC Planning Section Chief may establish a Death Care Situation Unit in ESF-8 to coordinate with the various cooperating Funeral Directors and the Morgue Services Unit.

The role of the Death Care Situation Unit Leader is to:
• Alert funeral homes, cemeteries, and cremation services in the event of a developing mass fatality event.
• Ensure that logistical needs and information flow is efficiently handled.
• Request death care professional assistance in search and recovery at the incident site, in morgue operations, and at the Family Assistance Center.
• As victims are identified, coordinate with the funeral home or cremation service requested by each victim’s family to arrange for final disposition.

**General Considerations for Handling Deceased Human Bodies**

• It is agreed and understood that the term "body" may include both full and partial human remains, no matter how small the remains may be. At all times, all deceased individuals shall be treated with dignity and respect, and handled as individual people.

• Human remains and/or partial human remains shall not be co-mingled. Every attempt shall be made to handle, identify, and transport remains separately per deceased individual. It is recognized that in a disaster situation, inadvertent co-mingling could occur by nature of the disaster itself. Final identification of remains shall make every attempt to separate different individuals for final disposition.

• Human remains and/or partial human remains shall not be co-mingled and cremated together, per Georgia law. Further, human remains and/or partial human remains shall not be co-mingled and buried together, except in the case where the individual with right of final disposition should so request. As an example only, families sometimes request that deceased infants be buried with their parent(s).

Each body or partial remain shall then be placed into an individual container.

- Disaster pouch body bag (heavy duty, handles), or
- Body Bag (white, medical grade, lighter weight plastic than a disaster pouch.)
- A casket can also serve as an individual container if the {insert county name} county ME/C has released the body for final disposition. It will be generally assumed that this person has already been identified and released to next of kin.
- Once the body or partial remain is placed inside the individual container outlined above, the deceased’s name or matching identification number shall be affixed to the outside of the disaster pouch. This is a critical step in that it eliminates repeated opening of the body bag which can degrade the body or destroy evidence.

• Georgia law currently does not have a requirement for a body to be embalmed, including for transportation purposes within the State. However, other U.S. states and common carriers may have conflicting laws. The {insert county name} County ME/C in charge (or federal authority if applicable) shall determine the need for embalming, accordingly.

• The {insert county name} County ME/C (or federal authority if applicable) will ensure that the funeral director (or Public Health official authorized to complete death certificates in the event of a Governor-designated disaster due to pandemic influenza) gets full information required to complete a final death certificate.

Cultural and religious considerations are typically the decision of the individual or individuals with the right of final disposition.

**Note to Planners:** See Right of Disposition of Authority in Appendix VI for more information.
In a mass fatality situation, the (insert county name) County ME/C shall have decision authority over embalming; recognizing that preservation of the body may take precedence over the cultural or religious preference of the individual(s) with final disposition.

**Note to Planners:** See *Cultural and Religious Reference Chart* in Appendix VI for further information.

**Transportation for Deceased Human Bodies**

Certain requirements must be met when transporting bodies outside the state. The ME or Public Health must sign-off, indicating that no infectious disease is present when transporting bodies across state lines or internationally. Also, the funeral home director must get consulate approval to ship bodies internationally.

Bodies exposed to biohazards or infectious diseases must be transported by non-commercial carriers, while non-infectious bodies can be transported via commercial carriers.
Section VII: Vital Records

Assumptions
The following are the key assumptions:

- A mass fatality incident will result in a surge of requests to register deaths that occur in the jurisdiction and for certified copies of death certificates for victims of the mass fatality that may create problems for overall mass fatality management.
- A mass fatality will result in a surge in requests for permits for disposition of human remains, including transit permits, which may create problems for overall mass fatality management.
- In the event that the local Registrar becomes overwhelmed, a request for assistance may be made to Georgia’s Vital Records Office.
- A plan to manage the surge will be needed in the event of a mass fatality.
- The nature of the mass fatality—particularly the complexity of the recovery process and the length of time recovery will take—will determine the level of surge capacity that will be required of the vital records system to manage its responsibilities in the mass fatality effectively.

Purpose of Vital Records
The purpose of the vital records system is: 1) to establish a permanent record that is legally recognized as prima facie evidence of the facts stated in the record, and 2) to provide a means for studying the statistical data for health evaluation and planning purposes.

All deaths require registration in the jurisdiction in which they occur. In Georgia, each death must be registered with the local registrar in the county in which the death was officially pronounced or the body was found within ten days after the death.

Upon registration by the local registrar, the death certificate becomes the State’s legal record of the death. The purpose of a certified copy of a death certificate is:

- To serve as the legal record of death and thus be prima facie evidence of the death in all courts
- In addition, a certified death certificate is used:
  - To settle the decedent’s estate
  - To apply for insurance benefits
  - To settle pension claims
  - To verify transfer of title or real and personal property.

The purpose of the permit for disposition is:

- To specify the disposition being authorized by the local registrar—burial, cremation, disposition of cremated remains other than in a cemetery, scientific use, temporary envaultment, and/or transit to another state or country for disposition
- To allow for the disposition of human remains.

Note to Planners: Please see the Official Code of Georgia in Appendix VII for information related to death certificates and disposition permits.


Section VIII: Family Assistance Center

Planning Assumptions

**Family is defined as any individual who considers him/herself to be a part of the victim’s family, even if there is not a legal familial relationship. This includes individuals other family members characterize as family. This is distinguished from the legal next of kin, who may be the legally authorized individual(s) with whom the ME/C coordinates or who is authorized to make decisions regarding the decedent.**

- In the immediate aftermath of a mass fatality, families and friends will seek assistance to determine the status of their loved ones. In the absence of direction from local authorities, they will naturally gravitate to the place where they believe they will find their loved one or where they believe they will get information about them. That often means a spontaneous gathering at either the incident site, or as near to it as they can get, or to area hospitals, where they hope their loved ones have been transported.

- It is imperative that local authorities plan for quickly establishing a safe and secure place for families to wait where they will not impede rescue and recovery operations at the site or pose an obstacle to emergency treatment activities at the hospitals.

- There probably will be multiple family members for each potential victim, and they may need to wait several days or even weeks before all victims are rescued or all remains are recovered and identified. Some may never be recovered.

- Expectations of the families for information will be high, and perhaps unrealistic.

Purpose

The purpose of a Family Assistance Center (FAC) is to provide a safe and private place, protected from the media, for families of deceased, missing or injured survivors to grieve and/or wait for information regarding their loved ones and the status of rescue or recovery activities. This is often the location where families will be informed about the positive identification of their loved one(s).

Key activities include:

- Providing privacy and support services to grieving families;
- Security from media and curiosity seekers;
- Facilitating information exchange between ME/C offices, local officials and the families in order to assist in identification of victims;
- Providing death notification, to facilitate the processing of death certificates and release of remains; and
- Providing information about recovery efforts.

While there is hope for survivors, officials may conduct group briefings on a pre-arranged time schedule, and/or conduct family interviews to help with the rescue and identification activities. Families whose loved one is rescued will be directed to the appropriate health care facility.
Triggers
When it is apparent that there will be a significant number of families potentially arriving at the scene to seek information about the welfare and status of their loved ones, and it is apparent that the wait for information will take at least several hours, the [insert county name] County Emergency Manager, in consultation with the county ME/C and [insert the name of the agency or organization responsible for managing the Center], will coordinate the establishment of a Family Assistance Center. The Center should be open within 24 hours of the event or sooner if possible.

Note to Planners:
The determination of when to open a FAC will be made by local authorities. Emergency Management should designate one local organization to have the responsibility for establishing, coordinating, staffing and managing the Family Assistance Center. This could be the local DFCS (Department of Family and Children Services), Public Health, American Red Cross, or other non-profit organization. It is recommended that the ESF-6 lead collaborate with the ARC to manage the FAC. In major aviation incidents, this role has been assigned by the NTSB, as the federal lead agency by law, to the American Red Cross.

The Emergency Manager, in consultation with the ME/C, should consider establishing a Call Center or at least a dedicated phone number for families to call to get initial information, be directed to the Family Assistance Center and to provide contact information for the family. Agencies who might be able to manage a call center include emergency management, the 911 center, DFCS, community mental health services, or community agencies such as The Salvation Army, Red Cross, or the local United Way or Voluntary Organizations Active in Disaster (VOAD).

The [insert county name] County Emergency Manager, in consultation with the ME/C, also will determine the need to establish a Joint Family Support Operations Center (JFSOC) in conjunction with the FAC, where all local, state and federal agencies can coordinate their activities to support the FAC and conduct press briefings and family conference calls. The county Emergency Operations Center may be used for this purpose if space permits. If a separate JFSOC is needed, it may be co-located at the same facility as the FAC, but its operations will be separate from the family area.

Management Roles
The [insert designated agency/organization] (e.g., County Emergency Manager, ME/C, etc.) will be responsible for managing the JFSOC or EOC to coordinate all activities to support the families. The [insert county name] County ME/C will be responsible for conducting family briefings, ante mortem data collection, and death notifications. The [insert name of designated agency or organization] will manage the Family Assistance Center and be responsible for staffing and managing support services to the families, including emotional and spiritual care, food services, physical care and first aid, child care, security and other support services. If needed, local law enforcement may provide support for security. The Call Center will be managed by [insert name of designated agency or organization].

Suggestion for Planners: Consider adding a FAC Schematic in your Appendix to show reporting relationships and responsibilities delineation. See Example Schematic of a Family Assistance Center in Appendix VIII.

Location
- When it is anticipated that there will be few survivors, the primary FAC should be at a safe location, reasonably close to the disaster site but far enough away to protect those waiting from distressing sights, sounds and, if possible, odors. The [insert county name] County ME/C in consultation with the [insert county name] County EMA will determine the location of the primary FAC.
• There may be the need for a secondary FAC at hospitals who have a large number of
survivors being treated there, but only those families with a loved one at that facility
should be directed there.

• Each hospital will be responsible for providing support to families waiting with their
injured family members or those that expire en route to or at the hospital. This may
include providing emotional and spiritual care, and possibly some support for meals or
refreshments. Families may be referred to the FAC for services exceeding the capability
of the hospital.

**Note to Planners:** Hospitals may have a plan to establish a start-up FAC, consistent with
the template developed by the Georgia Hospital Association (GHA), but these facilities
are usually more limited in scope and duration than a community FAC.

**Site Selection**
The site to be established will be selected from a list of pre-designated sites attached to this
plan as Appendix (insert Appendix name/number).

**Note to Planners:** Community centers, hotels, recreation facilities, conference centers,
school or college meeting spaces, and religious institutions can all be used as FACs.
Families who have been participants in previous FACs have indicated a general
preference not to use churches or synagogues if other suitable facilities are available. If
these are the sites selected, it is preferable to use parts of the facility such as education
buildings or family life centers rather than the main worship area. It is important to be
sensitive to the needs of those who do not share that particular faith background and to
provide spiritual care in all faiths if possible. It is also advisable to identify an interfaith
organization or board to serve as the clearinghouse for all clergy assigned to provide
spiritual care to families to ensure that all are able to meet and comply with the
**Standards for Disaster Spiritual Care** adopted by the National VOAD in 2009 (see
**Family Assistance Center (FAC) Site Selection** in Appendix VIII).

For information on site selection, see **Family Assistance Center (FAC) Site Selection** in
Appendix VIII.

**Activities**
Core family assistance services include:

• Family briefings
• Ante-mortem data collection to assist in identifying victims
• Death notifications
• Call center/Hotline
• Reception and information desk
• Spiritual care services
• Mental health services
• Medical/First aid services
• Translation/Interpreter services
• Child care
• Food services
• Phone bank
• Computer bank or hook-ups

**Note to Planners:** Detailed plans and resources for providing these activities can be
found in **Family Assistance Center Guidelines** in Appendix VIII.

Planners may consider developing a family questionnaire to obtain information
regarding the loved one’s unique characteristics, i.e., tattoos, hip/knee/other
replacements, or other identifying marks, that could assist with identification. It should
be a local discussion and decision to determine when and where this questionnaire may
be administered to the family.
Optional additional support services could include:

- Incident site visits
- Memorial tables
- Photo/Letter boards
- Incident site diagrams/charts
- Memorial services
- Special support events – prayer services, concerts, dignitary visits

In an aviation incident, airlines are required by law to provide lodging for families who travel to the site of the incident but may live far away. In other transportation-related incidents or incidents where there is a corporate party that may be deemed liable or responsible for the support to families, they may assume responsibility for some or all of the costs of the facility used for the FAC, meals and refreshments or for lodging for the families if needed. The (insert name of agency coordinating the FAC) will coordinate with any third party assuming financial responsibility to make logistical arrangements for those services and may make arrangements on behalf of that party as mutually agreed. If no third party assumes financial responsibility, the agency designated with the responsibility for the FAC or the organization providing the service may be responsible for the cost of operating the FAC.

**Note to Planners:** Consider pre-identifying community resources, e.g., grocery stores, retailers, nonprofits, etc.

Outside the Family Support Center, possibly in another location, additional services from many other organizations may be made available. These could include:

- Benefits counseling and assistance
- Financial assistance
- Financial planning
- Laundry services
- Legal assistance
- Therapy dogs
- Department of Justice Office of Victims Assistance Program
- Transportation services

**Dignitaries**

If dignitaries arrive, arrangements need to be made for families who wish to meet with them. Families should be consulted to determine how they would like this to be handled.

**Hours of Operation**

FACs are usually open and staffed 24 hours a day, especially if located in a hotel where families are staying. If recovery operations are prolonged and families are returning to their homes at night, the FAC Manager will determine hours of operation.

**Closing the FAC**

Generally, the need for the FAC will decrease as more of the missing are found and identified. Once most of the victims have been identified and following any community memorial service that may be held, the active FAC may transition to a walk-in center for families with need for information and referral services and/or mental health counseling. The (insert the name of the agency or organization responsible (ESF-14)) will designate an agency to coordinate long-term recovery activities and to ensure ongoing support as needed. Activities may include development and dissemination of a resource guide for families about relevant web sites and information on financial or mental health resources available, establishing a website as a secure site for useful information, and establishment of ongoing support groups.
**Note to Planners:** The FAC Plan can be an entire plan itself. Once you have completed it you may want to add it as an appendix to this plan, or it could be a separate plan developed and maintained by the agency designated with the responsibility for managing the FAC. In that case, you could just reference that more detailed plan in this summary.
Section IX: Public Communications

Key Assumptions
The following are the key assumptions underlying mass fatality public communications:

- A mass fatality is an overwhelming event that creates widespread traumatic stress that can impact an entire community’s sense of safety and security.
- Calming the fear and anxiety of families and loved ones of potential victims and of the impacted community is a primary goal.
- Family members and the public will have high expectations regarding mass fatality management:
  - The identification of the deceased,
  - The return of loved ones, and
  - Ongoing information and updates.
- There will be persistent media requests for interviews with city, county, state and federal officials, survivors, family members, and rescue workers.
- A Joint Information Center will be established to ensure that information released to the public will be accurate, consistent, and coordinated across the responding agencies.

Purpose
The purpose of emergency risk communications in a mass fatality event, similar to any large-scale emergency, is to communicate needed information to key audiences, including the general public and news media, during and after the event.

When a mass fatality event occurs, staff assigned to public information functions will develop key messages and deliver sound and thoughtful communications in a timely manner. These communications can help calm public fears and prevent potentially dangerous situations from arising due to mass public response during a mass fatality event.

In a mass fatality event, it is paramount that information be timely, accurate, empathetic, consistent, caring, pertinent and credible. Additionally, communications should disclose what is known, acknowledge any uncertainty, and recognize fears and concerns. Providing accurate, consistent and timely information assists responding agencies in maintaining the public's confidence. These communications objectives will be met through working in a Joint Information Center reporting to the Incident or Unified Command.

It is important to remember that the mass fatality event will happen with nearly impossible time constraints, and people will have to decide what steps to take within the parameters of imperfect choices during the event. Decisions are typically made with narrow time constraints, decisions may need to be made with imperfect or incomplete information, and decisions may be irreversible. Emergency risk communication provides expert opinions and accurate information in the hope that it benefits key audiences and advances a behavior or action that allows for rapid and efficient recovery from the event.

Responsibility
In the event of a mass fatality incident, the Incident or Unified Command will appoint a Lead Public Information Officer (PIO) to establish a Joint Information Center within the ICS.

Note to Planners: The county EMA through its normal planning efforts may have a lead PIO currently identified for this role. It is important that all agencies that may respond to a mass fatality incident have their PIOs meet to discuss individual roles.
This is typically the PIO with ICS experience and/or experience in a Joint Information Center and could be the county, city, Public Health, ME/C or EMA PIO depending on scale, location and type of incident.

The Lead PIO reports to the Incident Commander and is a member of the Incident Command Staff at the Emergency Operations Center EOC. He/she is responsible for assuring that:

- Accurate and timely information is provided to the public, as well as to government officials and collaborating agencies.
- Information that is released is coordinated across responding agencies.
- Information is verified and approved through the appropriate chain of command (e.g., Incident Commander).

**Joint Information System (JIS) and Joint Information Center (JIC)**

The JIS provides the process for the JIC—gathering information, coordinating information, preparing it for dissemination, and releasing information. It is a framework and system that includes plans, protocols, and structures for providing information to the public.

A JIC operating under the JIS enables coordinated:

- Gathering of information and intelligence,
- Development of consistent and coordinated messages, and
- Dissemination of messages and information.

The JIC is where public information efforts are coordinated. The JIC is staffed by PIOs from all agencies involved in the mass fatality response. The JIC allows for the co-location of key PIOs and provides a “one-stop shop” for the media and public to get all communication needs met. It enhances the likelihood that information released to the public will be accurate and coordinated across responding agencies and jurisdictions.

The Lead PIO consults with the Incident Command regarding selection of a JIC location, if it has not been established yet. **The JIC should be in a separate location away from deceased victims and from the Family Assistance Center.**

It is important to understand the general framework of a JIC and how it is structured, because precisely how it will operate in a large-scale mass fatality incident cannot be determined prior to the emergency. They may be large or small in size and/or a combination of physical and virtual JICs if communications staff cannot all get together. The base of operations for a JIC may be federal, state, and/or local, and its resources may flow from any of these sources.

As with the ICS, the JIC may be scaled to fit the situation by expanding or collapsing its services and resources.

**Note to Planners:** It is suggested that your local JIC Organizational Chart be added to your plan. See **Joint Information Center Organization Sample** in Appendix IX.

**Medical Examiner/Coroner**

The {insert county name} County ME/C has a significant role in the approval of information released regarding the mass fatality operation, determining the sensitivity of information released and how they affect the surviving families. A trained and experienced PIO from the ME/C office is an integral member of the JIC leadership and staff for a mass fatality event. If there is not an ME/C PIO available, the local EMA will work with the ME/C to assign a...
representative to the JIC, if staffing permits. This individual will serve as a liaison with ME/C representatives from the incident site, morgue and Family Assistance Center for news conferences and interviews as requested by the JIC.

When requested, {insert county name} County ME/C Office will provide information to the JIC to coordinate the release of information to the media and public. ME/C Office staff and representatives will refer all media requests to their supervisors, who will, in turn, refer requests to the JIC.

**Note to Planners:** See *Public Communications Messaging Considerations* and *Public Communications Mass Fatality Operational Considerations* in Appendix IX.
Section X: Pandemic Influenza Planning

What is a Pandemic?
The word “pandemic” is used to describe a disease that affects people on a worldwide scale. Flu pandemics have occurred roughly every 30 to 40 years throughout history, and the last influenza pandemic occurred in 2009-2010.

Three conditions must be met to result in a pandemic:
1. The emergence of a new influenza strain.
2. The ability of that strain to infect humans and cause serious illness.
3. The ability to spread easily among humans.

According to the World Health Organization, we are currently in Phase Three (of six phases) of the Pandemic Alert Period.

Many communities have developed pandemic influenza plans. However, managing the expected large numbers of deaths has not always been addressed.

Assumptions
These are examples of the potential impact of a worst-case scenario pandemic influenza event.

- Susceptibility to pandemic influenza will be universal.
- There may be a case fatality rate of up to 3% in addition to the average rate of deaths from other causes.
- Up to 40% of the workforce could be absent from work during peak periods.
- Mutual aid resources from state or federal agencies to support local response efforts may not be available.
- It is estimated that 50% to 75% of deaths will occur outside of a hospital or medical treatment facility.
- The death care services could expect to handle about six months worth of work within a six- to eight-week period.
- The time to complete fatality management of a pandemic influenza event may exceed six months to a year.

During a pandemic, local authorities have to be prepared to manage additional deaths due to influenza, over and above the number of fatalities from all causes that are normally expected. Trigger points for different ways of working are likely to vary. For some, it will be the number of increased deaths that will be the tipping point. Limited storage space at local mortuaries and funeral homes may be the tipping point. For others, absenteeism might be the tipping point. It is likely that a combination of a number of pressure points would see activation of different ways of working. The trigger point at which a jurisdiction activates its mass fatality plan should be part of the pandemic planning process.
The following is a proposed flow for chart consideration for handling human remains during peak periods of a pandemic influenza.

![Flowchart: Expediting Remains Processing During a Pandemic Influenza Event](chart.png)

**Source:** Morgue Operations, Identification, and Command and Control of Mass Fatalities resulting from a Pandemic Influenza Event in the United States

**Note to Planners:** It is recommended that the ME/C Office, local authorities, funeral directors, private cemeteries, crematoria, and religious groups/authorities be engaged in reviewing the flow chart above and reviewing, discussing and planning for addressing the issues identified in the General Pandemic Influenza Guidelines in Appendix X. This planning will augment existing MF management plans, which will be activated during a pandemic.
# Glossary of Terms

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>AFDIL</td>
<td>Armed Forces DNA Identification Laboratory</td>
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<tr>
<td>CO(^2)</td>
<td>Carbon Dioxide</td>
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<tr>
<td>DFCS</td>
<td>Department of Family and Children Services</td>
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<td>DHS</td>
<td>Department of Homeland Security</td>
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<td>DMORT</td>
<td>Disaster Mortuary Operational Response Team</td>
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<td>DNA</td>
<td>Deoxyribonucleic acid</td>
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<td>DOC</td>
<td>District Operations Center</td>
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<td>DPMU</td>
<td>Disaster Portable Mortuary Units</td>
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<td>DVP</td>
<td>Disaster victim packets</td>
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<td>EMA</td>
<td>Emergency Management Agency</td>
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<td>EMAC</td>
<td>Emergency Management Assistance Compact</td>
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<td>EOC</td>
<td>Emergency Operations Center</td>
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<td>ESF</td>
<td>Emergency Support Function</td>
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<td>FAC</td>
<td>Family Assistance Center</td>
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<td>FBI</td>
<td>Federal Bureau of Investigation</td>
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<td>FEMA</td>
<td>Federal Emergency Management Agency</td>
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<td>Georgia Bureau of Investigation</td>
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<td>GDCH</td>
<td>Georgia Department of Community Health</td>
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<td>GEMA</td>
<td>Georgia Emergency Management Agency</td>
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<td>GEOP</td>
<td>Georgia Emergency Operations Plan</td>
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<td>GHA</td>
<td>Georgia Hospital Association</td>
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<td>Hazmat</td>
<td>Hazardous Materials</td>
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<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<td>HSPD</td>
<td>Homeland Security Presidential Directive</td>
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<td>ICS</td>
<td>Incident Command System</td>
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<td>ID</td>
<td>Identification</td>
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<td>IRC</td>
<td>Information Resource Center</td>
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<td>JFSOC</td>
<td>Joint Family Support Operations Center</td>
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<tr>
<td>LE</td>
<td>Law Enforcement</td>
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<tr>
<td>ME</td>
<td>Medical Examiner</td>
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<tr>
<td>ME/C</td>
<td>Medical Examiner/Coroner</td>
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<tr>
<td>MF</td>
<td>Mass Fatality</td>
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<tr>
<td>MFI</td>
<td>Mass Fatality Incident</td>
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<tr>
<td>MRN</td>
<td>Morgue reference numbers</td>
</tr>
<tr>
<td>NDMS</td>
<td>National Disaster Medical Services</td>
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<td>NIMS</td>
<td>National Incident Management System</td>
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<td>NTSB</td>
<td>National Transportation Safety Board</td>
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<tr>
<td>OCGA</td>
<td>Official Code of Georgia</td>
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<tr>
<td>OIC</td>
<td>Officer in Charge</td>
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<tr>
<td>POD</td>
<td>Point of Dispensing</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
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<tr>
<td>VIP</td>
<td>Victim Identification Profile</td>
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<tr>
<td>VOAD</td>
<td>Voluntary Organizations Active in Disasters</td>
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Appendix Section

**Note to Planners:** The following appendices contain support documents and/or samples for your planning initiatives.

- Appendix I: Roles and Responsibilities
- Appendix II: Concept of Operations
- Appendix III: Command and Control
- Appendix IV: Morgue Services
- Appendix V: Recovery
- Appendix VI: Death Care Services
- Appendix VII: Vital Records
- Appendix VIII: Family Assistance Center
- Appendix IX: Public Communications
- Appendix X: Pandemic Influenza Planning
Appendix I: Roles and Responsibilities

Sample Invitation to Community Members

{date}

{Title, First Name, Last Name}
{Funeral Home Name}
{Address}
{City, State, Zip}

Dear {Name}:

On behalf of the {Name} Health District’s Mass Fatality Committee, I would like to personally invite you to an informational meeting regarding Pandemic Influenza (or a Mass Fatality Event) that may occur in our community.

| Date: | _________________ | Time: | __________ |
| Place: | _________________ | Health District Office | 
| (Address) | | |

Kindly RSVP no later than______________ to ________________ (name and phone)

The Mass Fatality Committee includes {insert the names of the committee members and where they are from}, and we have been meeting regularly.

Our hard work is paying off and the GOOD NEWS is that we have developed a plan that remains open to your input and suggestions. We would like to present the plan to you and receive your valuable input at the same time. We will be finalizing this plan with the Health District very soon.

The licensed staffs from the following funeral homes have been invited to the meeting: (List names and Funeral Homes of those invited).

We certainly hope that a pandemic event will NOT occur, however, we should be prepared for any disaster in our community or a neighboring community. It seems logical to pool our resources and skills together, thereby enabling us to work more efficiently and effectively. This combined effort would likely ensure our businesses' survival and endurance, while providing a necessary service to our local community. Remember that we are part of a critical infrastructure that is necessary during a pandemic or disaster and we know our community best!

Please complete the surveys included and return by fax or bring to the meeting. Also, please review the enclosed information (Pandemic Influenza Matrix, Human Remains Storage Record) to better prepare you for the meeting. We hope to see you there!

Sincerely,

{Signature}

{committee member names}
Mass Fatality Committee
Appendix II: Concept of Operations

Note to Planners: Section II: Concept of Operations requires no supporting documents.
Appendix III: Command and Control

Sample EOC Organization Chart

EOC Organization Chart
Emergency Support Function (ESF) & Liaison Assignments

EOC Manager
ESF 5, 11 & 14*

EOC Safety Officer
EOC Liaison Officer
EOC Public Affairs
ESF 15

EOC Operations Section Chief
Public Safety Branch Director
- Fire/Hazmat ESF 4 & 10
- Search & Rescue ESF 9
- Public Safety, LE Security - ESF 13
- Defense Support to Civil - ESF 20

Infrastructure Branch Director
- Transportation ESF 1
- Public Works & Engineering - ESF 3

Human Services Branch Director
- Mass Care/Housing Human Svc - ESF 6
- Public Health & Med Svc - ESF 8
- Energy ESF 12

EOC Planning Section Chief

Situation Unit Leader
Resource Support ESF 7

EOC Logistics Section Chief
Documentation Unit Leader
Communications Unit Leader
Telecom, Info Sys & Warning - ESF 2

EOC Finance/Admin Section Chief

County Liaison
City Liaison(s)
EMS Liaison

*ESF 5 - Emergency Management
ESF 11 - Agriculture & Natural Resources
ESF 14 - Long Term Community Recovery & Mitigation
Appendix IV: Morgue Services

Field Organization for Mass Fatality Morgue Services Sample

Source: Santa Clara County Public Health Department, Advance Practice Center
Morgue Operations/Examination

Morgue Operations
Morgue Operations includes the following components:

- Administration
- Admitting Station
- Receiving Station
- Screening/Triage Station
- Information Resource Center
- Documentation Station
- Print Station
- Final Holding
- Release of Human Remains
- After-Care Station

The Morgue Operations Group Supervisor, also referred to as the Officer in Charge (OIC), oversees the operational functions and personnel. The OIC obtains necessary supplies and equipment related to morgue operations duties by interacting with Morgue Services Logistics and maintains communication with other divisions/groups. The OIC will conduct a briefing prior to the commencement of morgue operations and at the beginning of each shift. The briefing will include but not be limited to:

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

Administration
Responsibilities include:

- Monitoring staffing, supply and equipment needs
- Documenting labor time and purchases
- Inputting electronic data
- Maintaining ample supplies of:
  - Death certificates
  - General morgue forms
  - Embalming forms
  - Release forms
  - Disaster victim packets

Admitting Station
At this station, remains and personal effects are admitted and assigned a morgue reference numbers (MRN). Trackers are assigned to accompany the remains until examination/identification is complete and to ensure the security of the case file. In addition, the tracker will ensure that proper documentation is complete, signed, and attached at each station. As remains are admitted, the Coroner, working with the Family Assistance Center, will consider religious and cultural customs when handling the remains.

Receiving Station
This is where the decedents (in body bags) are delivered from the Incident Site. All incoming body and property bags are documented and the chain of custody initiated. Bodies are placed in a temporary refrigerated holding morgue. All body bags are radiographed to facilitate safe handling of collected remains. The pathologist or anthropologist will read the radiographs in order to assess the contents of the bag for effective sorting and locating hazardous substances.

Screening/Triage
This function is performed per incident-based guidelines to separate remains, personal effects, evidence and debris delivered from the incident site in the body bag. This entails:

- Using radiographs of bags taken prior to screening/triage, separate diagnostic human tissue from material evidence, debris and personal effects
- Photograph prior to disturbing clothing, property, foreign objects
- Complete anatomic charting
- Document and describe any personal effects or evidence that is removed
- Route potential evidence to law enforcement using chain of custody forms
- Determine path for examination/identification based on protocol:
  - Long path: continue through all subsequent stations.
  - Short path: Photography, Radiology, Anthropology and DNA Retrieval Stations only.
• Bag human tissue/remains having potential for ID based on incident guidelines and probative value (remains with highest likelihood for identification)
• Store tissue that does not have potential for ID and unassociated personal effects as determined based on the incident
• If personal effects or dangerous material items (e.g., bomb fragments) could not be removed without possible damage, notify the Unit Leader and leave effects associated with tissue marking the disaster victim packets (DVP) alerting future stations
• Route to Admitting

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

**Information Resource Center (IRC)**
This center is the central repository for collecting, recording, and storing ante-mortem and post-mortem information including:
• Keeping the information systems and records secure
• Matching ante-mortem and post-mortem files
• Receiving electronic ante-mortem data from the Family Assistance Center
• Electronically logging ante-mortem and post-mortem data
• Separates post-mortem and ante-mortem records into four major file categories:
  - Unidentified remains case files
  - Missing person reports case files (ante-mortem data collection interviews)
  - Identified remains case files
  - Court issued presumptive death certificates and related documents (if applicable)
• Compare ante-mortem and post-mortem records
• Develops **Identification Summary Report** for Identification Team

All records and data must be kept secure and confidential because they are protected by the HIPAA of 1996, Public Law 104-191, and additional applicable local laws. No information will be released to any person(s) or agencies without proper authorization from the Coroner.

**Documentation Station**
All remains and personal effects are photographed and documented adhering to the Coroner’s policy of:
• Photographing prior to disturbing clothing, property, foreign objects
• Placing proper documentation in photo
• Including scale in photo
• Taking standard autopsy-type photographs (anatomical position) for complete bodies
• Taking full-face photographs when possible
• Ensuring entire remains are present in the photograph
• Sending digital files to Information Resource Center for inclusion in victim identification processes.

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

**Final Holding Station**
This is the refrigerated area where processed remains are held until release. All human remains (identified, unidentified, and common tissue) will be stored with dignity. The holding areas for processed victims and for common tissue will be separate from that for remains that have not been processed and from where specimens (e.g., for DNA, histology, and toxicology) are stored while awaiting transfer to the lab for analysis. Remains will be held until the victim can be released for final disposition.

**Release of Human Remains for Final Disposition**
Identified decedents and their personal effects are released to next of kin or a person authorized by next of kin. Release functions include, preparation, final identification review, and funeral home contact.
Preparation
Preparation of human remains may include re-association and/or aftercare (embalming and casketing). All human remains will be prepared with professionalism and transported to authorized funeral home or crematory with consideration.

Final Identification Review
When remains are ready to be released, the Identification Team Leader and forensic specialists involved in the identification will:
- Conduct a final review of the methods of identification
- Physically examine the remains to ensure that the remains match the biological attributes of the deceased (based on the ante-mortem information)
- Ensure that the numbers associated with each remain are accounted for
- Sign and date the form indicating that the remains have been reviewed for final identification and place it in the Disaster Victim Packet.

If next of kin/legal authority authorized after care and it is provided at the incident morgue, route to the After Care Station.

Contact with Funeral Home
Funeral homes and crematoriums will be contacted to coordinate picking up or the shipping of remains.

Final Release
Upon completion of the final identification, human remains and associated personal effects that are not deemed evidence will be released according to the standard operating procedure of the Coroner’s Office.
- Keep a log of remains/bodies that are cleared for release and those on hold
- Check/assure that remains/bodies are prepared for release as authorized by next of kin
- Complete Release of Human Remains form and Release of Personal Effects form
- Implement chain of custody
- Maintain a Release Log to document the overall release process

After-Care Station
After-care can include embalming, cremation, and casketing. Funeral homes and crematories may be so overwhelmed that final disposition cannot be carried out within a reasonable timeframe.

Sources:
  http://www.dmort.org/FilesforDownload/NAMEMIFplan.pdf

Morgue Examination and Identification
Prior to the commencement of examination and at the beginning of each shift, a briefing will be conducted by the Group Supervisor that will include:
- Orientation and/or updates
- Safety procedures
- Necessity for security and confidentiality of all records and data
- Workflow/procedural issues

Examination of human remains entails radiology, dental identification, pathology, anthropology/morphology, DNA retrieval, and identification confirmation.

Note to Planners: Examination of human remains will be performed by the ME.

Radiology
Radiographic examinations provide post-mortem radiographs for comparison with ante-mortem clinical radiographs. This station should be established in an area of the morgue that is secluded from other processing
stations and have portable lead protective walls. The radiology team leader will monitor radiation safety issues such as shielding, monitor radiation dosage of team members via dosimeters, and assign dosimeters to other morgue personnel, as appropriate.

**Dental Identification**
Dental identification is divided into three sections: Post-mortem (after death), Ante-mortem (before death), and the Comparison Sections.

- The Dental Post-mortem Section performs the dental autopsy, including post-mortem dental radiography, photography, and records.
- The Dental Ante-mortem Section works closely with the Family Assistance Center to procure dental records.
- The Comparison Section compares ante-mortem and post-mortem dental records for the purpose of identification.

**Pathology**
The ME will make the decision to perform a complete or partial autopsy. Some reasons for complete autopsies include: homicides, terrorism, indeterminate manner of death, flight crews (in which the same pathologist autopsies all members), unidentified human remains, and upon federal request.

**Anthropology**
Comprehensive forensic anthropological documentation of human remains may occur. This is where fragmented, incomplete, charred, and commingled remains are examined to determine a biological profile. A standardized forensic anthropology report will be completed including a biological profile of the decedent remains that contains the:

- Sex
- Age at death
- Ancestry
- Forensic stature
- Ante-mortem trauma or pathology
- Anomalies and idiosyncratic variation including surgical hardware and prosthetic devices
- Peri-mortem (around the time of death) trauma The forensic anthropologist may also assist with:
  - Obtaining DNA samples from bone
  - Taking radiographs (to ensure proper alignment of specimen)
  - Interpreting trauma in consultation with the pathologist
  - Obtaining and isolating dental evidence in consultation with the odontologists
  - Interpreting and comparing ante-mortem and post-mortem records and radiographs
  - Assisting the pathologists and odontologists in establishing identity via ante-mortem/post-mortem radiographic comparison
  - Examining identified remains prior to release to confirm that the biological evidence used for identification matches the biological parameters of the remains.

**DNA Identification**
At the pathology station, DNA is obtained from the decedent to assist with identification when other means are inadequate. DNA analysis is expensive and its funding must be addressed. FEMA provides funding for the DNA identification effort if the incident meets its criteria for a disaster. However, confirming that funding for DNA analysis has been secured and contracts with appropriate laboratories and analysts are in place is important. DNA specimen collection criteria and guidelines must be adhered to. The Armed Forces DNA Identification Laboratory (AFDIL) policies and procedures for mass fatality incident DNA collection can serve as a guide.

**Identification Station and Victim Identification Profile (VIP)**
The Identification Station is a designated meeting area where results from the various identification methods are compiled, reviewed and confirmed. The Identification Team, chaired by a pathologist, consists of representatives from pathology, anthropology, odontology, radiology, prints, DNA, and the Coroner’s Office. The Victim Identification Profile has been developed and is utilized by the Disaster Operation Response Teams. It is a two-part process that utilizes a sophisticated computer program for matching physical characteristics. The families of the
deceased provide as much information about them as possible: dental records, x-rays, photographs or descriptions of tattoos, clothing and jewelry, blood type, and objects that may contain the deceased's DNA such as hair or a toothbrush. The information gathered, called ante-mortem, or “before death” information, is entered into a computer program called VIP (Victim Identification Profile), which is capable of assimilating 800 different item categories, including graphics photographs and x-rays. As forensic scientists (pathologists, anthropologists, odontologists) examine the recovered remains, they enter their findings, called post-mortem data, into the VIP. Depending on the availability of data, the VIP system enables scientists to match the remains to their identity.

Once identity is confirmed by the Identification Team, the information is presented to the Coroner, who will review and, if approved, issue a death certificate.
Fact Sheet on Health Risk from Dead Bodies

KEY MESSAGE
There is no risk of contagion or infectious disease from being near human remains or for people who are not directly involved in recovery efforts.

Victims of natural disasters, accidents, or WMD events usually die from trauma and are unlikely to have acute or ‘epidemic-causing’ infections. In the event of an intentional release of a biological agent or natural pandemic resulting in mass casualties, the risk is greater from live victims rather than the dead. The microorganisms responsible for these diseases have limited ability to survive in a body that is cooling after death.

BASIC INFECTION CONTROL FOR STAFF HANDLING HUMAN REMAINS

The safety of personnel performing these functions is paramount. Measures should be taken to reduce the risk of infection associated with handling dead bodies.

- Standard precautions are essential for those handling dead bodies; avoid exposure to potential pathogens and via wounds/punctures or mucus membranes. Follow standard precautions for blood and body and enteric fluids.
- Other Personal Protective Equipment such as eyewear, gowns, and masks, may be required where large quantities or splashes of blood are anticipated.
- Appropriately dispose of used protective equipment such as gloves or other garments
- Avoid cross-contamination: personal items should not be handled while wearing soiled gloves. Hand washing is essential.
- In HazMat or WMD events, the appropriate level of Personal Protective Equipment is required depending on the agent.
- Vehicles used for transportation should be washed carefully with a disinfectant or decontaminated if appropriate
- Human remains pouches will further reduce the risk of infection and are useful for the transport of decedents that have been badly damaged. Wrapping with plastic and a sheet may be an economical and practical containment solution.
- There is NO risk of contagion from infectious diseases simply by being near or around human remains.
# Biological Contamination Safety and Handling Recommendations

<table>
<thead>
<tr>
<th>Bio Agent</th>
<th>General Handling</th>
<th>Autopsy</th>
<th>Burial</th>
<th>Cremation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthrax</td>
<td>• Standard precautions</td>
<td>• Wear additional respiratory PPE</td>
<td>• Contact with corpses should be limited to personnel wearing PPE</td>
<td>• Recommended</td>
</tr>
<tr>
<td></td>
<td>• Additional respiratory personal protective equipment (PPE) when performing activities that generate aerosols</td>
<td>• Bio-Safety Level (BSL) 3 practices when performing activities with high potential for aerosols</td>
<td>• Package in leak-proof containers</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Regulated by 42 Code of Federal Regulations (CFR)</td>
<td>• Avoid embalming</td>
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<td></td>
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<td>• Buy without reopening</td>
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<tr>
<td>Botulinum Toxin</td>
<td>• Standard precautions</td>
<td>• Wear additional respiratory PPE</td>
<td>• Contact with corpses should be limited to personnel wearing PPE</td>
<td>• No restrictions</td>
</tr>
<tr>
<td></td>
<td>• Additional respiratory PPE when performing activities that generate aerosols</td>
<td>• BSL 3 practices when performing activities with high potential for aerosols</td>
<td>• Recommend no embalming</td>
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<tr>
<td></td>
<td></td>
<td>• Regulated by 42 CFR</td>
<td>• No restrictions</td>
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<tr>
<td>Plague</td>
<td>• Standard precautions</td>
<td>• Wear additional respiratory PPE</td>
<td>• Contact with corpses should be limited to personnel wearing PPE</td>
<td>• No restrictions</td>
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<tr>
<td></td>
<td>• Additional respiratory PPE when performing activities that generate aerosols</td>
<td>• BSL 3 practices required when performing activities with high potential for droplet or aerosol or working with antibiotic resistant strains</td>
<td>• Recommend no embalming</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Regulated by 42 CFR</td>
<td>• No restrictions</td>
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<tr>
<td>Tularemia</td>
<td>• Standard precautions</td>
<td>• Wear additional respiratory PPE</td>
<td>• Contact with corpses should be limited to personnel wearing PPE</td>
<td>• No restrictions</td>
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<tr>
<td></td>
<td>• Additional respiratory PPE when performing activities that generate aerosols</td>
<td>• BSL 3 practices when performing activities with high potential for aerosols</td>
<td>• Recommend no embalming</td>
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<td></td>
<td></td>
<td>• Regulated by 42 CFR</td>
<td>• No restrictions</td>
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<tr>
<td>Viral Hemorrhagic Fever</td>
<td>• Standard precautions</td>
<td>• Wear additional respiratory PPE</td>
<td>• Minimize handling by all personnel, even in PPE</td>
<td>• Recommended</td>
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<tr>
<td></td>
<td>• Additional respiratory PPE</td>
<td>• BSL 4</td>
<td>• Package in leak-proof containers</td>
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<td></td>
<td>• Negative pressure rooms</td>
<td>• Avoid embalming</td>
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<td></td>
<td></td>
<td>• Autopsies should be performed only if absolutely indicated</td>
<td>• Bury without reopening</td>
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<tr>
<td>Smallpox</td>
<td>• Standard precautions</td>
<td>• Wear additional respiratory PPE</td>
<td>• Minimize handling by all personnel, even in PPE</td>
<td>• Recommended</td>
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<tr>
<td></td>
<td>• Additional respiratory PPE</td>
<td>• BSL 3</td>
<td>• Package in leak-proof containers</td>
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<tr>
<td></td>
<td>• Personnel should be under a fever watch or vaccinated</td>
<td>• Autopsies should be performed only if absolutely indicated</td>
<td>• Avoid embalming</td>
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<td>• Regulated by 42 CFR</td>
<td>• Bury without reopening</td>
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<tr>
<td></td>
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<td>• Personnel should be vaccinated</td>
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Chart information compiled from the following sources:
Human Remains Storage

The Disaster Mortuary Operations Response Teams have developed a number of Disaster Portable Mortuary Units (DPMU). These are pre-packaged units that contain administrative supplies, forensic equipment, support equipment and instrumentation required to operate a temporary morgue facility in the field. They may also be used to support an existing morgue in a surge situation. Additionally, these units contain office equipment to support a Family Assistance Center. DPMU’s can be ordered through a DMORT team and arrive on scene via a flat bed tractor trailer unit. Should DPMU’s not be available, it will be necessary to convert an existing site into a temporary morgue facility.

**Note to Planners:** Sites that are frequently used by the general public, such as public auditoriums and school gymnasiums, should not be used. Also, facilities with nearby stores or offices should not be used. Abandoned warehouse and airplane hangars are the best options for incident morgue facilities.

**Site Requirements**

Any facility used as a temporary morgue should meet the following requirements:

**Size**
- 10,000-12,000 square feet at a minimum
- Room for 53’ refrigerated trailers (number needed to be determined by incident)

**Structure Type**
- Hard, weather-tight roofed structure
- Separate accessible office space for the Information Resource Center
- Separate space for administrative needs/personnel
- Non-porous floors, preferably concrete
- Floors capable of being decontaminated (hardwood and tile floors are porous and not usable)

**Accessibility**

The temporary morgue site should have:
- Easy access for vehicles, equipment and a tractor trailer
- A 10’ x 10’ door
- Loading dock access or site should be at ground level
- Convenience to the incident scene
- Complete security (away from families)

**Electrical**

- Electrical equipment utilizes standard household current (110-120 volts)
- Power obtained from accessible on site distribution panel (200-amp service)
- Electrical connections to distribution panels made by local licensed electricians
- Two Diesel generators (7K) carried in DPMU cache
- DPMU may need 125K generator and a separate 70K generator for Administrative and IR Sections

**Communications Access**

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

**Water/Sanitation/Drainage**

- Single source of cold water with standard hose bib connection
- Water hoses, hot water heaters, sinks, and connectors in the DPMU
- Existing drainage to dispose of gray water
- Pre-existing rest rooms within the facility are preferable

* Biological hazardous waste, liquid or dry, produced as a result of morgue operations, will be disposed in accordance with local/state requirements. In the event that [insert county name] County does not have the capabilities to meet local/state requirements, cleanup and disposal can be contracted out to a private company that specializes in this service.
# Local Hospital, Morgue, Funeral Home, and Refrigerated Truck Capacity

## Local Hospitals

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Street Address</th>
<th>City</th>
<th>Contact Name &amp; Phone</th>
<th>Refrigerated Morgue Capacity</th>
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## Local Funeral Homes

<table>
<thead>
<tr>
<th>Organization</th>
<th>Street Address</th>
<th>City</th>
<th>Contact Name &amp; Phone</th>
<th>Mortuary Storage Capacity</th>
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## Refrigerated Trucks

<table>
<thead>
<tr>
<th>Truck Owner</th>
<th>Street Address</th>
<th>City</th>
<th>Contact Name &amp; Phone</th>
<th>After-Hours Contact Name &amp; Phone</th>
</tr>
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<tbody>
<tr>
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</table>
Recommendations for Temporary Storage of Human Remains

The following are recommendations for the temporary storage of human remains:

- **Refrigeration:** Refrigeration of human remains between 38° and 42° Fahrenheit (4° to 8° C) is the best option. This can be accomplished with the use of:

  *Refrigerated transport containers/trucks:* Large transport containers used by commercial shipping companies generally hold 25-30 bodies (laying flat on the floor with a walkway between). To increase storage capacity three-fold, lightweight temporary racking systems can be employed. Shelves should be set-up in such a way that allows for safe movement and removal of bodies (i.e., storage of bodies above the waist height is not recommended). When food, beverage and other consumer types of commercial vehicles are used, they will generally not be returned to their prior service function. The local jurisdiction will be ultimately responsible for replacing these vehicles. To reduce any liability for business losses, jurisdictions should avoid using trucks with markings of a supermarket chain or other companies, as the use of such trucks for storage of fatalities may result in negative implications for business. Using local businesses for the storage of human remains is not recommended and should only be considered as a last resort. Refrigeration units should be maintained at low humidity because mold can become problematic if there is too much moisture present. Storing human remains at 38° and 42° Fahrenheit will slow down, but not stop decomposition. Remains can be preserved at this temperature for 1-3 months. The primary downside to this type of storage facility is that a sufficient quantity of refrigerated trucks/containers is seldom available during mass fatality incidents.

- **Dry ice:** Dry ice (carbon dioxide (CO2) frozen at −78.5° Celsius) can be used for short-term storage. Approximately 22 lbs of dry ice will be needed daily for each individual set of remains. The dry ice should be applied by building a low wall with it around groups of about 20 remains and then covering with a plastic sheet. To prevent damaging the corpse, the ice should never be placed on top of remains, even when wrapped. The downside to using dry ice is that it requires handling with gloves to avoid “cold burns.” Additionally, it must be used in an area with good ventilation as it emits carbon dioxide as it melts. Further, this product is costly and often difficult to obtain during an emergency.

The following storage options are **less optimal** than refrigeration or the use of dry ice:

- **Embalming:** This frequently used technique provides transitory preservation meant to maintain the body in an acceptable state for up 72 hours post-mortem. The downside to embalming is that it requires considerable time and expense which is not practical during a mass fatality event. Additionally, a licensed professional is required to embalm. Also, this process is not possible is the integrity of a corpse is compromised.

- **Chemical Preservation:** Chemicals can be used to pack a decedent for a short period of time. Powdered formaldehyde and powdered calcium hydroxide may be useful for preserving fragmented remains. After these substances are applied, the body or fragments should be wrapped in several nylon or plastic bags and sealed completely. The downside to this technique is that these chemicals have strong odors and can be irritating to workers.

- **Temporary Interment:** This method enables immediate storage when no other method is possible. This is not a true form of preservation and should primarily be considered when a great delay in final disposition is anticipated. Because the temperature underground is lower than surface temperature, a natural form of refrigeration occurs. To ensure future recovery of bodies, the following should be adhered to:
  - Each body should be labeled with a metal or plastic identification tag.
  - Bodies should also be clearly marked at ground level.
  - Bodies should be placed in a single layer (not stacked).
  - Burial should be 5 feet deep and 1 foot should be left between bodies.
Bodies should be at least 600 feet from drinking water sources.

In extreme situations, trench burial can be used for larger numbers.

The following human remains temporary storage options are NOT recommended:

- **Stacking:** Placing bodies on top of one another is not only disrespectful to the decedents and their families, but it can also distort the faces of the victims, which can impede visual identification. Additionally, it is difficult to manage stacked decedents and challenging to read the identification tags.

- **Freezing:** For several reasons, this is a poor option. To begin with freezing causes tissues to dehydrate which changes their color. This can make visual recognition by family members challenging and can also have a negative impact on the interpretation of injuries. When bodies are rapidly frozen, post-mortem injuries, including cranial fracture can occur. Additionally, the process of freezing and thawing will accelerate decomposition of the remains.

- **Packing in Ice:** This is not recommended as large quantities of ice are necessary to preserve a body even for a short period of time. Not only is ice heavy and difficult to manage, it is often used for emergency medical units during a major emergency. Further, the use of large quantities of ice results in large amounts of run-off water.

- **Ice-Rinks:** While ice skating rinks may sound like the perfect solution, they are not recommended. A body placed 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.

Potential Sources of refrigerated trucks/containers, and in {insert county name} County include:

- Dry ice
- Refrigerated trucks, trailers and cold boxes (temporary & portable units)

**Sources:**

- Department of Coroner, Department of Health Services EMSA, Department of Public Health, Los Angeles County: *Mass Fatality Incident Management: Guidance for Hospitals and Other Healthcare Entities* August 2008
# Morgue Supply List Sample Chart

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Your Facility Notes / How to Access Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Protection</strong></td>
<td></td>
</tr>
<tr>
<td>Personal protective equipment (minimum standard precautions)</td>
<td>Storage area:</td>
</tr>
<tr>
<td></td>
<td>How to access:</td>
</tr>
<tr>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td>Worker safety and comfort supplies</td>
<td>Storage area:</td>
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<tr>
<td></td>
<td>How to access:</td>
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<tr>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td>Communication (radio, phone, etc.)</td>
<td>Storage area:</td>
</tr>
<tr>
<td></td>
<td>How to access:</td>
</tr>
<tr>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td><strong>Decedent Identification</strong></td>
<td></td>
</tr>
<tr>
<td>Identification wristbands or other identification</td>
<td>Storage area:</td>
</tr>
<tr>
<td></td>
<td>How to access:</td>
</tr>
<tr>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td>Method to identify each decedent (pouch label, tag or rack location)</td>
<td>Storage area:</td>
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<tr>
<td></td>
<td>How to access:</td>
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<td></td>
<td>Notes:</td>
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<tr>
<td>Cameras (may use dedicated digital, disposable, or instant photo cameras)</td>
<td>Storage area:</td>
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<td>How to access:</td>
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<td>Notes:</td>
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<tr>
<td>Fingerprints</td>
<td>Storage area:</td>
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<td>How to access:</td>
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<td>Notes:</td>
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<tr>
<td>X-rays or dental records</td>
<td>Storage area:</td>
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<td></td>
<td>How to access:</td>
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<td></td>
<td>Notes:</td>
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<tr>
<td>Consideration</td>
<td>Your Facility Notes / How to Access Equipment</td>
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<td>---------------------------------------------------</td>
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<tr>
<td><strong>Personal belongings bags/evidence bags</strong></td>
<td>Storage area:</td>
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<td>How to access:</td>
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<td>Notes:</td>
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<tr>
<td><strong>Decedent Protection</strong></td>
<td></td>
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<tr>
<td><strong>Human remains pouches</strong></td>
<td>Storage area:</td>
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<td></td>
<td>How to access:</td>
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<td>Notes:</td>
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<tr>
<td><strong>Plastic sheeting</strong></td>
<td>Storage area:</td>
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<td></td>
<td>How to access:</td>
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<td>Notes:</td>
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<td><strong>Sheets</strong></td>
<td>Storage area:</td>
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<td>How to access:</td>
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<td>Notes:</td>
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<tr>
<td><strong>Decedent Storage</strong></td>
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<tr>
<td><strong>Refrigerated tents or identified overflow morgue area</strong></td>
<td>Storage area:</td>
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<td>How to access:</td>
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<td>Notes:</td>
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<tr>
<td><strong>Storage racks</strong></td>
<td>Storage area:</td>
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<td>How to access:</td>
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<td>Notes:</td>
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<tr>
<td><strong>Portable air conditioning units</strong></td>
<td>Storage area:</td>
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<td>How to access:</td>
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<td><strong>Generators for lights or air conditioning</strong></td>
<td>Storage area:</td>
</tr>
<tr>
<td></td>
<td>How to access:</td>
</tr>
<tr>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td><strong>Ropes, caution tape, other barricade equipment</strong></td>
<td>Storage area:</td>
</tr>
<tr>
<td></td>
<td>How to access:</td>
</tr>
<tr>
<td></td>
<td>Notes:</td>
</tr>
</tbody>
</table>
## Temporary Morgue Sites Identified

*Insert sites below* (Example: Airports, Highways, or Interstates)

<table>
<thead>
<tr>
<th>SITE</th>
<th>ADDRESS &amp; PHONE</th>
<th>CONTACT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Appendix V: Recovery

Note to Planners: Section V: Recovery requires no supporting documents.
Appendix VI: Death Care Services

Funeral Home Survey

{insert county name} County Mass Fatality Planning Committee

**FUNERAL HOME SURVEY**

This survey will be used and submitted to the {insert county name} County Mass Fatality Planning Committee for the Emergency Plan only. Please complete to the best of your ability and return the survey at the meeting on {insert date of meeting} or fax to {insert contact name and fax number}. Thank you!

<table>
<thead>
<tr>
<th>NAME OF FUNERAL HOME</th>
<th>CONTACT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTACT TITLE</th>
<th>(_____) CONTACT PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Personally, would you be willing to volunteer during a pandemic influenza or other mass fatality event?

- [ ] YES  - [ ] NO  - [ ] UNDECIDED

How many of the following does your funeral home employ?

<table>
<thead>
<tr>
<th># EMPLOYED</th>
<th>POSITIONS</th>
<th># EMPLOYED</th>
<th>POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Licensed Funeral Director only</td>
<td>1</td>
<td>Registered Apprentice</td>
</tr>
<tr>
<td>2</td>
<td>Licensed Embalmers</td>
<td>2</td>
<td>Full-time Non-Licensed</td>
</tr>
<tr>
<td>3</td>
<td>Part-time Non Licensed</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

How many chapels are in your funeral home?

- [ ] 1  - [ ] 2  - [ ] 3  - [ ] 4

<table>
<thead>
<tr>
<th>APPROPX SIZE IN SQ FEET</th>
<th>How do you describe the area in size? (check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapel 1</td>
<td>□ Small  □ Medium  □ Large  □ Very Large</td>
</tr>
<tr>
<td>Chapel 2</td>
<td>□ Small  □ Medium  □ Large  □ Very Large</td>
</tr>
<tr>
<td>Chapel 3</td>
<td>□ Small  □ Medium  □ Large  □ Very Large</td>
</tr>
<tr>
<td>Chapel 4</td>
<td>□ Small  □ Medium  □ Large  □ Very Large</td>
</tr>
<tr>
<td>Prep Room</td>
<td>□ Small  □ Medium  □ Large  □ Very Large</td>
</tr>
</tbody>
</table>

How many church trucks do you have? ________________

Do you have a casket lift?

- [ ] YES  - [ ] NO

How many funeral services (burials and cremations) can you perform in a week? ________________

Do you have an active Prep Room?

- [ ] YES  - [ ] NO
How many workable embalming machines are in your prep room? _______

What is your morgue capacity? ________________

Is your morgue climate controlled by: ☐ Refrigeration  ☐ A/C  ☐ Other  ☐ N/A

How many removal vehicles does the funeral home possess?

<table>
<thead>
<tr>
<th>QTY</th>
<th>TYPE OF REMOVAL VEHICLE</th>
<th>QTY</th>
<th>TYPE OF REMOVAL VEHICLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Van</td>
<td></td>
<td>SUV/Truck</td>
</tr>
<tr>
<td></td>
<td>Hearse</td>
<td></td>
<td>Wagon</td>
</tr>
</tbody>
</table>

How many workable stretchers do you use? _______ Reeves Stretchers? _______

How many pouches are stocked at any given time? _______ Disaster Pouches? ______

Do you customarily perform your own:  Removals? ☐ YES  ☐ NO  Embalming? ☐ YES  ☐ NO

How many active phone lines does your funeral home have right now? _______

How many phone lines could your current system be capable of holding? _______

Do you have any items or equipment that might be useful in the retrieval, storage and disposition of human remains? (Any heavy equipment, hydraulic equipment, etc.) Please specify.

<table>
<thead>
<tr>
<th>QTY</th>
<th>ITEM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

Please share any comments or suggestions regarding a mass fatality event or pandemic influenza.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Thank you!

Note to Planners: Create a spreadsheet to hold the Survey results where applicable data can be automatically calculated.
Right of Disposition of Authority

Below is information outlining Georgia law related to who has right of final disposition for a deceased individual. This order of authority should be followed in determining who will ultimately provide instructions for funeral and burial/cremation, and who will ultimately receive the body or cremated remains for final disposition when law enforcement and related mass fatality authorities are ready to release the deceased. It should be noted that this order of authority grants the right of final disposition to the state or local jurisdiction, followed by the funeral director, if all attempts to locate next of kin have been unsuccessful.


§ 31-21-7. Preneed contracts and revisions; affidavit on disposition of remains; role of probate court; warrant as to truthfulness; liability of funeral home

(b) Except as provided in subsection (c) of this Code section, the right to control the disposition of the remains of a deceased person; the location, manner, and conditions of disposition; and arrangements for funeral goods and services to be provided vests in the following, in the order named, provided that such person is 18 years or older and is of sound mind:

(1) The health care agent, as defined in Code Section 31-32-2;

(1.1) If the deceased person died while serving in any branch of the United States Armed Forces as defined in 10 U.S.C. Section 148, the person, if any, designated by the deceased person as authorized to direct disposition as listed on the deceased person's United States Department of Defense Record of Emergency Data, DD Form 93, or any similar successor form adopted by the Department of Defense;

(2) (A) A person designated by the decedent as the person with the right to control the disposition in an affidavit executed in accordance with subparagraph (B) of this paragraph.

(B) A person who is 18 years of age or older and of sound mind wishing to authorize another person to control the disposition of his or her remains may execute an affidavit before a notary public in substantially the following form:

<table>
<thead>
<tr>
<th>State of Georgia</th>
</tr>
</thead>
<tbody>
<tr>
<td>County of ________________</td>
</tr>
</tbody>
</table>

I, ______________________, do hereby designate ______________________ with the right to control the disposition of my remains upon my death. I, ______________________, have ___ have not ____ attached specific directions concerning the disposition of my remains with which the designee shall substantially comply, provided that such directions are lawful and there are sufficient resources in my estate to carry out the directions.

Subscribed and sworn to before me this ______ day of the month of ______________
of the year ______.

______________________________ (signature of affiant)  ______________ (signature of notary public)

(3) The surviving spouse of the decedent;

(4) The sole surviving child of the decedent or, if there is more than one child of the decedent, the majority of the surviving children; provided, however, that less than one-half of the surviving children shall be vested with the rights under this Code section if they have used reasonable efforts to notify all other surviving children of their instructions and are not aware of any opposition to those instructions on the part of more than one-half of all surviving children;
(5) The surviving parent or parents of the decedent. If one of the surviving parents is absent, the remaining parent shall be vested with the rights and duties under this Code section after reasonable efforts have been unsuccessful in locating the absent surviving parent;

(6) The surviving brother or sister of the decedent or, if there is more than one sibling of the decedent, the majority of the surviving siblings; provided, however, that less than the majority of surviving siblings shall be vested with the rights and duties under this Code section if they have used reasonable efforts to notify all other surviving siblings of their instructions and are not aware of any opposition to those instructions on the part of more than one-half of all surviving siblings;

(7) The surviving grandparent of the decedent or, if there is more than one surviving grandparent, the majority of the grandparents; provided, however, that less than the majority of the surviving grandparents shall be vested with the rights and duties under this Code section if they have used reasonable efforts to notify all other surviving grandparents of their instructions and are not aware of any opposition to those instructions on the part of more than one-half of all surviving grandparents;

(8) The guardian of the person of the decedent at the time of the decedent's death if one had been appointed;

(9) The personal representative of the estate of the decedent;

(10) The person in the classes of the next degree of kinship, in descending order, under the laws of descent and distribution to inherit the estate of the decedent. If there is more than one person of the same degree, any person of that degree may exercise the right of disposition;

(11) If the disposition of the remains of the decedent is the responsibility of the state or a political subdivision of the state, the public officer, administrator, or employee responsible for arranging the final disposition of decedent's remains; or

(12) In the absence of any person under paragraphs (1) through (11) of this subsection, any other person willing to assume the responsibilities to act and arrange the final disposition of the decedent's remains, including the funeral director with custody of the body, after attesting in writing that a good faith effort has been made to no avail to contact the individuals under paragraphs (1) through (11) of this subsection.
The chart below provides summary information related to cultural and religious preferences regarding care of the deceased. Attempts should be made to care for the deceased consistent with these preferences. However, public health considerations and guidelines provided by regulatory bodies will also be considered. In the event there is conflict between public health considerations and cultural or religious preferences, public health considerations will take precedence.

<table>
<thead>
<tr>
<th>Religion/Culture</th>
<th>Preference</th>
<th>Other Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan / Islam</td>
<td>Rapid Burial</td>
<td></td>
</tr>
<tr>
<td>Amish / Mennonites</td>
<td>No Restrictions</td>
<td></td>
</tr>
<tr>
<td>Arab Cultures / Islam</td>
<td>Rapid Burial</td>
<td></td>
</tr>
<tr>
<td>Buddhist</td>
<td>No Restrictions</td>
<td></td>
</tr>
<tr>
<td>Chinese / Hindu</td>
<td>Cremation</td>
<td>Burial</td>
</tr>
<tr>
<td>Christian Scientist</td>
<td>No Restrictions</td>
<td>Cremation</td>
</tr>
<tr>
<td>Cuban / Roman Catholic</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Eastern Orthodox</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Filipino / Roman Catholic</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Guatemalan / Roman Catholic</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino (other) / Roman Catholic</td>
<td>Burial (Generally)</td>
<td></td>
</tr>
<tr>
<td>Indian / Hindu</td>
<td>Cremation</td>
<td></td>
</tr>
<tr>
<td>Japanese / Buddhist</td>
<td>No Restrictions</td>
<td></td>
</tr>
<tr>
<td>Jewish</td>
<td>Rapid Burial</td>
<td></td>
</tr>
<tr>
<td>Korean</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>LDS</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Mexican / Roman Catholic</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Native American</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>Rapid Burial</td>
<td>No coffin</td>
</tr>
<tr>
<td>Polynesian</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Puerto Rican / Roman Catholic</td>
<td>Burial</td>
<td></td>
</tr>
<tr>
<td>Rastafarian</td>
<td>Don’t believe in burial</td>
<td>Ask for Preference</td>
</tr>
<tr>
<td>Sri Lanka / Buddhist</td>
<td>No Restrictions</td>
<td></td>
</tr>
</tbody>
</table>
Appendix VII: Vital Records

Official Code of Georgia

(as of May 2011)

Below is the Official Code of Georgia sections dealing with death certificates and disposition permits:

§ 31-10-15. Death certificate; filing; medical certification; forwarding death certificate to decedent's county of residence; purging voter registration list

(a) A certificate of death for each death which occurs in this state shall be filed with the local registrar of the county in which the death occurred or the body was found within ten days after the death as follows:

(1) If the place of death is unknown but the dead body is found in this state, the certificate of death shall be completed and filed in accordance with this Code section. The place where the body is found shall be shown as the place of death. If the date of death is unknown, it shall be the date the body was found and the certificate marked as such; or

(2) When death occurs in a moving conveyance in the United States and the body is first removed from the conveyance in this state, the death shall be registered in this state and the place where it is first removed shall be considered the place of death. When a death occurs in a moving conveyance while in international waters or airspace or in a foreign country or its airspace and the body is first removed from the conveyance in this state, the death shall be registered in this state but the certificate shall show the actual place of death insofar as can be determined.

(b) The funeral director or person acting as such who first assumes custody of the dead body shall file the certificate of death within 72 hours. Such director or person shall obtain the personal data from the next of kin or the best qualified person or source available and shall obtain the medical certification from the person responsible therefore.

(c) (1) The medical certification as to the cause and circumstances of death shall be completed, signed, and returned to the funeral director or person acting as such within 72 hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death, except when inquiry is required by Article 2 of Chapter 16 of Title 45, the "Georgia Death Investigation Act." In the absence of said physician or with that physician’s approval the certificate may be completed and signed by an associate physician, the chief medical officer of the institution in which death occurred, or the physician who performed an autopsy upon the decedent, provided that such individual has access to the medical history of the case, views the deceased at or after death, and death is due to natural causes. If, 30 days after a death, the physician in charge of the patient’s care for the illness or condition which resulted in death has failed to complete, sign, and return the medical certification as to the cause and circumstances of death to the funeral director or person acting as such, the funeral director or person acting as such shall be authorized to report such physician to the Georgia Composite Medical Board for discipline pursuant to Code Section 43-34-38.

(2) In any area in this state which is in a state of emergency as declared by the Governor due to an influenza pandemic, in addition to any other person authorized by law to complete and sign a death certificate, any registered professional nurse employed by a long-term care facility, advanced practice nurse, physician assistant, registered nurse employed by a home health agency, or nursing supervisor employed by a hospital shall be authorized to complete and sign the death certificate, provided that such person has access to the medical history of the case, such person views the deceased at or after death, the death is due to natural causes, and an inquiry is not required under Article 2 of Chapter 16 of Title 45, the "Georgia Death Investigation Act.” In such a state of emergency, the death certificate shall be filed by the funeral director in accordance with subsection (b) of this Code section; or, if the certificate is not completed and signed by an appropriate physician or coroner, the public health director of preparedness shall cause the death certificate to be completed, signed, and filed by some other authorized person.
within ten days after death.

(d) When death occurs without medical attendance as set forth in subsection (c) of this Code section or when inquiry is required by Article 2 of Chapter 16 of Title 45, the "Georgia Death Investigation Act," the proper person shall investigate the cause of death and shall complete and sign the medical certification portion of the death certificate within 30 days after being notified of the death.

(e) If the cause of death cannot be determined within 48 hours after death, the medical certification shall be completed as provided by regulation. The attending physician or coroner shall give the funeral director or person acting as such notice of the reason for the delay, and final disposition of the body shall not be made until authorized by the attending physician, coroner, or medical examiner.

§ 31-10-20. Permits for disposition, disinterment, and reinterment

(a) The funeral director or person acting as such or other person who first assumes custody of a dead body or fetus shall obtain a disposition permit for cremation or removal from the state. A disposition permit may be required within the state by local authorities.

(b) Such disposition permit shall be made available by the local registrar of the county where the death or fetal death occurred, or body or fetus was found, 24 hours a day, seven days a week. The registrar will issue a disposition permit immediately upon request from the licensed funeral director or his agent in charge of the body or fetus. The request for a disposition permit may be received by the registrar either orally or in writing. The registrar may respond to the request by any means utilized in the normal course of transacting business including, but not limited to, transmission by facsimile machine.

In the event of a mass fatality, the Georgia State Registrar will provide such assistance as reasonably necessary to the local registrar to ensure the timely and accurate filing of death certificates and/or issuance of disposition permit.
Appendix VIII: Family Assistance Center

Example Schematic of a Family Assistance Center
16.5 *Family Assistance Center Layout*

**Family Access Areas**
- Reception-Security Desk
- Private Briefing Interview Rooms
- General Briefing Room
- Dining Hall

**Staff Access Areas**
- Family Hotel Rooms
- Lounge
- Interfaith Reflection Room
- Child Care Room
- Mental Health Counselors Office
- OCME Office
- Staff Briefing Area
- Joint Family Support Operations Center (JFSOC)
- Other Service Agencies Office
- Staff Briefing Area
- Family Liaisons Office
- Funeral Home Liaison Office

16.6 *Family Information Center Layout*

**Family Access Areas**
- Reception & Information
- Private Family Briefing Areas
- Mental Health Support
- Refreshment Area

**Staff Access Areas**
- Data Entry Stations
- Mental Health Support
- Refreshment Area
- OCME Office
- Support Agencies Office
- Staff Briefing Area
- Mental Health Counselors Office
- Staff Briefing Area

*June 2010. Revision 5*
Standards for Disaster Spiritual Care
(adopted by the National VOAD in 2009)

NATIONAL VOLUNTARY ORGANIZATIONS ACTIVE IN DISASTER POINTS OF CONSENSUS

DISASTER SPIRITUAL CARE

In 2006 the National Voluntary Organizations Active in Disaster’s Emotional and Spiritual Care Committee published *Light Our Way* to inform, encourage and affirm those who respond to disasters and to encourage standards insuring those affected by disaster receive appropriate and respectful spiritual care services. As a natural next step following the publication of *Light Our Way* and in the spirit of the NVOAD “Four C’s” (cooperation, communication, coordination and collaboration), the Emotional and Spiritual Care Committee then began working to define more specific standards for disaster spiritual care providers. The following ten “points of consensus” set a foundation for that continuing work.

1. Basic concepts of disaster spiritual care
   Spirituality is an essential part of humanity. Disaster significantly disrupts people’s spiritual lives. Nurturing people’s spiritual needs contributes to holistic healing. Every person can benefit from spiritual care in time of disaster.

2. Types of disaster spiritual care
   Spiritual care in disaster includes many kinds of caring gestures. Spiritual care providers are from diverse backgrounds. Adherence to common standards and principles in spiritual care ensures that this service is delivered and received appropriately.

3. Local community resources
   As an integral part of the pre-disaster community, local spiritual care providers and communities of faith are primary resources for post-disaster spiritual care. Because local communities of faith are uniquely equipped to provide healing care, any spiritual care services entering from outside of the community support but do not substitute for local efforts. The principles of the National VOAD - cooperation, coordination, communication and collaboration - are essential to the delivery of disaster spiritual care.

4. Disaster emotional care and its relationship to disaster spiritual care
   Spiritual care providers partner with mental health professionals in caring for communities in disaster. Spiritual and emotional care share some similarities but are distinct healing modalities. Spiritual care providers can be an important asset in referring individuals to receive care for their mental health and vice versa.

5. Disaster spiritual care in response and recovery
   Spiritual care has an important role in all phases of a disaster, including short-term response through long-term recovery. Assessing and providing for the spiritual needs of individuals, families, and communities can kindle important capacities of hope and resilience. Specific strategies for spiritual care during the various phases can bolster these strengths.

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1 See *Light Our Way* pp. 52-54. 2 Ibid. 3 Ibid. 4 Ibid.
6. Disaster emotional and spiritual care for the care giver
Providing spiritual care in disaster can be an overwhelming experience. The burdens of caring for others in this context can lead to compassion fatigue. Understanding important strategies for self-care is essential for spiritual care providers. Disaster response agencies have a responsibility to model healthy work and life habits to care for their own staff in time of disaster.\(^1\) Post-care processes for spiritual and emotional care providers are essential.

7. Planning, preparedness, training and mitigation as spiritual care components\(^6\)
Faith community leaders have an important role in planning and mitigation efforts. By preparing their congregations and themselves for disaster they contribute toward building resilient communities. Training for the role of disaster spiritual care provider is essential before disaster strikes.

8. Disaster spiritual care in diversity
Respect is foundational to disaster spiritual care. Spiritual care providers demonstrate respect for diverse cultural and religious values by recognizing the right of each faith group and individual to hold to their existing values and traditions. Spiritual care providers:
- refrain from manipulation, disrespect or exploitation of those impacted by disaster and trauma.
- respect the freedom from unwanted gifts of religious literature or symbols, evangelistic and sermonizing speech, and/or forced acceptance of specific moral values and traditions.
- respect diversity and differences, including but not limited to culture, gender, age, sexual orientation, spiritual/religious practices and disability.

9. Disaster, trauma and vulnerability
People impacted by disaster and trauma are vulnerable. There is an imbalance of power between disaster responders and those receiving care. To avoid exploiting that imbalance, spiritual care providers refrain from using their position, influence, knowledge or professional affiliation for unfair advantage or for personal, organizational or agency gain.

Disaster response will not be used to further a particular political or religious perspective or cause – response will be carried out according to the need of individuals, families and communities. The promise, delivery, or distribution of assistance will not be tied to the embracing or acceptance of a particular political or religious creed.\(^8\)

10. Ethics and Standards of Care
NVOAD members affirm the importance of cooperative standards of care and agreed ethics. Adherence to common standards and principles in spiritual care ensures that this service is delivered and received appropriately. Minimally, any guidelines developed for spiritual care in times of disaster should clearly articulate the above consensus points in addition to the following:
- Standards for personal and professional integrity
- Accountability structures regarding the behavior of individuals and groups
- Concern for honoring confidentiality\(^4\)
- Description of professional boundaries that guarantee safety of clients\(^4\) including standards regarding interaction with children, youth and vulnerable adults
- Policies regarding criminal background checks for service providers
- Mechanisms for ensuring that caregivers function at levels appropriate to their training and educational backgrounds\(^5\)
- Strong adherence to standards rejecting violence against particular groups
- Policies when encountering persons needing referral to other agencies or services
- Guidelines regarding financial remuneration for services provided

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\(^{1}\) Ibid.  
^{2}\) Ibid.  
^{3}\) Church World Service “Standard of Care for Disaster Spiritual Care Ministries”  
^{4}\) Church World Service “Common Standards and Principles for Disaster Response”  
^{5}\) See Light Our Way, p. 16
Family Assistance Center (FAC) Site Selection

If the event is of the magnitude that there are few or no survivors and identification of the fatalities may require some time. A primary FAC should be established at a safe and secure location. If there is a need for a secondary FAC at the hospitals due to a large number of survivors, each hospital will be responsible for providing support to families waiting with their injured or deceased family members.

Location
- Close to disaster site but far enough away to obscure from distressing sights, sounds and odors.
- Easy access and parking for a large number of vehicles.

Space Requirements
- Area close to entrance for a reception and/or information desk.
- One large room (auditorium, gymnasium, etc.) with comfortable sofas and chairs arranged in conversational groupings, preferably with some chair-side tables.
  - Part of this room could house tables, chairs, writing paper, cards, puzzles and games.
- 1-2 small rooms where individuals/families can quietly pray, read or meditate.
  - Suggest providing access to books, Bibles and the Koran.
- 2-3 smaller rooms where families can gather for plans/calls, or to meet with officials or ME/C.
- One separate secure room for child care (close proximity to large room serving as main lounge).
- Room for refreshments and/or meals to be available around the clock.
  - Facilities with existing kitchen, lunchroom and/or break facilities are desirable.
- Room for first aid.
- Room for behavioral health.
- Break room for staff who are managing the center (locate away from families if possible).
- Room for staff in-processing, meeting and administrative areas.

Communications Access
- TV room(s) with comfortable seating.
- Bank of computers.
- Telephones/fax machines.

Note to Planners: Pre-selected Point of Dispensing (POD) sites may be good options, as the requirements of POD facilities closely mirror FAC.
Family Assistance Center Guidelines

What are the guidelines for core family assistance services?

The core family assistance services or functions are:

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

A brief description with guidelines for these functions appear below.

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

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

Family Briefings

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

Family briefings are convened to meet this need. Their purpose is to provide information to all families (at the FAC and not at the FAC) on the progress of recovery efforts, identification of victims, the investigation, and other areas of concern.

In general:

- Always provide information to families before releasing it to the general media.
- Maintain contact with families once it is established regardless of whether additional information is available.
- Bring in subject matter experts as needed. And, plan to have rescue workers (selected via the Joint Information Center) and officials visit the families so that they can thank the workers for their efforts and support. When this occurs will depend on the nature of the incident.

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

Information of Interest to Families

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

- Establish procedures for family briefings.
  - When guests are invited to present to families on topics of interest, orient/brief them on the family briefing procedures.
- Prepare family briefing room:
  - Setup a conference call bridge in the room where briefings will be held and provide a toll free number to connect to the bridge to families so that families who are not on site can listen to the briefing.
- Arrange for translators as needed.
- Prepare a schedule for daily family briefings (minimum two per day, e.g., one in the morning at 9:30 and one in the afternoon at 3:30; however, more frequent information sessions may often be held).
- Post the schedule in the FAC. Inform families that they may attend as often as they like and may bring as many people as they like.
- Consider preparing an informational letter for all families in the beginning that addresses key concerns, such as, identification methods, disposition options, issuance of death certificates, and matters related to unidentified remains.
- Collect information from the incident site, the morgue, the FAC, and the Joint Information Center (JIC) for briefings and consult with the JIC as needed to ensure that families are informed first and for consistency in messages to families and to the public.  
  
  **Note:** If the incident is the result of a crime, the ME/C must sensitively convey information to families during recovery that is consistent with the information provided to the prosecution.
- Prepare briefings.
- Convene families and friends at FAC for scheduled briefings.
  - Briefings are important even if there is no new information to report.
- Provide information relating to victims and progress of the response effort to families.
  - Emphasize that the FAC is the best source of current and accurate information for families at each briefing.
  - Present information in terms family members can understand.
  - Repeat information frequently during the briefing to accommodate families at various levels of receptiveness in the grieving process.
  - Plan for question and answer sessions after each briefing (may last up to 2 hours). If a question cannot be answered, get the answer by the next briefing.
  - The JFAC Officer in Charge should attend all briefings and make him/herself available after each briefing to meet with families one-on-one at a designated area in the family briefing room, spending as much time as needed to address their concerns.
- Provide copies of transcripts of daily briefing notes (translated as needed), resource and services information, and other pertinent handouts for pick-up in the family briefing room to help families keep track of the difficult and overwhelming information they are receiving.
  - In the aftermath of a mass fatality, families are often in shock and may not be able to accurately recall what was said to them. Not having the correct information can be very distressing at the time of the event and later.
- Participate in daily JFAC Management meetings to review daily activities, resolve problem areas, and synchronize future family support activities.
Ante-mortem Data Collection

The purpose of ante-mortem data collection is to collect vital information to assist in positive identification of the victims. Ante-mortem data may include a victim's physical, clothing and jewelry descriptions, unique characteristics (like tattoos, scars and birthmarks), dental records, medical records, and fingerprint records.

DNA reference samples are collected when conventional means of identification are exhausted or may be inadequate. Family reference samples and personal effects of the victim containing biological material may provide the only method by which victim remains can be identified.

ME/C or ME/C designated personnel will collect ante-mortem data. They will meet with family members in private areas within the family assistance center or contact them by phone to collect ante-mortem information. Families may also call the call center and be referred to a member of the ante-mortem data collection team for an interview.

All interviewers should be personnel specially trained in dealing with grieving individuals. It is helpful to have experienced DNA professionals available to help establish credibility in the DNA identification process.

Ante-mortem Data Collection Guidelines

- Establish ante-mortem data collection procedures.
  - Process for setting up family interviews.
  - Documentation—an ante-mortem data acquisition and entry plan.
    - Determine if interviewers will enter the ante-mortem data into a database of if data entry clerks will transcribe the data from an interview form into a database that will be used for comparisons with postmortem data.
    - Consider using the DMORT questionnaire, the VIP Personal Information Questionnaire. It is a universal questionnaire designed to expedite ante-mortem data collection.
      - Add local jurisdiction death certificate information to the questionnaire so that families do not have to provide this in another interview at the funeral home.
      - Note: Directions for filling-in the VIP Personal Information Questionnaire are available at: http://www.dmort.org/forms/Forms%20Manual-VI-DMORT.doc.
  - For multicultural populations:
    - Ensure proper formatting of first and last names and correct spelling of similar sounding names.
    - Note information about the family's religious or spiritual beliefs, including practices and rituals, daily prayer times, important dates, beliefs about autopsy, and other information that may be relevant to the rescue, recovery and disposition of their loved ones. Leaders of religious or spiritual communities can also provide guidance.
      - Demonstrating sensitivity to cultural beliefs and practices of the victims' families in a mass fatality—even when needs cannot be met—is important to effective response.
  - Identify an address for receipt of all ante-mortem records (e.g., the ME/C Office).
    - Be prepared to add changing and new information to each person’s file as it is collected from family members, friends, dentists and doctors after the initial interview.
    - Maintain logs of the files, of all incoming data/samples, and of all forwarding data/samples.
- Accountability for forwarding and receiving records is essential.
  - Be prepared for some family members to not want to provide ante-mortem information or supply DNA for kinship matches because they view doing so as a sign that they have given up hope.
- Orient/brief Ante-mortem Data Collection Team on the information they need to collect from families (forms, procedures, etc.) and their role as a representative of the ME/C Office.
- Coordinate operations with the Morgue Information Resource Center and the Morgue Records Supervisor.
- Schedule interviews with families. Allow 2 hours for each interview with a 30 minute period between interviews.
- Conduct interviews in rooms that are private and quiet.
- Reassure families that all information will remain confidential.
- Collect ante-mortem data using ME/C approved form. Once form is completed, ante-mortem information is given to the ME/C, the Morgue Information Resource Center, and any other appropriate agencies approved by the ME/C.
  - Dissuade families from acquiring or carrying the victim’s medical or dental records to the JFAC.
    - Ask family members to sign release forms to allow for the release of the missing person’s dental and medical records.
  - Call dentist and physician offices to request original dental records, x-rays, and medical records.
    - Follow-up call by sending an authorization fax that includes the HIPAA Exemption for Medical Examiners and Coroners, CFR 164.512(g), to verify and confirm the request for the victim’s medical/dental record and request timely delivery of records.
  - Monitor the status of incoming dental records, x-rays, and medical records to insure that all records are original and have been received.
    - Inform families when ante-mortem data and samples have been received.
    - Have victim records in foreign languages translated as needed.
  - Follow-up on requests that have not been received.
- Arrange for collection of DNA samples.
  - Establish DNA collection procedures to ensure proper collection procedures, prevent cross contamination, and ensure the best possible specimens are collected for subsequent laboratory testing.
  - Provide families with a copy of Appendix G, Identifying Victims Using DNA: A Guide for Families, in the National Institute of Justice’s Lessons Learned From 9/11: DNA Identification in Mass Fatality Incidents, September 2006. The family guide is available in English and Spanish and how to access it is included later in this section under Associated Tools and Resources.
  - Answer family members’ questions regarding collection of DNA samples. Explain the differences between Forensic DNA and Kinship DNA analysis.
  - Maintain an open, honest and sensitive approach to questions surrounding lineage when requesting samples for Kinship DNA analysis.
  - If buccal swabs are used, assist family members in collecting the samples.
  - If blood samples are used, arrange for family members to meet with staff who will be collecting blood samples. Allow families to go to their family physician to collect their blood sample, if they prefer to do so.
- If family members do not visit the FAC, interviews can be conducted over the telephone following the same procedures.
• For families that do not come to the FAC, DNA samples can be arranged through the ME/C and local law enforcement agencies. Send letters and consent forms to families that do not visit the FAC. If necessary, make arrangements to collect samples from anywhere in the world. When families are sending DNA samples, it is important that they are aware of complex mailing procedures for specimens and that not all companies provide this service.

• If telephone contact is made before a family arrives at the FAC, follow a scripted checklist to request location and information on the following:
  - Physician
  - Dentist
  - Hospital
  - Fingerprints
  - Photographs
  - Military service records
  - Essential vital statistics.

• Arrange for collection samples to be sent to the DNA laboratory that the ME/C Office has approved at the end of each day.

• Get daily status reports from the DNA lab.

• Once the form for ante-mortem data collection has been completed and copied/printed at the FAC, direct it to the Information Resource Center at the Morgue for review and analysis. This may also be done electronically.

• Maintain chain of custody of records via sign-in and sign-out logs.

• Keep copies of forms at the FAC for reference. When the FAC is closed, the forms will be maintained by the ME/C Office or destroyed.

**Death Notifications**

The purpose of death notification is to notify next of kin/family members when their loved one has been positively identified. Once notified, the release of the remains between the family, the morgue and the selected funeral home is coordinated.

The death notification process facilitates the return of remains and allows families to grieve, memorialize their loved ones, settle estates, and resolve legal issues.

Death notification is the responsibility of the local ME/C Office. A Death Notification Team is preferred for notifications and may include a representative of the ME/C Office, a crisis counselor, and/or clergy.

**Death Notification Guidelines**

• Establish death notification procedures.
  - Notify family members of a loved one’s death in person, if at all possible.
    • Notification can take place at the FAC or at a location of the family’s choice, such as their home. If the family’s selected location is too far for the local ME/C Office to go to, enlist the assistance of local law enforcement for that area.
    • A team rather than an individual is preferred for notification. It is better to err on the side of having support persons present in case needed than to need them and not have them present.
• Brief Death Notification Team members on death notification procedures and their role as a representative of the ME/C Office.

• Identify the Death Notification Team that will notify the family of a loved one’s death. In cases where local law enforcement in another area is making the notification, encourage them to bring a local mental health professional or member of the clergy.

• When assistance is needed to find next of kin, notify appropriate authorities.
  – If the victim lived out-of-state, the State Office of Emergency Services may assist by contacting the law enforcement agency where next of kin lives.
  – If the victim is from another country, the Agency for International Development, Office of Foreign Disaster Assistance may assist in contacting a deceased foreigner’s family through the appropriate embassy.

• Prepare a fact sheet for each family with relevant information:
  – Explain how identification was determined.
  – Explain process for release of remains.
  – Include:
    ▪ FAC number to call for services and/or referrals.
    ▪ ME/C Office contact person and phone number for further questions and information on how and when the ME’s report will become available, if they are interested.

• Assemble the Death Notification Team and ensure that all members are thoroughly briefed—before meeting with the family—on the information that will be given to the family so that they can answer as many questions as possible.

• Notify next of kin when an identification has been made and the Death Notification Team is ready to meet with them.

• In cases of fragmentation or commingling of remains, counsel families on the available options for disposition of any subsequently identified remains:
  – Notification each time additional remains are identified.
  – Notification at the end of the identification process.
  – Return of the currently identified remains to the family now for final disposition.
  – Return of all remains at the end of the identification process.
  ▪ **Note:** If DNA analysis is the method used to conduct identifications of fragmented/commingled remains, the physical re-association of all remains may take place several weeks or months after the incident.
  – Consider other requirements the family may have if they do not impact overall identification efforts.
    ▪ Counsel families on the likelihood of common tissue. **Note:** Due to the length of time required to complete the scientific identification of the tissue and/or the time required to investigate and complete legal proceedings if the incident is the result of a crime, inform families that internment of common tissue will not occur soon.

• Document the family’s decision. Complete a Release Authorization and place it in the victim’s file.

• Ask family members and loved ones if they desire crisis assistance or someone to talk to. If family members are undecided or say no, give them the family assistance call center number to use if they change their mind in the future.

• Give families copies of the fact sheet prepared for the notification and of the Release Authorization with their decision on disposition of any subsequently identified remains documented.

• Coordinate the release of the remains between the family, the morgue and the selected funeral home.
Call Center/Hotline

The call center is an important communications link to victims’ families. It manages all calls coming into the family assistance center via a dedicated toll-free telephone number. It is set up as soon as possible after notification of a mass fatality incident.

The purpose of the call center is:

- To provide a critical communications link to victims’ families and to families requesting information on missing persons.
- To act as a primary contact point for all incoming calls to the FAC.

Since most mass fatality events will also have survivors, plan to organize the call center so that it can meet the needs of family and loved ones of both decedents and survivors in the beginning. Each call received should trigger an organized and compassionate process to help find the missing and to help identify the victims.

It is recommended that the setup of the call center be coordinated with the Joint Information Center.

Plan to operate the call center 24/7, with most staffing during the day.

The call center’s communication link can be solely phones or phones and e-mail. If e-mail is included, e-mail protocols will need to be developed and staff will be needed to respond to e-mails.

Call Center Training Manual

A resource for developing the call center staff resource information and training manual is the Pentagon Family Assistance Center Information and Training Manual. The manual contains an Introduction; Pentagon Family Assistance Center (PFAC) Call Center Operation (purpose, primary functions, and PFAC services and providers); Crisis Intervention Training Basics (emotional reactions to crisis, hints for helping, and talking about death); Ground Rules for Staff; Confidentiality; Media Requests; Values Clarification; Taking Care of Yourself; Volunteer Information; Call Record and Family Member Contact Information; Questions and Concerns; and Call Center Forms and Additional Information. It is included later in this tool under Associated Tools and Resources.

Resource Information Binder for Call Center Phone Operators at Each Phone Station

A resource information binder is recommended at each phone station with:

- Call center staff resource information and training manual.
- Family assistance center information:
  - points of contact phone numbers
  - scripts for frequently asked questions*
  - daily family briefing updates
  - lists of injured, unaccounted for, and casualties
  - press releases
  - services that are available at the family assistance center
  - local area lodging information
  - transportation information.

*The Pentagon FAC had 15 phones with headphones. It received over 5,000 calls, averaging 170 calls per day. They noticed that types of calls changed over the evolution of the operations. In the beginning the calls had a tone of urgency from close family members and friends seeking information on loved ones. In the second week distant relatives and friends began to call. As victims are identified and the call center number had been increasingly publicized, callers began offering to volunteer and wanted to make donations. In the last two weeks of the operations, calls were overwhelmingly focused on a few key areas that included the memorial service, family briefing times, and FAC services.
• Donation information.
• Volunteer information (refer to Staff and Volunteer Processing Center).
• A bomb threat checklist (if deemed appropriate).

* The scripts for frequently asked questions need to be updated daily to reflect current questions and concerns of family members from family briefings and Joint Information Center public communications.

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**Call Center Guidelines**

- Establish call center procedures:
  - Respect, consideration, and sensitivity for all callers.
  - Confidentiality.
  - Based on caller:
    - Family members:
      ✓ referral to Ante-mortem Data Collection Team for collecting sensitive victim and family information,
      ✓ referral to DNA personnel (Ante-mortem Data Collection Team) to provide guidance on questions such as whether it would be helpful for a certain family member to provide a kinship DNA sample, and
      ✓ referral to Mental Health Team or Spiritual Care Team when caller is in immediate need of help beyond what is provided in call center.
    - Interested volunteers (referral to Staff/Volunteer Processing Center).
    - Donations (referral to designated agency handling donations).
    - Media (always refer to Joint Information Center).
      - Monitoring of call-type trend information and process for feedback to JFAC OIC for managing FAC activities.
  - Take time with each caller as needed—staff is dedicated to meeting the needs and understanding the concerns of each caller. This requires taking time to listen.
  - Prior to requesting information, thoroughly explain to family members the process and purpose for requesting personal information.
  - Fill out the **Call Record And Family Member Contact Form** (a Pentagon FAC form that is scripted for standard call processing and data collection and can be modified as needed) or **Crisis Call Center Intake Form**. Basic information includes:
    - Name of caller, telephone or contact information, if follow-up is required.
    - Family member/victim information, including primary next of kin, addresses, telephone numbers.
    - Reason for call.
    - Type of information provided.
    - Follow-up needed and call center or FAC staff who has responsibility for the follow-up.
  - Assess emergency and non-emergency needs of callers.
    - If a caller is in immediate need of speaking with a counselor/chaplain, ask the supervisor to bring one to the call center. If the caller is stable enough, take a name and number to pass to the chaplain/counselor for follow-up.
  - Discuss FAC services. Provide information and referral for the appropriate FAC on-site service provider.
  - If staff/volunteer needs to vent after receiving an unusual or stressful call, please do so appropriately with a co-worker or the supervisor. Take these opportunities as needed. Be sure that callers and visitors cannot hear any ‘processing’ conversations.
  - Take and distribute messages to FAC staff and service providers.
• Turn in collected information on forms to the shift supervisor at the end of each shift.
  - Data entry personnel will enter important personal and demographic information on victims and their families into the database to share with other FAC staff.
  - The supervisor will review contact sheet records and assess required follow-up contact and arrange for follow-up calls.
• Add updated information to phone operator resource binder.
• Maintain confidentiality of family information.

**Reception and Information Desk**
The reception and information desk should be in a central, highly visible area. It is the families first point of contact and plays a critical role is setting the tone of the FAC experience.

The purpose of the reception and information desk is to welcome and check-in families and visitors to the FAC to ensure FAC security, assess immediate needs of family members, and assist families in accessing services.

The reception and information desk plays an important role in taking care of families by monitoring their visits, assessing their needs, and by reporting to leadership on how families are responding to services at the FAC. This feedback allows the FAC to be proactive and flexible.

Be prepared to:
• Meet families as they arrive.
• Assist when necessary in coordinating activities to meet families’ needs.
• Provide liaison between the family and the agencies involved as needed.
• Control who gains access to the FAC. Each family member should receive a photo identification badge to allow access to secured areas and maintain the privacy of all families.

The Reception and Information Desk Team includes staff working at the desk and escorts. Staff and escorts should receive an orientation briefing that includes training on:
• Awareness of and responding to family grief.
• Importance of confidentiality.
• Continual support of families while in the FAC.
• List of services available at the FAC.
• Tour of the FAC.

**Reception and Information Desk Guidelines**
• Establish reception and information desk procedures:
  - FAC is only for families and loved ones of anticipated victims and pre-approved guests. Media, curiosity seekers, etc., are not welcome.
  - Consider establishing an order for family members to register and visit various agencies (based on family needs) to ensure that families get the assistance they need.
• Welcome families when they arrive. Escorts may meet families at the entrance and accompany them to the reception and information desk if it is not at the FAC entrance.
• Check-in families, ensuring that they are treated with respect, consideration and sensitivity. Allow people to move through the process at their own pace:
  - Ask them to sign the **FAC Daily Sign In Log**.
• Gather locator information on primary and secondary next of kin and who will be visiting the FAC on the FAC Family/Friend Registration Form. Thoroughly explain the process and purpose of requesting this personal information prior to asking questions.
  ▪ Forward this information to administration, the call center, and the ante-mortem data collection team for further processing and reporting.
• Provide each family member/friend with a photo ID badge for identification with a same day pass. The photo ID badge should be a different color from staff badges so that family members and staff can be quickly distinguished. On subsequent visits, check IDs and issue same day passes.
• Assess emergency and non-emergency needs of family member(s).
• Offer information on available services and connect families with the appropriate on-site service providers.
• Give directions for signing in on future visits and for signing out.
  • Assign an escort to each family who can take them to a designated area where they will be more comfortable and can be located if necessary or to requested service provider.
    • Escorts can inform families of available services, provide written information that has been developed, provide the schedule for family briefings, assist families in navigating FAC services, and help them with any need that arises during their stay at the FAC.
      ▪ **Expect families visiting the FAC for the first time to use the escorts extensively and to rely less on them during subsequent visits.**
  • Provide information and referral services.
• When families leave the FAC, ask them to check-out and confirm that the FAC has their address and phone number so that they can be contacted with additional information, including notification of a loved one’s death.

**Spiritual Care Services**
The purpose of spiritual care services is to:

• Provide interdenominational pastoral counseling and spiritual care for people of all faiths who request it.
  – Being accessible to the families, friends, and co-workers of victims and to the FAC staff and volunteers during all FAC hours, particularly during large group meetings and events.
• Conduct religious services and provide worship opportunities.
• Provide emotional support/crisis intervention and assist mental health staff as needed.
• Serve as a member of the Death Notification Teams.

At the Pentagon FAC chaplains were at the FAC the day it opened. They were located at the main entrance point (near the reception/information desk and mental health services), which made their services highly visible. More than 58 chaplains and 22 assistants provided spiritual care with nine to 16 per shift. More than 4,800 contacts were made, of which about 3,800 included family members and friends and about 1,000 were FAC staff and volunteers.

**Spiritual Care Guidelines**

• Establish the procedures for spiritual care services.
  – Emphasize reaching across faith group boundaries and not proselytizing. In coordination with mental health counselors, protect family members from being confronted by unwelcome forms of spiritual intrusion.
- Be available throughout the FAC to keep a watchful eye on the emotional reactions of those around them. Guide family members to a private room where they can talk about their loss and pray as needed.
- At a minimum, maintain records of the number of contacts and the assistance provided to document FAC activities and manage staffing requirements.

- Orient team to procedures.
- Monitor the information received at family briefings, particularly the numbers of positive identifications and of missing victims.
- Choose strategic positions throughout the family briefing room during briefings to reach out to any family experiencing grief or trauma.
- Assist with ante-mortem interviews and death notifications as needed.
- Assist with callers to the call center as needed.
- Walk around the FAC, visiting and talking to people and monitoring how families and how FAC staff and volunteers are holding up over time.
- Share meals with families to provide support.
- Make counseling in private rooms available.
- Arrange suitable inter-faith memorial service in the days following the incident. Offer single-denominational services at the FAC on Sundays.
- Make materials available to help those who are grieving and to positively reinforce the pastoral contacts with family members.
- Work with mental health staff in providing emotional support for FAC staff and volunteers.
- Work closely with the mental health services staff to maximize assets and minimize functional overlap.
- Attend all special events (e.g., visits to the incident site) to monitor family reactions during activities and provide support.

**Mental Health Services**

The purpose of mental health services is to:

- Assist family members and FAC staff and volunteers in understanding and managing the full range of grief reactions.
  - Being accessible to families and staff and volunteers during all FAC hours, particularly during large group meetings and events.
- Provide Psychological First Aid, crisis intervention, mediation, and management of ‘at risk’ family members, including child and adolescent counseling.
- Provide referrals, as requested, to mental health professionals and support groups that are in the family member’s local area.
- Provide Psychological First Aid and grief process educational materials for the FAC.

**Mental health services goals** are to provide services based on the most current best practices:

For families: To help families grieve and stabilize as they prepare to move on to the next phase of their lives.
- The sooner educational information and counseling staff are available, the more likely family members will become aware of issues and seek assistance.

For staff and volunteers: To help staff and volunteers cope with the common stress symptoms that result from working in mass fatality response and prevent/mitigate traumatic stress and its symptoms—physical illness and disease, mental and psychological disorders, and relationship problems.
Mental Health Services Approach

Psychological First Aid* is the recommended mental health strategy in the immediate aftermath of the disaster. This focus can last for several weeks for large-scale incidents.

* The literature suggests that psychological debriefing may have adverse effects on some disaster survivors and first responders. As a result, many disaster response organizations have chosen to utilize PFA as the supportive intervention of choice for responders in the early aftermath of disaster. It is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and foster short and long-term adaptive functioning.

An additional approach to consider has been developed by the Palo Alto Medical Reserve Corps—a three-stage treatment alternative to Critical Incident Stress Debriefing. Its three phases are: Phase I—psychological first aid, Phase II—intermediate support/anxiety control, and Phase III—continued support/control or support/control plus prolonged exposure. All three phases are empirically derived therapeutic interventions for acute stress reactions following mass casualty trauma.

Resources for Psychological First Aid and the Palo Alto Medical Reserve Corps model are presented later in this document under Associated Tools and Resources.

Mental Health Services Staffing

It is important to maintain an appropriate mix of professionals—social workers; marriage, family and children therapists; psychologists, psychiatrists, and grief counselors—on duty. Aim to develop a core team for continuity.

The Mental Health Services Team will participate in orientation/training in Psychological First Aid (PFA). For long-term FAC operation, Team members may also participate in orientation/training for evidence based interventions developed by the Palo Alto Medical Reserve Corps to assist families.

At the Pentagon FAC there were an average of 20 counselors and two administrative assistants on each shift. Each counselor averaged 23 in-person and six telephone contacts a day. An estimated 18,000 contacts were made during the first month. Counselors were located at the main entrance point (near the reception desk and spiritual care services), which made their services highly visible.

In response to the 2001 World Trade Center attack, American Red Cross Disaster Mental Health Services had a ratio of one worker to 10 family units at the Pier 94 FAC.

Mental Health Services Guidelines

- Establish mental health/emotional support services procedures.
  - Use of Psychological First Aid.
  - Availability throughout the FAC.
  - Recordkeeping. At a minimum maintain records of the number of contacts and the assistance provided to document FAC activities and manage staffing requirements.
  - Confidentiality and privacy protection.
  - Medication. Disaster Psychiatry Outreach is a resource for information on the disorders victims are likely to develop, medications appropriate to dispense on site, and crisis interventions.

- Orient team to procedures and to local resources.
  - Make referral lists available to all staff.
  - Consider using the generic title of ‘counselor’ for all mental health staff to help lessen the avoidance some people have toward the term mental health.

- Walk around the FAC, visiting and talking to people and monitoring how families and how FAC staff and volunteers are holding up over time. Serve as mental health eyes and ears throughout the FAC.
- Guide family members to private rooms for counseling—re: spectrum of normal grief reactions, crisis intervention, mediation, management of ‘at-risk family members, child/adolescent counseling, family counseling, consultation services, and referrals for longer-term follow-up counseling as needed.
- Provide mental health services/consultation in child care center as needed.
- Make PFA handouts for survivors and educational materials on the grief process, how to answer children’s questions about the tragedy, etc., available for distribution throughout the FAC.
- Monitor the information received at family briefings, particularly the numbers of positive identifications.
- Assist with ante-mortem interviews and death notifications as needed.
- Provide behavioral health assessments and appropriate interventions for callers to the call center as needed.
- Attend all special events (e.g., incident site visits) to monitor behavioral health reactions during activities.
- **Provide mental health services for the FAC staff and volunteers** and direct staff and volunteers to additional counseling resources as needed.
  - This is a significant role for the team. A crisis situation is an intense experience for those involved in the response effort—physically, emotionally and psychologically. Research shows that the closer an individual works with traumatized victims, the more likely he or she will experience secondary trauma. Emotional and spiritual support can help minimize the vicarious trauma impact on personnel who are directly supporting victims.
- Work closely with the chaplains to maximize assets and minimize functional overlap.
- Provide consultation to FAC leadership and leaders of other teams.

**First Aid/Medication**

The medical aid station’s purpose is to:
- Provide immediate emergency medical evaluation and stabilizing care to family members and FAC staff and volunteers.
- Serve as a liaison with medical service providers in the event of a medical emergency.
- Assist family members by providing general support and comfort.

The FAC medical area for the Oklahoma City bombing had eight beds and was staffed by registered nurses, paramedics and doctors.

The staff will consist of doctors, nurses, and technicians and is ideally stationed near mental health and spiritual care services.
Appendix VIII: Family Assistance Center

**First Aid/Medication Guidelines**

- Establish first aid/medication procedures.
  - Including access to pharmaceuticals.
- Position throughout the facility during family briefings and other events when large numbers of families are gathered for activities.
- Provide first aid/medication as needed.
- Arrange for transport to hospital as needed.

**Translation and Interpretation Services**

The purpose of translation and interpretation services is to:

- provide translation and interpretation services in individual and family meetings and during family briefings and
- to translate FAC materials and ante-mortem records as needed.

At the 9/11 New York City Pier 94 FAC, 35-75 volunteer translators worked 8-12 hours shifts and were kept busy all of time.

**Translation/Interpretation Services Guidelines**

- Establish translation and interpretation services guidelines and procedures.
- Be available to all families and all agencies and staff/volunteers during all hours of operation.
  
  Assist with translation for:
  
  - Services for families.
  - Written materials that are available for families.
  - Translation of dental and medical records from other countries.

**Child Care**

The purpose of child care is to provide a safe and secure environment for FAC families’ children during main FAC operating hours. The primary goal is to establish a friendly and healthy setting for short-term care while providing some respite for parents as they deal with a very difficult, challenging situation.

Services include:

- Providing activities and caring support for children.
- Providing structure, comfort and acknowledgement to minimize the impact of traumatic stress and to meet children’s unique needs.
- Providing information and referral for families who need more extensive child care after FAC hours.

It is recommended that only licensed child care providers be used to provide these services.

The Pentagon FAC cared for 140 different children, aged 2 months to 21 years (including youth with special needs) from 66 families. On average, the staff cared for 21 children per day.

Operating hours were:

- 8:00 a.m. to 8:00 p.m. daily (in initial phase)
- 8:00 a.m. to 5:00 p.m. daily (later when the intensity of the operation decreases).

Hours were adjusted for special events.
Child Care Center Guidelines

- Establish child care center procedures.
  - Whether or not parents/guardians must be on site at FAC when their children are in child care.
  - How security will be ensured, e.g., take a Polaroid photo of each child and his/her parent when the child is brought to child care. Check the photo and/or identification prior to releasing child.
  - Evacuation plan.
- Make sure room(s) is child safe based on the state’s recommendations for child care operations.
- Set up the room(s) daily:
  - Organize play areas with toys accessible to children.
  - Set up bathroom and diaper changing areas.
  - Arrange for snacks, juice, and meals.
  - If a television is available, only use it for tapes and DVDs—not for general TV programs to avoid news broadcasts.
- Orient new staff:
  - Review safety standards.
  - Review hygiene standards for diapering and toileting.
  - Review sign-in and sign-out procedures.
  - Provide information available on dealing with children’s grief/disaster response, number to call if help is needed, evacuation plan, etc.
- Brief staff at the beginning of each shift.
- Sign-in (parent/guardian’s name, child’s name and age, time in).
  - Get any special instructions from parents, such as food allergies, medication, approximate time of return and planned location(s) in the building in case parents must be notified if their child is experiencing distress and since they have primary responsibility for evacuating their child(ren) in case of emergency.
- Engage children in age-appropriate activities/provide care.
- Coordinate/monitor special needs of children and coordinate activities to meet those needs (art therapy, trained therapy dogs, child psychiatrists, social workers, etc.).
- Communicate with parents/guardians to pass on appropriate information on activities and issues.
- Sign-out (parent/guardian check Polaroid photo of parent and child/show identification as needed, signs name and time out).
- Daily closing procedures:
  - Ensure that all children have been accounted for.
  - Prepare a daily shift report.
  - Disinfect toys—especially those that children put in their mouths. Place in a sink or tub and spray with bleach solution, rinse, and air dry.
  - Organize room and leave any special instructions for opening—sweeping, replacement of towels, etc.
  - Return key to the FAC Officer in Charge.
Food Service
Food for families and for staff is required. The purpose of food services is to provide three high quality meals daily and make snacks and drinks available during all hours of operation.

Food Services for Families and Staff Guidelines

- Arrange for two dining areas—one for families and staff and one for staff only (for when staff want private time/time to regroup).
- Provide food (catered, made on premises, food vouchers for the hotel restaurant if the FAC is in a hotel).
  - Three high quality meals daily.
  - Beverages and snacks during all FAC hours of operation.
- Spiritual Care counselors and mental health counselors should be available throughout the hours of operation in both dining rooms and in snack/beverage areas.

Support Ideas and Activities Families Will Appreciate
At the Pentagon Family Assistance Center (PFAC), families identified the following things as valued support in addition to the many available services:

- Memorial Table.
- America’s Heroes Board.
- Pentagon (Incident) Site Visits.
- Families Connecting with Other Families.
- Pentagon Remnant Vials.

These supportive measures can easily be modified for replication during other mass fatality incidents.

Examples of PFAC Support Ideas and Activities Families Appreciated

Memorial Table
The memorial table lined one side of the family briefing room. It provided space for families to place mementos, photos, and letters honoring their loved ones. The memorial table became a powerful and emotional area where family members, visitors, staff, and volunteers solemnly and reverently read the touching letters and viewed the photos of victims.

Heroes Board
The graphics specialists produced a special board that was displayed at the front of the family briefing room. The display was lined with laminated photographs and biographies of the victims that had been published in The Washington Post. New biographies were added daily as they were printed in the paper. The biographies provided a more personal description of the victims than a standard obituary. The American Heroes Board became a place where families, staff, and volunteers would frequently gather to read about the lives of those who had perished.
### Examples of PFAC Support Ideas and Activities Families Appreciated

#### Incident Site Diagrams and Charts
A number of family members had a need to know where their loved one was in the Pentagon or in the aircraft at the time of the attack and how the attack site was changing over time. In response, graphics specialists developed graphic displays of the affected Pentagon offices and seating diagrams of Flight 77. To a number of families, seeing where their loved one was at the time of the attack helped them better understand and process what happened. As the recovery process progressed, families were kept updated on the status of the operation and diagrams were used to show the progress of the efforts at the attack site. These charts and diagrams proved to be a powerful way to communicate information to families.

#### Incident Site Visits
Family members asked to view the site where their loved ones died. This was originally discouraged, but when it became clear how important this was to the families, necessary arrangements were made for visits. FAC staff conducted the first site visit, which occurred the weekend after the attack. Family members were escorted to the site on buses. A mental health counselor and chaplain were assigned to each bus. Medical personnel and therapy dog teams were on-site to provide additional support. The viewing site was 100 yards from the actual attack site, since recovery work was still being done. FAC staff arranged for a table at the site where families could leave flowers (provided by the FAC) and other mementos of their loved one. A viewing platform was erected for families to see the site from an elevated position. Families were also briefed on the attack, using diagrams and charts to explain what happened. Families were allowed to stay at the site as long as they wished. Blankets were provided as days got colder. Several more visits were arranged. The final set of visits allowed families to get closer to the attack site since the recovery phase had been completed. Going to the actual location where loved ones died proved to be a significant part of the grieving process.

#### Families Connecting with Other Families
Families were very interested in meeting colleagues of loved ones and wanted to connect with other families experiencing a similar loss. Locations in the family briefing room were designated for families to gather and meet. This provided interested families with opportunities to share information, develop relationships, and form support groups.

#### Incident Remnant Vials
Many family members requested remnants from the attack site. Remnants were obtained, placed in vials and put in small wooden boxes (designed specifically for this purpose, they were produced and donated by a wood carver). The FAC managed distribution to ensure that every family received one. FAC staff stressed that the vials contained rubble from the site, free of human remains and toxic materials, and were not to be considered as the partial remains of loved ones. To the families, the vials were reminders of where their loved ones had perished.

#### Special Support Activities
On September 24, a large number of families attended a special Kennedy Center concert hosted by the First Lady. The concert was a special tribute to those who were lost or missing, family members, and survivors. Although family members did not request this, this event and others like it provided a brief reprieve for families.
### Examples of PFAC Support Ideas and Activities Families Appreciated

#### Memorial Service and Support

One month after the event, a memorial service was held. It appeared to serve as an important milestone in the families’ grieving process. After the memorial service, many families began returning to work, reconnecting to their communities, and resuming their lives.

Some families preferred not to go to the Pentagon for the service. To meet their needs a live satellite dish was positioned to broadcast the event via satellite to the family briefing room so family members, staff, volunteers, and hotel personnel could watch the event. The decision to have a dedicated satellite dish allowed the FAC staff sufficient time to coordinate the logistics for the transmission and avoid the risk of complications that could result from a last minute link-up with a public broadcast network.

Children at the child care center who were eight years old or older and had their parent’s/guardian’s permission, were brought to the family briefing room to view the service. Professional staff members were on hand to support any issues the children or family members had. The FAC staff also made arrangements to provide all families with a video tape of the memorial service.

#### Additional FAC Services

Following a large-scale event, family assistance typically involves a range of services provided by local, state, and federal agencies as well as nonprofit and private organizations. The additional family assistance center services needed will depend on the nature of the incident and on the victim population. Examples of these services—in alphabetical order—include:

- Benefits Counseling and Assistance.
- Financial Assistance.
- Financial Planning.
- Laundry Services.
- Legal Assistance.
- Physical Health Services.
- Salvation Army Services.
- Therapy Dogs International Services.
- US Department of State Services.
- US Department of Veterans Affairs Services.
- US Federal Bureau of Investigation Victim Witness Assistance Program.
- US Social Security Administration Benefits Assistance.
- Web Search/Lead Investigation Center to manage large numbers of missing persons that are not presumed dead.

If the victim population includes members of the armed services or government employees, there are many services available that can be accessed for victim families. If the victim population is predominantly comprised of employees of a large corporation, it is also likely that the impacted corporation will be actively involved in the family assistance center.

The many additional services that provide on-site services at the FAC will need to:

- Appoint a Team Leader.
- Establish procedures for operation.
- Maintain data on the numbers of families/family members served.
FAC Logistics

The FAC logistics requirements are extensive. This section outlines the general requirements for:

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

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

Procedures For Managing Logistics/Support Requirements

The FAC Logistics Officer will identify FAC service and support needs and will work closely with Emergency Operations Center Logistics and the Staff and Volunteer Processing Center to procure and allocate service and support needs. The FAC Logistics Officer will also work closely with FAC administrative staff to track and maintain required documentation for supplies, equipment and personnel.

Staffing Requirements

A core staff from the FAC managing agency and from the local ME/C Office will be important to ensuring continuity for families. Involving additional agencies with experience in providing family assistance for mass fatalities is strongly recommended. The remainder of the FAC staff will be a largely volunteer staff from multiple agencies and organizations.

Guidelines for Staffing the FAC

Information on agencies with expertise in mass fatality family assistance is followed by FAC lead organization and tables for staffing requirements and for additional services/resources.

Agencies with Expertise in Mass Fatality Family Assistance

Examples of agencies that have experience in managing a family assistance center include the American Red Cross and the DMORT Family Assistance Center Team.

American Red Cross

American Red Cross (ARC) involvement is activated by contacting the local Red Cross chapter. Local chapter paid and volunteer staff provide the initial response in the form of a Disaster Action Team (DAT). In larger incidents, the DAT may conduct an initial assessment and alert the chapter of the need for a Disaster Relief Operation (DRO). If the disaster is deemed to be beyond local capacity, the local chapter will contact the Red Cross state lead chapter for assistance. If the state lead chapter determines that an incident requires resources beyond the Red Cross resources of the entire state, the state lead unit requests assistance from the Red Cross National Disaster Operations Center (DOC), which will then bring to bear Red Cross resources from across the nation.

The American Red Cross Disaster Services functions and activities that may be available as part of a mass fatality response include:

- Assistance in setting up the FAC and in escorting family members to the site.
- Administration—coordinate and ensure appropriate performance of the Red Cross functions, including effective communication with other agencies, ARC headquarters, daily activity reports, staffing, equipment and supply requests.
• Immediate Emergency Assistance To Families—provide money for travel and transportation, food, clothing, shelter, and funeral costs.

• Hotline to provide immediate access to national and community-based resources, ranging from grief counseling to how to answer questions from children related to the tragedy.

• Disaster Mental Health Services—provide mental health services to families and staff at the FAC.

• Spiritual Care—provide spiritual care services and reach across faith group boundaries without proselytizing. Work in coordination with mental health counselors to protect family members from being confronted by unwelcome forms of spiritual intrusion. Provide supportive spiritual care through empathic listening, demonstrating an understanding of persons in spiritual and emotional distress.

• Child Care—ensure that children at the FAC are provided a safe and secure environment to play while their families are at the FAC. Provide structure, comfort, and acknowledgement to meet the unique needs of children immediately following a disaster and to minimize the impact of traumatic stress.

• Interpretation and Translation Services—staff the FAC and be available to clients, agencies and personnel during the hours of operation.

• Supervision and management of staff and family dining areas.

• Provide food for staff and volunteers.

• Public Affairs—provide appropriate information to the media outside the FAC and work with mental health services to prepare family members who wish to address the media.

• Logistics—support the physical management of ARC activity at the FAC and act as a liaison with the FAC Logistics Officer and/or facility landlord to address facility requirements and daily supply needs.

• Coordination of therapy dogs.

• Family Gift Program, a cash grant program to assist with living expenses for up to one year while long-term recovery issues are being addressed.

**DMORT Family Assistance Center Team**

DMORT assistance is accessed in California through the California Coroner Mutual Aid process. The DMORT Family Assistance Center Team (FACT), working under the local ME/C, can:

• Provide guidance in setting up the FAC.

• Collect ante-mortem data, including the collection of DNA reference samples.

• Provide information to next of kin.

• Assist the ME/C with death notifications.

The expertise of organizations such as the American Red Cross and the DMORT FACT will improve response time in activating a joint family assistance center, minimize management and training issues, and enhance operational capability.
**FAC Local Organization**
To the extent possible, staffing and training requirements should be planned in advance to avoid confusion. Government and nonprofit organizations are ideally the primary providers of FAC services. Some commercial businesses may also become involved.

It is recommended that service providing organizations and commercial businesses be carefully screened and approved by the appropriate legal policy and general counsel officials prior to being integrated into the operation.

**Family Assistance Center Staffing Requirements**
A family assistance staff table and a table for additional FAC services are provided to assist your planning.

The family assistance staff table presents the beginning of the process to identify the types of personnel and the alternate staff/potential resources for these staff positions. Continue to fill in the Alternate Staff/Resources column based on what is appropriate for your jurisdiction.

The quantity or number of staff needed will be determined at the time of the incident, based on its complexity and the estimated number of potential victims.

When determining the number of staff required, *plan for 8 to 10 family members/loved ones for each missing or deceased disaster victim.*

### Family Assistance Staff

<table>
<thead>
<tr>
<th>Staff</th>
<th>Quantity</th>
<th>Alternate Staff/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>JFAC Management Staff</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAC Officer in Charge</td>
<td></td>
<td>Agency in Charge</td>
</tr>
<tr>
<td>Deputy Officer in Charge</td>
<td></td>
<td>Agency in Charge</td>
</tr>
<tr>
<td>Family Assistance ME/C Officer in Charge</td>
<td></td>
<td>Local ME/C Office</td>
</tr>
<tr>
<td>FAC Logistics Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Logistics Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Advisor (to research and resolve complex legal issues raised by staff and families)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FAC Administration/Finance Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shift Supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative/Clerical Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Entry Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graphics Specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel/Interagency Coordination Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shift supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-3 phone/receptionists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information &amp; Communications Systems Technical Support Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tech Support Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family Briefings Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Leader</td>
<td></td>
<td>Local ME/C Office, DMORT FACT</td>
</tr>
</tbody>
</table>

Appendix VIII: Family Assistance Center
### Family Assistance Staff

<table>
<thead>
<tr>
<th>Staff</th>
<th>Quantity</th>
<th>Alternate Staff/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coroner Investigators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin Support Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ante-mortem Data Collection Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shift Supervisors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coroner Investigators</td>
<td></td>
<td>DMORT FACT, law enforcement agents, funeral service personnel</td>
</tr>
<tr>
<td>DNA Specialists/Genetic Counselors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Staff for blood draws (DNA collection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Entry Clerks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Death Notification Team

| Team Leader                                |          | Experienced death investigators, funeral directors             |
| Coroner Investigators                      |          |                                                                |
| Admin/Support Staff                        |          |                                                                |

#### Call Center Team

| Team Leader/Lead Supervisor                |          | Local hotline staff, Red Cross                                  |
| Shift Supervisors                         |          |                                                                |
| Phone Operators                           |          |                                                                |
| Data Entry Staff                          |          |                                                                |

#### Reception & Information Desk Team

| Team Leader                                |          | Red Cross, Salvation Army                                       |
| Shift Supervisors                          |          |                                                                |
| Intake Specialists                         |          |                                                                |
| Escorts (may be helpful if they have counseling training) |        |                                                                |

#### Spiritual Care Team

| Team Leader                                |          | Public Safety Chaplains, Faith-based Disaster Relief Services (e.g., Lutheran, Baptist, Methodist, Muslim, Assembly of God, etc.), Tzu Chi Foundation, local Council of Churches, local churches |
| Shift Supervisors                          |          |                                                                |
| Chaplains                                  |          |                                                                |
| Chaplain Assistants                        |          |                                                                |

#### Mental Health Services Team

| Team Leader                                |          | Mental Health Department and approved contractors, Drug and Alcohol Department and approved contractors, National Association of Social Workers, State Association of Marriage and Family Therapists, State Psychological Association, Disaster Psychiatry Outreach, American Red Cross Disaster Mental Health Services |
| Shift Supervisors                          |          |                                                                |
| Mental Health Professionals                |          |                                                                |
| Administrative Assistants                  |          |                                                                |

#### First Aid/Medication Team

| Team Leader                                |          | Jurisdiction Health & Hospital Agency, Public Health Department, Medical Volunteers for Disaster Response, Occupational Health & Safety Agency, Federal Disaster Medical Assistance |
| Doctors                                    |          |                                                                |
| Nurses                                     |          |                                                                |
### Family Assistance Staff

<table>
<thead>
<tr>
<th>Staff</th>
<th>Quantity</th>
<th>Alternate Staff/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paramedics</td>
<td></td>
<td>Teams, State Disaster Medical Assistance Teams, American Red Cross</td>
</tr>
<tr>
<td><strong>Translation/Interpretation Services Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Leader</td>
<td></td>
<td>Local CBOs serving non-English speaking populations, Social Services Agency, local Consulate and Embassy representatives, US Department of State</td>
</tr>
<tr>
<td>Translators/Interpreters</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Care Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Leader/Lead Supervisor</td>
<td></td>
<td>Church of the Brethren (MOU with Red Cross), Save the Children, Local Recreation Department</td>
</tr>
<tr>
<td>2 Staff caregivers (minimum)</td>
<td></td>
<td>Use standard staff/child ratios</td>
</tr>
<tr>
<td><strong>Food Services Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Leader</td>
<td></td>
<td>Red Cross, Salvation Army, &amp; Jurisdiction’s Department of Corrections, State Restaurant Association</td>
</tr>
<tr>
<td>Assistants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Services Teams</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To be determined</td>
<td></td>
<td>Determined based on required teams</td>
</tr>
</tbody>
</table>

This table does not include the American Red Cross or DMORT FACT, which were described at the beginning of the staff section and included in the required staff table above.

### Additional FAC Services

<table>
<thead>
<tr>
<th>Additional FAC Service Categories</th>
<th>FAC Resources Agencies &amp; Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits Counseling and Assistance</strong></td>
<td></td>
</tr>
<tr>
<td>• Assists with death claim benefits, victims’ unpaid compensation, Workers’ Compensation Program employee injury and death claims, death gratuities, and medical, disability and/or life insurance benefits, settlements, and claims.</td>
<td></td>
</tr>
<tr>
<td>• Coordinates the wide range of servicing organizations to facilitate how to access all available financial benefits to which families may be eligible and the processing of payments to families.</td>
<td></td>
</tr>
<tr>
<td><strong>Financial Assistance Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Assists families with donations, cash assistance, food stamps, and other benefits as needed.</td>
<td></td>
</tr>
<tr>
<td><strong>Financial Planning Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Advises on banking issues, payment of bills, and budget and cash flow management.</td>
<td></td>
</tr>
<tr>
<td>• Advises on organization of family finances.</td>
<td></td>
</tr>
<tr>
<td>• Advises on savings options and stocks versus bonds or certificates of deposit for short-term resources.</td>
<td></td>
</tr>
<tr>
<td>• Advises on analysis of future investments.</td>
<td></td>
</tr>
<tr>
<td>• Advises on annuities and insurance policy information.</td>
<td></td>
</tr>
<tr>
<td>• Advises on working with other professionals, such as accountants, attorneys and insurance professionals.</td>
<td></td>
</tr>
</tbody>
</table>
## Additional FAC Services

<table>
<thead>
<tr>
<th>Additional FAC Service Categories</th>
<th>FAC Resources Agencies &amp; Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Laundry Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Washers and dryers for facility needs. May also be needed for families.</td>
<td></td>
</tr>
<tr>
<td>• Laundry service.</td>
<td></td>
</tr>
<tr>
<td><strong>Legal Assistance</strong></td>
<td></td>
</tr>
<tr>
<td>• Meets with each family to ascertain relevant facts concerning legal issues and provides consultation on issues such as:</td>
<td></td>
</tr>
<tr>
<td>- Securing victim’s automobile(s), housing and personal effects;</td>
<td></td>
</tr>
<tr>
<td>- Accessing victim’s single-holder bank and brokerage accounts;</td>
<td></td>
</tr>
<tr>
<td>- Creditor matters;</td>
<td></td>
</tr>
<tr>
<td>- Identity theft;</td>
<td></td>
</tr>
<tr>
<td>- Child custody;</td>
<td></td>
</tr>
<tr>
<td>- Media relations;</td>
<td></td>
</tr>
<tr>
<td>- Estate administration; and</td>
<td></td>
</tr>
<tr>
<td>- Probate issues.</td>
<td></td>
</tr>
<tr>
<td>• Advises on how to respond to and evaluate solicitations for representation in possible mass casualty tort claims.</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Massage</td>
<td></td>
</tr>
<tr>
<td>• Chiropractic treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Salvation Army Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Has disaster response teams. Typical focus is on aiding emergency response workers.</td>
<td></td>
</tr>
<tr>
<td>• Provides grief counseling at FAC.</td>
<td></td>
</tr>
<tr>
<td>• Willing to assist in the FAC in any way needed, e.g., warmly greeting families and attending to their needs.</td>
<td></td>
</tr>
<tr>
<td><strong>Therapy Dogs International Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Specially trained therapy dogs and qualified handlers to support the FAC mission.</td>
<td></td>
</tr>
<tr>
<td>• The dog teams help comfort families and provide companionship during FAC visits.</td>
<td></td>
</tr>
<tr>
<td>- Dogs are available for petting and hugging, providing unconditional acceptance and affection.</td>
<td></td>
</tr>
<tr>
<td>• They provide a great deal of comfort to the children in the child care center.</td>
<td></td>
</tr>
<tr>
<td>- Handlers assist FAC by defusing the stress so that all can enjoy a few moments of focusing on matters other than those associated with the tragedy.</td>
<td></td>
</tr>
</tbody>
</table>
### Additional FAC Services

<table>
<thead>
<tr>
<th>Additional FAC Service Categories</th>
<th>FAC Resources Agencies &amp; Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>US Department of Justice Office of Victims of Crime and State Victim Assistance and Compensation Programs</strong> (if the mass fatality is related to a criminal act)</td>
<td></td>
</tr>
<tr>
<td>• Provides a representative to the family assistance management team to coordinate with other members on DOJ-related issues.</td>
<td></td>
</tr>
<tr>
<td>• Provides information to victims’ family members, on-site and off-site, as required under the Victims of Crime Act of 1984, the Victim and Witness Protection Act of 1982 as amended, other relevant statutes, and the 1995 Attorney General Guidelines for Victim Assistance.</td>
<td></td>
</tr>
<tr>
<td>• Assists the FAC with additional trained and experienced crisis counselors through the Office for Victims of Crimes Community Response Program.</td>
<td></td>
</tr>
<tr>
<td>• Provides updates to victims’ family members on the progress of the criminal investigation.</td>
<td></td>
</tr>
<tr>
<td><strong>US Department of State Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Official notification of foreign governments that have citizens involved in the mass fatality.</td>
<td></td>
</tr>
<tr>
<td>• Assistance with notifying and obtaining ante-mortem information from families of victims living in other countries.</td>
<td></td>
</tr>
<tr>
<td>• Maintenance of daily contact with foreign families that do not travel to the United States.</td>
<td></td>
</tr>
<tr>
<td>• Assistance with entry into the United States and to extend or grant visas for families of foreign victims.</td>
<td></td>
</tr>
<tr>
<td>• Assistance in the effort to provide the ME/C with the necessary information on foreign victims to complete death certificates.</td>
<td></td>
</tr>
<tr>
<td>• Facilitation of necessary consulate and customs services for the return of remains and personal effects to the victim’s country.</td>
<td></td>
</tr>
<tr>
<td><strong>US Department of Veterans Affairs</strong></td>
<td></td>
</tr>
<tr>
<td>• Claims Processing</td>
<td></td>
</tr>
<tr>
<td>• Toll-Free Telephone Service</td>
<td></td>
</tr>
<tr>
<td>• Web Page</td>
<td></td>
</tr>
<tr>
<td><strong>US Federal Bureau of Investigation Victim Witness Assistance Program</strong> (if the mass fatality is related to a criminal act)</td>
<td></td>
</tr>
<tr>
<td>• Notifies victims of their rights as a Federal crime victim.</td>
<td></td>
</tr>
<tr>
<td>• Provides information on the FBI’s criminal investigation through a victim notification system, if the victim chooses to be notified.</td>
<td></td>
</tr>
<tr>
<td><strong>US Federal Emergency Management Agency Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Helps families apply for assistance through other agencies.</td>
<td></td>
</tr>
<tr>
<td>• Offers limited assistance in the areas of crisis counseling, mortgage and rental assistance, and unpaid funeral expenses.</td>
<td></td>
</tr>
<tr>
<td>• Helps with financial assistance to cover lost wages, loss of support, and uncovered or uninsured medical treatment.</td>
<td></td>
</tr>
</tbody>
</table>
# Additional FAC Services

<table>
<thead>
<tr>
<th>Additional FAC Service Categories</th>
<th>FAC Resources Agencies &amp; Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>US Social Security Administration Benefits Assistance</strong></td>
<td></td>
</tr>
<tr>
<td>• Provides families with information on eligibility requirements for benefits.</td>
<td></td>
</tr>
<tr>
<td>- Survivor benefits for an eligible widow or widower age 60 or older, 50 or older if disabled,</td>
<td></td>
</tr>
<tr>
<td>and any age if caring for a child under the age of 16.</td>
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</tr>
<tr>
<td>- Survivor benefits for children under age 16 or unmarried and under age 19, but still in high</td>
<td></td>
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<tr>
<td>school.</td>
<td></td>
</tr>
<tr>
<td>- Survivor benefits for disabled adult children.</td>
<td></td>
</tr>
<tr>
<td>- Survivor benefits for parents, if the worker was the primary means of support.</td>
<td></td>
</tr>
<tr>
<td>- A special one-time payment of $255 to the worker’s surviving spouse or minor children.</td>
<td></td>
</tr>
<tr>
<td>• Helps families file claims for earned Social Security, disability benefits, and disbursed</td>
<td></td>
</tr>
<tr>
<td>death benefits without a death certificate.</td>
<td></td>
</tr>
<tr>
<td><strong>Web Search/Lead Investigation Center</strong></td>
<td></td>
</tr>
<tr>
<td>A Web Search/Lead Investigation Center will be needed if the mass fatality involves large</td>
<td></td>
</tr>
<tr>
<td>numbers of missing persons who are not presumed injured or dead (e.g., Hurricane Katrina).</td>
<td></td>
</tr>
<tr>
<td>The purpose of the Web Search/Lead Investigation Center is:</td>
<td></td>
</tr>
<tr>
<td>• To perform searches for missing persons using numerous resources—mounting sophisticated</td>
<td></td>
</tr>
<tr>
<td>Internet searches, making calls, and doing mailings. Finding missing persons who are alive</td>
<td></td>
</tr>
<tr>
<td>allows the ME/C to focus the human remains identification process on those who are truly</td>
<td></td>
</tr>
<tr>
<td>missing.</td>
<td></td>
</tr>
<tr>
<td>• To follow the wishes of the individual found concerning reunification with family and</td>
<td></td>
</tr>
<tr>
<td>notifications made to family or friends.</td>
<td></td>
</tr>
<tr>
<td>• To assist in locating relatives for DNA samples and for information essential to making</td>
<td></td>
</tr>
<tr>
<td>positive identifications of human remains.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>If a Web Search/Lead Investigation Center is required, involve stakeholder agencies as early as</td>
<td></td>
</tr>
<tr>
<td>possible. This includes the State Police, National Center for Missing and Exploited Children,</td>
<td></td>
</tr>
<tr>
<td>and the National Center for Missing Adults. They have the greatest expertise in finding</td>
<td></td>
</tr>
<tr>
<td>missing persons and have access to databases that are not accessible by the public. These are</td>
<td></td>
</tr>
<tr>
<td>also the agencies to which this function will be transitioned when the FAC closes.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix IX: Public Communications

Joint Information Center Organization Sample

A well-organized JIC can increase the ability to release accurate information that is coordinated across responding agencies quickly and effectively. The following is an example of a JIC organization.

The **Lead Public Information Officer (PIO)** in a JIC is responsible for overall JIC operations and for providing prompt and organized responses to the news media. The Lead PIO coordinates all public information efforts out of the JIC, ensures protocols are followed, ensures that all messages are approved by the Incident Commander before release, attends EOC Command briefings, and coordinates these efforts with local, state, and federal partners.

The **JIC Manager** manages the operations of the JIC and coordinates the flow of information between functional areas and staff. He/she acts as the Lead PIO when the Lead PIO attends EOC Command briefings.

The **Admin/Information Technology Support** unit provides administrative, clerical, documentation, technical, and information technology support for the entire JIC operation.

**Media Relations** unit is responsible for dealing with all media requests and logistics. They distribute news releases, brief and support spokespersons, determine and set up media-briefing area(s), generate reports, and obtain approvals from the Lead PIO.

**Research and Writing** unit is responsible for researching, verifying information, and writing media advisories, releases and other materials. They generate reports and obtain approvals from the Lead PIO.

**Special Projects** unit is responsible for working with key partners, posting accurate information to Web sites, and making sure information is distributed to non-media partners, organizations, agencies and audiences. They monitor Web sites, generate reports, and obtain approvals from the Lead PIO.

Additionally, in a mass fatality event, **Deputy/Field PIOs** will be stationed in the field (incident site, incident morgue and Family Assistance Center) to handle on-site media inquiries and requests. The Deputy/Field PIO coordinates with the Media Relations Lead and the Incident Commander in the field and reports information back to the JIC.
Public Communications Messaging Considerations

What are the public communications messaging considerations in a mass fatality incident?

The public communications messaging considerations below are based on experience and lessons learned from recent mass fatalities.

General Mass Fatality Messaging Considerations

- Information must first be provided to the family, then to the media.
- Recovery operations (progress, staffing levels and assistance provided, and estimate of time to complete recovery/identifications).
- The victims (total number, condition of the bodies, and numbers of missing persons reports).
- Identifications (names of identified victims and methods used to identify victims).

Family Messaging Considerations

- Remember that victims’ families are the priority in a mass fatality.
- Keep the families and loved ones of potential victims in mind in all communications.
  - Respect families’ sensitivities, such as, continued hope for survivors.
- Communicate awareness of and sensitivity and respect for the cultural/religious practices of the victims and their families.
  - Religious and cultural beliefs and practices surrounding death will be important to survivors. However, in a mass fatality, it is unlikely that the ME/C Office will be able to be responsive to family requests regarding their beliefs and practices.
- Only coordinate media interviews of victims’ family members who are willing to be interviewed by the media.
  - Protect the privacy of families and loved ones of potential victims who do not want to be interviewed.
- Do not allow ‘public interest’ to become a legitimization for inquiry that it so intensive and invasive that it overrides concerns about sensitivity for the bereaved.

Community Health and Safety Messaging Considerations

- Only disseminate information based on scientific fact.
- There may be a public belief and concern over a disease epidemic caused by dead bodies. Dispelling this myth and calming public fear and anxiety will require a concerted and coordinated effort.

Response Worker Messaging Considerations

- Remember that all emergency response workers—at the incident site, the morgue and the Family Assistance Center—will be working under extreme emotional duress. Consider this in communications and when scheduling interviews for them with the media.
- Do not allow ‘public interest’ to become a legitimization for inquiry that it so intensive and invasive that it overrides concerns about sensitivity for responding personnel.
What are the public communications operational considerations in a mass fatality?

The public communications operational considerations below are based on experience and lessons learned from recent mass fatalities.

**Potential Crime/Terrorist Act**
- If the incident is the result of a suspected crime, public communications must take into consideration the future prosecution of the crime.
- The Federal Bureau of Investigation (FBI) will be in charge of the investigation if terrorism is suspected. The FBI can provide consultation regarding public communications.

**Mass Fatality Site Operations**
Experience in recent mass fatalities strongly urges that the media have very limited, if any, access to mass fatality site operations. However, your state’s laws regarding media access will take precedence over recommendations.
- Be prepared to assign a field PIO to each site and to utilize strategies that address media needs while protecting the integrity of mass fatality operations.

Consider the following suggestions:

**Incident Site**
- Accommodate the media at the incident site. News media serve as the eyes and ears of the people. Providing preferred vantage points and the ability to understand what is going on at the incident site serve legitimate public interest. The incident command post should have at least one person at the incident site that is dedicated to assuring that media representatives have appropriate access when possible without creating safety hazards.

**Incident Morgue**
- Restrict the media from entering the morgue. If media tours are provided, do not allow any pictures—cameras or cell phones.
- Establish a morgue briefing area near but not in the morgue.
- Remind the media of the morgue’s critical objectives and to consider victims’ families when information on morgue services is communicated.
- At the incident morgue there is substantial pressure to preserve remains to facilitate identification and to collect and preserve evidence. Morgue services are performed in accordance with professional protocols to achieve these objectives.

**Family Assistance Center**
- Restrict the media from entering the Family Assistance Center (FAC). The FAC is a private place for families. The literature on mass fatality family assistance often says to never permit the media to enter the FAC.
  - If media tours are provided, do not allow any pictures—cameras or cell phones.
  - Remind the media of the trauma and grief the families are experiencing and of the need to respect families’ wishes for privacy at this difficult time.
  - Establish a media briefing area near/next to but not in the Family Assistance Center.
  - Coordinate media interviews with family members who are willing to be interviewed; conduct interviews at the media briefing area and not in the Family Assistance Center.
- When managing VIP visits by public figures to the Family Assistance Center, remind the VIPs that the needs of families and loved ones of victims always remain the priority.
- Coordinate the collection of biographical information and photos of the victims and prepare a formal presentation of this information for the Family Assistance Center that is updated daily as necessary.

**Resource:** See the *Family Assistance* section of the mass fatality toolkit for suggestions on strategies used in recent mass fatalities (e.g., the Heroes Board, Memorial Table, and Incident Site Diagrams and Charts) that families identified as supportive and meaningful.

**Managing the Media at all Sites**

- Consider setting up a system for issuing one-time credentials for journalists and requesting members of the news media to bring their current credentials and/or business identification (business card). Planning for this must include setting standards for separating true journalists from those who just want a closer look.

**Coordinating Public Communications and Family Briefings**

- Make keeping the Family Assistance Center leadership informed a priority. This will enable them to anticipate potential crises for families and to better meet families’ needs.
- Do not release information to the media unless it has been discussed with families of potential victims first and approved by Incident Command through the JIC.
  - Families will be kept informed through regularly scheduled family briefings by the ME/C Office—a minimum of two per day—at the Family Assistance Center.

**Meeting the Needs of Response Workers**

- Remember that emergency response workers make up one of your audiences. Keep this audience informed, perhaps through end-of-shift briefings.
  - A frequently mentioned problem in recent mass fatalities is that on-site response workers knew less than those at home watching television.

Consider a “Faces of Service” campaign to inform the public about the organizations and individuals involved in the response and to highlight their contributions.
Appendix X: Pandemic Influenza Planning

General Pandemic Influenza Guidelines

Potential Roles of Public Health Staff

District Emergency Preparedness Division:
- Lead pandemic planning and preparedness efforts for Health District and associated county health departments, in conjunction with local, district, state and federal response partners.
- Conduct training, drills and evaluated exercises to enhance the pandemic readiness of public health partners within the health district area of responsibility.
- Coordinate ESF-8 activation and response by county health departments to provide support for county emergency operations centers (EOC).
- Coordinate the activation and management of the District Operations Center (DOC).

District Epidemiology Section:
- Carry out district wide surveillance activities, including epidemiological investigations, as appropriate.
- Provide information and technical support concerning surveillance, epidemiology, and clinical issues, including case identification, laboratory testing, and prioritization of antiviral medicines and vaccines within the health district.
- Establish average daily death rate for counties

District Public Health, Nursing and Clinical Services Division:
- Assure participation of the county health department leadership to develop capacity for community-based influenza evaluation and treatment clinics.
- Provide planning assistance and supervision for mass vaccination activities.
- Coordinate county health department participation in the “Nurse Call Line.”
- Disseminate infection control information to county health departments, in coordination with the Health District Epidemiology Section.

District Pharmacy Director:
- Coordinate with District Emergency Preparedness Division and appropriate state and federal agencies for acquisition of anti-viral medicines and vaccines for counties.
- Provide technical advice and support to District PH divisions and county agencies regarding pharmaceutical interventions for infection control of pandemic viruses.
- Provide technical advice and support to District PH divisions and county agencies regarding use of prophylaxis for prevention and/or treatment of pandemic virus infection.

District Public Information Officer (PIO):
- Perform PIO duties for all Health District area counties to address public health-related media inquiries and provide public information and education concerning public health subject matter.
- Provide accurate and timely information to the public regarding preparations for a pandemic, its potential impact, disease control recommendations and local pandemic response operations, including anti-viral and vaccine distribution.
- Provide public information concerning use of effective infection control measures during a pandemic.
• Respond to pandemic-related media inquiries and arrange interviews with appropriate county and district health officials.

• Activate and direct the management of public information call centers.

**District Environmental Health Director:**

• Assist in surveillance for animal influenza viruses through liaison with the State Department of Agriculture and the State Department of Natural Resources.

• Work with the District Public Information Officer to develop and disseminate risk communications messages to the public concerning zoonotic influenza transmissions, food safety, animal waste disposal issues and burial sites.

**All Sections and Staffs:**

• Identify staff that can be cross-trained to perform the duties of absent key personnel, and/or perform critical emergency response functions.

• Identify functions that could be temporarily discontinued or performed via telecommuting during periods of high pandemic activity, perhaps for several weeks.

• Be prepared to mobilize all available staff to support District pandemic response operations, as directed by the District Health Director.

**Above Source:** Adapted from North Georgia District Pandemic Influenza Plan

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**All personnel will wear personal protective equipment as directed by the Health Officer.**

• Protecting employee health and reducing the spread of infection among workers is a priority.

• All personnel handling dead bodies in mass fatality response will also receive proper immunizations as appropriate; training in blood borne pathogens, personal protective equipment (PPE), and proper lifting techniques; and PPE as defined by existing regulations, for example:
  - Disposable, long-sleeved, cuffed gown (waterproof if possibly exposed to body fluids).
  - Single-layer non-sterile ambidextrous gloves which cover the cuffs of the long-sleeve gown.
  - Surgical mask (a particulate respiratory if handling the body immediately after death).
  - Surgical cap and face shield if splashing of body fluids is anticipated.
  - Waterproof shoe covers if required.

• Proper hand washing is always recommended when handling remains.

**Family Care Plans.** The ME/C, vital records system, and death care services should encourage employees to develop “family care plans” knowing that they may not be able to be with their families for extended periods during waves of severe disease during the pandemic period.

**Issues Related to Managing Increased Numbers of Deaths in a Worst-Case Scenario Pandemic Influenza**

<table>
<thead>
<tr>
<th>PLANNING FOR POSSIBLE SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Operations Center and Public Health Department Actions for Managing Deceased</strong></td>
</tr>
<tr>
<td>• Consider ME/C Office and death care services personnel as first responders.</td>
</tr>
<tr>
<td>‒ Classify ME/C Office and death care services personnel as first responders for priority prophylaxis and antivirals.</td>
</tr>
<tr>
<td>‒ Ensure the ME/C Office’s and death care services’ priority access to labor, supplies, personal protective equipment, vaccines, fuel, raw materials, communication bandwidth, transportation, security, temporary housing as needed, and other resources.</td>
</tr>
</tbody>
</table>
PLANNING FOR POSSIBLE SOLUTIONS

- Consider involving Public Health, the ME/C, and police in developing specific investigative checklists, which clarify the concepts of medico-legal determination of cause and manner of death, victim identification procedures, scene documentation, overall investigative requirements, and required PPE and personal decontamination, for all call centers and responders to unattended deaths during a pandemic influenza event.

- Train all first responders in the field about the symptoms of pandemic influenza deaths and the actions to take when a suspected pandemic influenza event related death is found vs. when non pandemic influenza event related deaths are found.

- Consider establishing a dispatch/tracking system with a centralized database that is separate from emergency medical services and 911 systems to track patients and deaths. Design it so that it can be managed through family assistance and patient tracking centers. Link all first responders/health care centers/collection points/morgues/family assistance/ME/C Office/law enforcement/etc. to this system. Consider facilitating its use by private citizens.

- Consider establishing a county voluntary registry of next of kin so families can register information before a disaster.

- Implement reciprocal licensing of mortuary services personnel to overcome variations in state licensing of funeral directors, embalmers, cemetery, and crematory operations, and unionized labor. (State level only)

- Educate behavioral health professionals, social service organizations and religious leaders regarding the process for managing human remains to ensure the process is understood and can be properly communicated to the general population in their response activities.

- Advise the ME/C Office and death care services of additional respiratory protection that is needed
  - During autopsy procedures performed on the lungs or during procedures that generate small-particle aerosols (e.g., use of power saws and washing intestines) in case the decedent was infectious when he/she died.
  - During embalming procedures prior to burial or cremation.

- If families will be transporting loved ones who have died from pandemic influenza, provide education on general precautions for handling dead bodies. Special precautions are not required since the “body” is not contagious after death.

- Track federal, state, and local laws applicable to the handling of human remains that impact the ME/C, vital records system, and death care services. Existing laws, such as time requirements for completing death certificates and disposition permits, may need to be amended/waived. Alert all parties to waivers and modifications that impact services.

<table>
<thead>
<tr>
<th>Requirements:</th>
<th>Person legally authorized to perform this task.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limiting Factors:</td>
<td>If death occurs at home, then one of these people will need to be contacted.</td>
</tr>
<tr>
<td>Availability of people able to do this task.</td>
<td>Provide public education on what to do if someone dies, how to access an authorized person to certify death, and where to take the deceased if family or friends must transport them.</td>
</tr>
<tr>
<td></td>
<td>- Consider planning an on-call system 24/7 specifically for this task that is separate from the 911 System. Keep 911 focused on calls pertaining to life safety missions.</td>
</tr>
<tr>
<td></td>
<td>ALL who interface with decedents should record official personal identification information for patients who enter their systems and maintain this information in the patient’s police report and/or medical record.</td>
</tr>
<tr>
<td></td>
<td>- If a deceased patient enters the system without an official photo identification, and identity is never established, healthcare facilities should report this person to the patient’s local police department. There is a possibility the deceased has been reported missing by a family member who can visually identify the decedent.</td>
</tr>
<tr>
<td></td>
<td>Consult with Native Americans, Jews, Hindus, Muslims and other religious groups that have special requirements for the treatment of bodies and for funerals and involve them in planning for funeral management, bereavement counseling, and communications with their respective communities in the event of a pandemic. During the pandemic, the wishes</td>
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</tbody>
</table>
### PLANNING FOR POSSIBLE SOLUTIONS

<table>
<thead>
<tr>
<th></th>
<th>of the family will provide guidance, however, if no family is available local religious or ethnic communities can be contacted for information.</th>
</tr>
</thead>
</table>

#### Step: Death Certified
**(signing of a death certificate stating the cause of death)**

**Requirements:**
Person legally authorized to perform this task.

**Limiting Factors:**
Legally, may not necessarily be the same person that pronounced the death.

- ALL who interface with the deceased should record official personal identification information (first, middle, last name and suffix; race/ethnicity, color of eyes, hair, height, and weight; home address, city, state, zip and telephone number; location of death and place found; place of employment and employer’s address; date of birth, social security number and age; and next of kin—or witness—name, contact number and address).

- To ensure proper identification of the deceased, consider implementing standardized methodology for collecting samples of deceased such as a right thumbprint, DNA sample (e.g., saliva swab or blood stain card), and a facial photograph. In the case of decomposed bodies, this may also include assistance from the ME/C for identification—anthropological markers, dental impressions, and, if possible, fingerprints, etc.
  - Although these identification samples may not need to be processed, those in authority are able to substantiate the identification of the decedent at a later time should individuals question the ME/C about a decedent’s identity.

- Healthcare facilities may want to consider designating a single physician, familiar with patients’ records, as responsible for expeditiously signing death certificates.

- Consider pre-identifying “collection points” for the deceased to centralize processing and hold remains at the lowest appropriate local level. Have an authorized person certify deaths en masse and batch process death certificates of identified decedents to improve efficiency.
  - At the designated collection point, trained personnel should sort bodies by cause and manner of death (identified pandemic influenza cases vs. ME/C cases) to ease subsequent processing (victim identification and issuing a death certificate).
    - Attended deaths will have a known identity and may have a signed death certificate. Unattended deaths may require the ME/C to further process remains to determine identification, issue the death certificate, track personal effects, and notify next of kin.

- Establish a uniform method for numbering and tracking decedents, such as the state abbreviation, zip code, and a case number (with name if identified).

- When moving, storing, and/or releasing remains and personal effects, keep detailed records like that of a chain-of—evidence for each individual body and personal effects bag.

- Consider broadening the range of professionals who can certify deaths. See OCGA § 31-10-15-2. **Death certificate; filing; medical certification; forwarding death certificate to decedent’s county of residence; purging voter registration list**
  - (2) In any area in this state which is in a state of emergency as declared by the Governor due to an influenza pandemic, in addition to any other person authorized by law to complete and sign a death certificate, any registered professional nurse employed by a long-term care facility, advanced practice nurse, physician assistant, registered nurse employed by a home health agency, or nursing supervisor employed by a hospital shall be authorized to complete and sign the death certificate, provided that such person has access to the medical
### PLANNING FOR POSSIBLE SOLUTIONS

If the history of the case, such person views the deceased at or after death, the death is due to natural causes, and an inquiry is not required under Article 2 of Chapter 16 of Title 45, the “Georgia Death Investigation Act.” In such a state of emergency, the death certificate shall be filed by the funeral director in accordance with subsection (b) of this Code section; or, if the certificate is not completed and signed by an appropriate physician or coroner, the public health director of preparedness shall cause the death certificate to be completed, signed, and filed by some other authorized person within ten days after death.

- Establish a call line for ME/C consultations and physician-patient data to assist in determination of death.

#### Step: Body Wrapped

<table>
<thead>
<tr>
<th>Requirements:</th>
<th>Person(s) trained to perform this task. Body bags or post mortem kits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limiting Factors:</td>
<td>Supply of human and physical (body bags/post mortem kits) resources. If death occurs in the home: the availability of these requirements.</td>
</tr>
</tbody>
</table>

- Clearly tag the body and pouch with the individual decedent’s identifiers such as name, date of birth, SSN, location of origination, medical record number, etc. Complete labeling reduces the number of times mortuary staff needs to open pouches to confirm contents.
- Consider developing a rotating six months inventory of body bags, given their shelf life.
- Consider training or expanding the role of current staff to include this task.
- Consider providing this service in the home in conjunction with pronouncement and transportation to the morgue.
- If personal effects accompany the remains in the human remains pouches, ensure that the funeral director and family are made aware of this so that effects may be safely retrieved before cremation or burial. Funeral directors and others should sign a receipt for items as well as the body.

#### Step: Transportation

<table>
<thead>
<tr>
<th>Requirements:</th>
<th>In hospital: trained staff and stretcher. Outside hospital: informed person(s), stretcher, and vehicle with driver suitable for this purpose.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limiting Factors:</td>
<td>Availability of human and physical resources.</td>
</tr>
</tbody>
</table>

- Consider the use of volunteers, family members, etc., to transport the deceased.
- **In hospital:**
  - Consider training additional staff working within facility.
  - Consider keeping old stretchers in storage instead of discarding.
- Look for alternate suppliers of equipment that could be used as stretchers in an emergency e.g., trolley manufactures.
- **Outside hospital:**
  - Provide public education or specific instructions through a toll-free phone service regarding where to take the deceased if the family must transport.
  - Identify alternate vehicles that could be used for this purpose.
  - Consider use of volunteer drivers.

#### Step: Morgue Storage

| Requirements: | A suitable facility that can be maintained at 34-37°F, the ideal temperature for storing and preserving human remains. It does not prevent decomposition of the decedent, which continues, albeit at a slow |

- Pre-identify and plan for possible temporary morgue storage sites:
  - Refrigerated trucks with temporary shelves and ramps.
  - Temporary portable facilities.
  - Cold storage lockers.
  - Conex boxes with diesel or electrical power.
  - Hangars.
  - Warehouses.
  - Refrigerated rail cars.
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| Limiting Factors: Capacity of such facilities. | • Empty public buildings that lend themselves to cooling and proper security.  
• An organized, segregated storage system will provide the public a higher level of confidence that government agencies are managing the pandemic influenza event well.  
• Consider ice skating rinks as a resource when all other resources have been exhausted.  
• Use processes routinely used in mortuaries to track and locate deceased.  
• Consider some facilities maintained at -15°/-25° C or 5°/-13° F, used in forensic institutes, especially for bodies which have not yet been identified. The body is completely frozen and decomposition totally halted. |

### Step: ME/C Office and Autopsy if Required/Requested

| Requirements: Person qualified to perform autopsy and suitable facility with equipment. Limiting Factors: Availability of human and physical resources. May be required in some circumstances. | • Ensure that it is public knowledge—that all physicians and families are aware that an autopsy is not required for confirmation of influenza as cause of death.  
• However, for the purpose of health surveillance, respiratory tract specimens or lung tissue for culture or direct antigen testing could be collected postmortem to confirm the early cases that start the pandemic.  
• Examine the capacity, continuity of operations planning, and surge capacity of the ME/C Office in your jurisdiction.  
• Shift ME/C resources to the most vital public health functions, including body recovery, abbreviated processing, temporary storage, and tracking.  
  • Employ a phased operation to ensure bodies are properly identified and handled with dignity.  
• Identify ways to augment staff.  
  • Break down functions into tasks so that disaster service workers and volunteers are able to provide more effective assistance.  
  • Consider requesting a volunteer category for death care professionals be added to established organized volunteer Citizen Corps and/or Medical Corps.  
  • Provide just-in-time training for current staff who will be performing new management/oversight roles, for suitable drivers and handlers to support the human remains recovery and for other positions as practicable.  
• Keep daily death cases separate from pandemic influenza event cases and number them using different identifiers.  
• Ensure that critical morgue supplies are stockpiled or develop a rotating six month inventory of essential equipment/supplies.  
• Consider putting in place contracts and memoranda of agreement to ensure that the ME/C Office receives priority distribution of water, generators, and gasoline.  
• If an autopsy is required, usual protocols based on current law will prevail.  
  • Consider advocating for amending regulations regarding reportable deaths. For example, the ME/C assumes jurisdiction over deaths of persons in correctional custody, deaths in mental institutions, and sometimes in nursing care facilities, regardless of the circumstances. Consider requiring ME/C jurisdiction only when the cause of death is of suspicious nature during the pandemic.  
  • Seek direction from Health Officer re: additional respiratory protection |

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### PLANNING FOR POSSIBLE SOLUTIONS

needed during autopsy procedures performed on the lungs or during procedures that generate small-particle aerosols (e.g., use of power saws and washing intestines) in case the decedent was infectious when he/she died.

### Step: Cremation

**Requirements:**
- Suitable vehicle and driver for transportation from morgue to crematorium.

**Limiting Factors:**
- Capacity of crematorium/speed of process.
- Availability of authorized official to issue death certificate.
- Availability of staff and resources in vital records office to certify death certificate and issue permit for disposition of remains.

- Identify alternate vehicles that could be used for transport.
- Examine the capacity, continuity of operations planning, and surge capacity of crematoriums within the jurisdiction.
- Arrange for maintenance and inspection of equipment—ahead of periods of peak usage—with backup equipment and replacement parts stockpiled.
- Consider streamlining the completion of required cremation forms.
- Discuss and plan appropriate storage options if the crematoriums become backlogged.
- Seek direction from Health Officer re: additional respiratory protection needed during embalming procedures to prepare for cremation for those who die from the pandemic in case the decedent was infectious when he/she died.
- Examine the capacity, continuity of operations planning, and surge capacity of the vital records office.
- Consider developing arrangements between crematoriums and the local registrar to expedite the filing of a large number of death certificates and applications for cremation.

### Step: Embalming

- Examine the capacity, continuity of operations planning, and surge capacity of funeral homes in your jurisdiction.
- Consult with funeral homes regarding availability of equipment/supplies and potential need to stockpile or develop a rotating six month inventory of essential equipment/supplies.
- Consider “recruiting” workers that would be willing to provide this service in an emergency (e.g., retired workers or students in mortuary training programs).
- Consider providing embalming and casketing services in a temporary morgue.
- Seek direction from Health Officer re: additional respiratory protection needed during embalming procedures for those who die from the pandemic in case the decedent was infectious when he/she died.
- Examine the capacity and surge capacity of the vital records office.
- Consider developing arrangements between funeral directors and local registrar to expedite the filing of a large number of death certificates and applications for disposition permits.

### Step: Funeral Service

**Requirements:**
- Appropriate locations(s), casket or urn, funeral director.

**Limiting Factors:**
- Examine the capacity, continuity of operations planning, and surge capacity of funeral homes in your jurisdiction.
- Contact supplier to determine lead time for casket and urn manufacturing and discuss possibilities for rotating six month inventories—with a more...

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| Availability of caskets/urns. | that normal supply of low cost caskets and low cost alternatives. |
| Availability of location for service and visitation. | • Consult with funeral directors to determine surge capacity and possibly the need for additional sites (e.g., use of churches, etc. for visitation). |
| Social distancing and/or quarantine measures that may be in effect during pandemic waves. | • Develop strategies for handling services when social distancing measures and/or quarantine are in effect. |
| | – Consider alternatives such as video-conferences to allow for funerals to occur with relatives of the decedents having the ability to mourn but at a non-public venue. |
| | – Be prepared to clearly explain why limitations have become necessary. |

### Step: Temporary Storage while Awaiting Burial

**Requirement:** Access to and space in temporary storage.

**Limiting Factors:** Temporary storage capacity and accessibility.

- Expand capacity by increasing temporary storage sites.
- Expand capacity by increasing temporary vault sites with security features such as covered windows and locks on doors. (Note: A vault is a non-insulated storage facility for remains that have already been embalmed, put into caskets, and are awaiting burials.)

### Step: Burial

**Requirement:** Grave digger and space at cemetery.

**Limiting Factors:** Availability of grave diggers and cemetery space.

- Examine the capacity, continuity of operations planning, and surge capacity of cemeteries in your jurisdiction.
- Identify sources of supplementary workers.
- Consider temporary mass burials where bodies will be temporarily buried in body bags in common graves in cemeteries or at a designated location until they are exhumed at a later time. (Only as last resort)
- Be prepared to make public statements regarding storage solutions, particularly the employment of long-term temporary interment.

### Step: Family Assistance

**Requirement:** The ME/C Office is responsible for providing family assistance in the event of a mass fatality.

**Limiting Factors:** The catastrophic scope of the disaster and mandated social distancing will prohibit a traditional family assistance center and dictate limitations to the provision of direct services.

- Identify a local agency/organization to manage family assistance during a pandemic.
- Implement a virtual family assistance center model that includes:
  - Broadcasting information "pushed" to families through mass media channels. Content may include: coping with death and dying at home, coping with illness and death at work, financial support, health issues, emotional and behavioral health concerns, Social Security questions, and legal issues.
  - "Warm Lines" established and staffed to provide a more direct line of communication with families and track/manage death and missing persons calls. Issues may include: death care guidance, body removal, burial sites, death certificate information, and psychological support. "Warm Lines" may include toll-free telephone lines staffed by behavioral health providers working from their homes and Internet "Counseling Rooms" established for computer-based interactions between behavioral health providers and community members needing assistance.
    - May want to consider a separate fatality/missing person information telephone number to report fatalities that can incorporate this information into a national patient tracking system. Consider the National Find Family Hotline as a model.
  - Face-to-Face Crisis Interventions provided by trained behavioral health services professionals with appropriate PPE for those individuals with acute psychiatric reactions.
  - Strategies for providing psychological first aid and educational/informational materials for all response personnel.
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<td>- Identify interventions and strategies for assisting at-risk and/or special populations, such as those with mental and behavioral illness or disabilities and/or with general pharmaceutical needs or medication withdrawal issues, homeless, senior citizens, immigrants, and undocumented residents.</td>
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