**Hospital Fatality Management Plan**

**Template**





*[Information Element; Delete from final plan - This template has been designed to help your organization develop a fatality management plan. Refer to the SEMN Disaster Health Coalition Guideline for additional information to help complete the template.*

*Some sections have been completed for you while others require input. Each template includes critical planning elements but planning teams may continue to add additional elements as they see fit. Each facility has unique needs and each plan should be tailored to meet those needs. This is ONLY a template and is meant to provide additional guidance in your planning efforts.]*

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## Introduction

A mass fatalities incident (MFI) is any event that causes multiple fatalities and that exceeds the routine capability of the hospital, requiring additional staff and equipment resources to meet the demands of the response.

The purpose of this fatality management plan is to provide basic guidelines and procedures to properly manage a mass fatalities incident (MFI).

***Factors Impacting the Identification of Decedents in a Mass Fatalities Incident***

*There are four factors that impact the processing of remains and identification of decedents in a mass fatalities incident and therefore impact the ability of the hospital to effectively manage decedents. The factors are:*

* ***Number of fatalities.*** *The number of remains is a significant driver in the amount and type of resources needed to search, recover and identify the dead. In general, the higher the number of remains, the more resources required to manage and process the dead.*
* ***Decedent population (open or closed).*** *There are two types of decedent groups—closed populations and open populations.*

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

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

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

* ***Availability of ante mortem information.*** *Collection and examination of ante mortem information to help identify decedents can begin immediately in a closed population incident, such as a commercial airline accident*
* ***Condition of remains (e.g. complete or fragmented, commingled remains).*** *Fragmented and commingled remains require a significantly longer examination process. Whether the population is open or closed also makes a difference. With a closed population, forensic investigators work to identify all of the victims, with an understanding that not all remains will be identified due to the technological limitations of DNA. In an open population when there is high-fragmentation and commingling of remains, the focus must be on identifying all remains as the number and names of the decedents are not known.*

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

***Decedent Operations***

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

*Medical Examiner decedent operations may include:*

* *Remains Recovery.*
* *Victim Identification Center.*
* *Family Assistance (medical examiner activities).*

*Other decedent operations which require coordination and cooperation include:*

* *Family Assistance (Non-medical examiner activities).*
* *Public Information.*
* *The Vital Records System.*

#

# Plan Maintenance and Distribution

The [Insert Hospital Name/Department Name] is responsible for the distribution and maintenance of this fatality management plan. The plan will be reviewed annually and revised as needed to incorporate federal, state, and regional guidelines applicable to address operational issues identified during training, exercises and incidents.

# Record of Changes

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| **Date of Change(s)** | **Page(s)** | **Brief Description of Change(s)** | **Feedback Provided By:** | **Change(s) Made By:** |
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# Purpose and Scope

**Purpose**

The purpose of the fatality management plan is to establish the overall framework in which the hospital will operate in an integrated and coordinated fashion before, during and after a mass fatalities incident.

Specifically, the fatality management plan establishes the key policies, roles and responsibilities necessary to respond to a mass fatalities incident. The plan is designed to accomplish the following:

1. Establish the systems and coordination that will allow for optimal response to and recovery from a mass fatalities incident.
2. Outline coordination and key activities required to respond to and recover from a mass fatalities incident.
3. Define the policies and roles and responsibilities that may be requested to provide assistance before, during or after a mass fatalities incident.
4. Guide strategic organizational behavior before, during, and after a mass fatalities incident.
5. Assist in developing an enhanced level of disaster preparedness and awareness throughout the hospital.
6. Identify linkages to the emergency/disaster policies and plans that guide and/or support the fatality management Plan.
7. Synchronize (both vertically and horizontally) with relevant policies, plans, systems, and programs to ensure full integration and unity of effort.
8. Outline procedures for requesting and coordinating state and federal disaster assistance.
9. Acknowledge the importance of flexibility in disaster response, and allows for the creative and innovative approaches that will be required to address the problems presented by mass fatalities incidents.

*\*Note: A mass casualty plan’s goal—to ensure adequate and coordinated efforts to minimize loss of life, disabling injuries, and human suffering of those who survive the incident—will typically operate alongside the mass fatalities plan. Refer to the hospital mass casualty plan for details.*

**Scope**

The fatality management plan addresses all hazards, all phases of emergency management, all potential impacts, all people, and all stakeholders. The scope of this plan includes hospital fatality management operations, not community-based fatality management operations, although the two activities will typically be integrated together.

# Authorities and References

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

This plan is consistent with:

* 2013 Minnesota Statutes, Chapter 390 (Medical Examiner), Individual sections as they apply to individual jurisdictions

***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 fatalities response. Medical and dental providers of suspected victims are relieved of confidentiality restraints by the Health Insurance andPortability and Accountability Act (HIPAA) Exemption for Medical Examiners (CFR 164.512).

# Situation and Assumptions

**Situation**

1. A mass fatalities incident, by definition, is any situation where more deaths occur than can be handled by local resources
2. A disaster resulting in mass fatalities would quickly overwhelm the resources of the hospital
3. Regardless of the size of the mass fatalities incident, the medical examiner/coroner is the legal authority to conduct victim identification (or augment the lead investigative agencies to complete victim identification), determine the cause and manner of death; manage death certification, and notification of next of kin.
4. The Minnesota Disaster Mortuary Emergency Response Team (DMERT) and Disaster Portable Mortuary Unit (DPMU) can be activated in accordance with the Minnesota Department of Health DMERT Plan.
5. The Minnesota National Guard CBRNE Enhanced Response Force can be activated to support fatality management operations.

**Assumptions**

1. Most mass fatalities incidents will require resources and assistance from regional, state, and federal partners.
2. Mass fatalities incidents create widespread traumatic stress – for responders, families that are impacted, and at times, the community-at-large. Traumatic stress can lead to physical illness and disease, precipitate mental and psychological disorders, and can destroy relationships and families.
3. Under certain circumstances (e.g., commercial airline accident or terrorist act) select federal agencies will have critical on-scene responsibilities, requiring close and ongoing coordination with the medical examiner/coroner’s office, local and state agencies.
4. In the event of pandemic influenza or similarly contagious disease, external resources might not be available and some services will need to be delivered differently to minimize the spread of disease.
5. Mass fatalities incidents due to chemical, biological, radiological, nuclear, or explosive factors will present an added difficult dimension to the mass fatalities response, recovery, identification, and final disposition of deceased victims.
6. In most instances, a mass fatalities incident may not generate state and federal disaster declarations and their inherent provisions and support.
7. A mass fatalities incident may be the result of (or occur during) a disaster that has severely impacted critical infrastructure, systems, supplies, and or other essential services.
8. A mass fatalities scene that is contaminated or extremely hazardous may prohibit the medical examiner/coroner’s office from evaluating in a timely manner and may require additional assistance.
9. Contaminated deceased victims may require decontamination on-scene/at the hospital prior to admitting to a Victim Identification Center.
10. The expectations of family members, the general public, elected leaders and the media concerning identification of victims will be high.
11. Remains may require appropriate storage for days or weeks due to the time involved in making positive identification.
12. Activation of a hospital operations center will depend on the scope of the incident and the need for additional support.

# Concept of Operations

This section outlines overall goals and summarizes the conceptual flow of decedent operations. The overall goals of fatality management are to recover, identify and effect final disposition of remains in a dignified and respectful manner; and collect evidence (as needed); and provide family assistance to victims’ relatives and loved ones.

As [Insert Hospital Name] can adequately store and maintain [INSERT NUMBER] of full-body remains, the possibility must be recognized that circumstances could result in surge of hospital deaths that would exceed the hospital’s capacity to process, prepare and inventory remains. Such circumstances would transition the intuitional post mortem care process into a community-based collaborative process. In the event the incident exceeds the hospital’s morgue capacity, the following steps will be initiated:

1. Notify the [Insert Jurisdiction Name] Medical Examiner/Coroner Office and [Insert Jurisdiction Name] Emergency Manager of the situation, circumstances and need to activate the hospital fatality management plan and, if appropriate, community fatality management plan.
2. Alternative remains storage facilities will be considered as outlined herein.
3. In general, the hospital will likely be responsible for storage of its own decedents. Involvement of law enforcement and the coroner/medical examiner will be situation dependent. It will really be dependent on the circumstances surrounding the mass fatality event.
4. All tracking and documentation of off-site storage of remains will be under the direction of the Coroner/Medical Examiner and pursuant with the [Insert Jurisdiction Name] Fatality Management Plan.
5. Final disposition of remains may be delayed if volume exceeds the capacity of funeral homes. Pursuant with [Insert Jurisdiction Name] Fatality Management Plan, remains may need to be retained in inventory until capacity of disposition is able to meet the demand.

[Insert Reference to Organizational Decedent Management Policy/Procedure.] [Note: If no organizational policy/procedure exists, refer to Appendix C in the SEMN Disaster Health Coalition Fatality Management Guidelines for an example.]

# Plan Activation

Plan activation is a based on the ability of the hospital to manage fatalities.

[Insert #] of decedents is the likely threshold required to activate the hospital fatality management plan.

[Insert #] of decedents would likely require activation of the community fatality management plan.

The following individuals are authorized to activate the hospital’s fatality management plan:

* [Insert Title of Individuals authorized to activate the plan, e.g., HICS Incident Commander, Administrator on Call, etc.)

The hospital fatality management plan is activated by:

1. [Insert steps to activate the hospital fatality management plan.]

If the hospital requires activation of the Community Fatality Management Plan, a request can be made to the [Insert Jurisdiction Name] emergency management agency.

Activation of the Community Fatality Management Plan is dependent on various criteria presented below. The activation of the Community Fatality Management Plan will allow for the formation of Unified Command, consisting of representatives from [Insert County/City Authority Name and Emergency Management Agency Name and Medico-Legal Authority Name] and any other necessary command representative.

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

• Any incident having the potential to yield [Insert #] or more fatalities

• Any incident involving a protracted or complex decedent recovery operation

• Any situation in which there are remains contaminated by chemical, biological, radiological, nuclear, or explosive agents or materials

• Any incident or other special circumstance requiring a multi-agency or regional response to support fatality management plan operations

# Plan Activation Notifications

In the event the hospital is the first to recognize a cause of death as a potential public health threat or the hospital activates is mass fatality plan, notify:

* Hospital Incident Command System (HICS)
* [Insert Coroner/Medical Examiner Office Name]
* SEMN Healthcare Multi-Agency Coordination Center
* [Insert City/County Emergency Management Agency Name]

# Incident Management

The hospital uses an incident command system model to manage disaster operations. A Morgue Unit Leader, within the Operations Section, coordinates fatalities management operations for the hospital. The Morgue Unit Leader will interface directly with the Medical Examiner/Coroner’s Office to coordinate fatality management operations.

The hospital Liaison Officer, within the Command Section, is the lead role to interface with external organizations for operational coordination.

## Morgue Surge

Storage space in the hospital morgue is limited on a day-to-day basis. Routine capacity is [Insert max # of bodies – routine capacity].

The following spaces have been identified as onsite temporary morgues:

* [Insert location of temporary morgues]

The following vendor(s) are contracted to provided refrigerated trailers for temporary morgues:

* Polar Leasing, 9309 83rd Ave North Brooklyn Park, MN 55445, 877.428.2532 8AM-5PM, 260.625.3525 After Hours

Remains, prior to transfer to the Medical Examiner or selected funeral home/mortuary, should be placed in secure storage in [Include the room location] Morgue facilities should be capable of sustaining a temperature of 1.1-4.4 degrees Celsius (34-40 degrees Fahrenheit). If the proper temperature is not attainable, the Coroner/Medical Examiner should be promptly informed and an alternative storage venue should be identified. If a funeral home/mortuary has been selected by the family or Coroner/Medical Examiner, coordination with the funeral home/mortuary will be beneficial to expedite a resolution to the storage temperature problem.

Notify the local Emergency Management Agency when there is anticipation that morgue capacity, routine and surge, will be exceeded.

## Data/Information Management

Remains, prior to transfer to the Coroner/Medical Examiner or selected funeral home/mortuary, should be placed in secure storage in [insert room number and or location description].

Morgue facilities for storing remains should be capable of sustaining a temperature of 1.1-4.4 degrees Celsius (34-40 degrees Fahrenheit). If the proper temperature is not attainable, the Coroner/Medical Examiner should be promptly informed and an alternative storage venue should be identified.

If a funeral home/mortuary has been selected by the family or Coroner/Medical Examiner, coordination with the funeral home/mortuary will be beneficial to expedite a resolution to the storage temperature problem.

## Hazardous Material Decontamination

In the event that the deceased remains are contaminated either due to the inability to effectively decontaminate or as the result of a decision to preserve forensic evidence, careful attention to safety must be maintained. If decontamination is to be undertaken, the hospital’s, or community HazMat Team, current decontamination procedures should be followed. In the event that successful decontamination is compromised (e.g. off-gassing of cyanide), further consultation from appropriate resources may be appropriate such as the [Insert name of community designated HazMat Decon Response Team and contact number], and Poison Control Center.

## Data/Information Management

It is critical that death certificates be processed accurately.

* Death certificates issued according to procedures normally in place and as directed by the Coroner/Medical Examiner
* The administrative or judicial issuance of death certificates in situations in which there is an absence of positive physical forensic scientific identification is a responsibility of the ME in conjunction with local legal and public health authorities. (Presumption of death from absence, MN statue **576.141 )**
* When circumstances suggest that a death has occurred although a dead body cannot be produced to confirm the fact of death, a death record shall not be registered until a court has adjudicated the fact of death. ( **144.221 sub 3 )**

## Release of Remains

The release of any remains will be handled by the [Insert Jurisdiction Name] County Medical Examiner/Coroner. Release of the remains will only be made to a licensed funeral director from an active state licensed funeral home. If the decedent is to be removed from the state, it will be necessary for the arrangements to be made through a state licensed facility.

# Multiagency Coordination

Exceeding hospital routine and surge fatality management capabilities might require additional coordination with external organizations to meet fatality management operations objectives.

[Insert #] of decedents would likely require activation of the community fatality management plan or request support through the Hospital Disaster Preparedness and Response Compact via the SEMN Healthcare Multi-Agency Coordination Center.

The following individuals are authorized to request activation of the community’s fatality management plan or the SEMN Healthcare Multi-Agency Coordination Center.

* [Insert Title of Individuals authorized to activate the plan, e.g., HICS Incident Commander, Administrator on Call, etc.)]

Request activation of the community fatality management plan by contacting [Insert Organization Name and Contact Information]

Request activation of the SEMN Healthcare Multi-Agency Coordination Center (H-MACC) by contacting the Mayo Clinic Emergency Communications Center:

* 1. Primary phone number 855.606.5458, or
	2. Backup phone number 507.255.2808, or
	3. Backup radio on MN ARMER “SE Hospital” Talkgroup
		1. Example radio script to contact Mayo Clinic ECC: “Mayo Clinic ECC this is [Your Hospital/LTC facility Name] on SE Hospital.”

As applicable, the hospital will coordinate with the local Emergency Management Agency/Emergency Operations Center and/or SEMN Healthcare Multi-Agency Coordination Center to achieve fatality management operations objectives.

# Public Information

Public information will be coordinated in accordance with the hospital’s Crisis Communication Plan.

When requested, the hospital will provide information to the Joint Information Center (JIC), or participate as part of the JIC, to coordinate the release of information to the media and public. All media requests should be funneled through the hospital PIO and to the JIC, if activated.

# Resource Coordination

The hospital will use routine and contingency plans to meet fatality management resource needs. Refer to Appendix F for anticipated resource needs.

Logistics to support fatality management operations will be coordinated through the HICS Logistics Section using routine and disaster logistics procedures.

If unable to meet operational logistical needs, requests for support will occur through the jurisdictional Emergency Operations Center/Emergency Management Agency (typically via the HICS Liaison Officer). Additionally, as appropriate, requests can be submitted to the SEMN Healthcare Multi-Agency Coordination Center.

Overall, the jurisdictional Emergency Operations Center/Emergency Management agency where the incident occurs, in collaboration with the Medical Examiner/Coroner’s Office, will coordinate resources to support fatality management operations, including non-hospital-based storage facilities.

All storage options should weigh the storage requirements against the time it takes to collect information that is necessary for identification, determination of the cause and circumstances of death, and next of kin notification.

The hospital will consider the following for the temporary storage of remains:

***Refrigeration:*** Refrigeration of remains between 1.1-4.4 degrees Celsius (34-40 degrees Fahrenheit) 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 (lying 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. 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 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 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 down side 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:

* ***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.

The following remains temporary storage options are **NOT recommended**:

* ***Stacking:*** Placing remains 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 remains 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 remains 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 safely risk.

# Transportation

The Morgue Unit Leader will coordinate transportation of remains from the hospital to surge morgues, funeral homes, or location deemed appropriate by the Coroner/Medical Examiner. Refer to Appendix E for details of transportation assets.

Transportation needs not me through routine and contingency plans will be submitted to the local Emergency Operations Center for action.

# Chain of Custody

[Insert or reference hospital decedent chain of custody procedure.]

Familiarize staff with the Decedent Tracking Log. Ensure that this form is utilized and maintained properly during a disaster.

Patient information may be utilized for the “matching” process, whereby unidentified decedents are recognized as other definitive identifying information becomes available. Directions will be provided regarding the frequency of updates.

The Morgue Unit Leader will establish a documentation method for quickly identifying the location of a decedent. This can also be monitored on the Decedent Tracking Log if the decedent needs to be moved from one decedent storage area to another within the facility.

**Ensure as many decedents as possible are directed to mortuaries. Key considerations include:**

* Contact mortuary/ME/Coroner to discuss methods to expedite decedent release.
* Ensure that all necessary documentation is completed on the part of the healthcare facility.
* For scenarios that call for physicians to sign death certificates (e.g. pandemic), coordinate just-in-time training for physicians regarding the signing of death certificates. Consider the activation of the “Physician in Charge” death certificate signing method, if practiced and part of facility policy.
* Advise admissions staff to collect decedent processing information from patients as part of the admissions process, to include preferences regarding mortuaries, burial/cremation, and religious/cultural practices as appropriate.

If a hospital’s capacity to manage fatalities has been overwhelmed AND a Victim Identification Center has been activated, the following should be considered prior to transporting decedents:

* 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/Coroner 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/Coroner 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/Coroner 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/Coroner 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 decedent and personal effects bag.

# Volunteers & Credentialing

The hospital policy is to not use volunteers to support hospital operations. Spontaneous volunteers will be referred to the [Insert Jurisdiction Name] Emergency Operations Center or Volunteer Management Center.

Credentialing of shared hospital staff is defined in the Hospital Disaster Preparedness & Response Compact. Visitor credentialing will occur in accordance with hospital security procedures.

Note: The medical examiner to could ad hoc credential hospital staff to serve as an investigator.

# Psychological First Aid

The hospital implements Psychological First Aid practices to support behavioral health needs. The HICS Behavioral Health Unit Leader coordinates behavioral health support as necessary to support response operations. Additionally, the hospital Employee Assistance Program is available to support employee and employee dependent’s mental health needs.

# Family Assistance Center

Refer to the hospital’s family assistance plan.

# Demobilization

[Insert Title], in collaboration with HICS, is authorized to deactivate hospital mass fatality operations.

Upon making the decision to deactivate hospital mass fatality operations, notify the following:

* [Insert Internal Departments/Titles]
* [Insert Jurisdiction Name] Emergency Operations Center/Emergency Management Agency
* [Insert Jurisdiction Name] Medical Examiner/Coroner’s Office

Upon making the decision to deactivate the hospital mass fatality operations, the following actions will occur:

* [Insert actions/steps for returning to normal operations, e.g., decontaminate morgue sites, restock inventory, etc.]

# Training and Exercise

Refer to the hospital’s training and exercise plan.

# Appendices

1. Acronyms
2. Definitions
3. Policies
4. Job Action Sheets
5. Transportation and Surge Morgue Sites
6. Equipment and Supplies
7. Key Contacts List
8. Decedent/Missing Person Information Form
9. Decedent Tracking Log
10. Cultural Considerations

# References

1. [List Applicable Hospital Policies/Procedures]
2. Hospital Disaster Preparedness & Response Compact
3. Community Emergency Operations Plan/Fatality Management Plan
4. HIPAA
5. Stafford Act

# Appendix A: Acronyms

AAR After Action Review

AM Ante mortem

ARC American Red Cross

BCP Body Collection Point

CBRNE Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive

DHS Department of Homeland Security

DMORT Disaster Mortuary Operational Response Team

EMS Emergency Medical Service

EOC Emergency Operations Center

EOP Emergency Operations Plan

FAC Family Assistance Center

FBI Federal Bureau of Investigation

FM Fatality Management

Hazmat Hazardous Materials

HCC Hospital Command/Coordination Center

HHS Health and Human Services

HVA Hazard Vulnerability Assessment

HVAC Heating, Ventilation, and Air Conditioning

IC Incident Command or Incident Commander

ICS Incident Command System

JIC Joint Information Center

JIS Joint Information System

MA Mortuary Affairs

MFI Mass Fatalities Incident

MOU Memorandum of Understanding

NIMS National Incident Management System

NGB National Guard Bureau

NGO Non-Governmental Organization

NOK Next of Kin

NPO Non-Profit Organization

NRF National Response Framework

NTSB National Transportation Safety Board

PD Police Department

PE Personal Effects

PIO Public Information Officer

PM Postmortem

PPE Personal Protection Equipment

SME Subject Matter Experts

SOP Standard Operating Procedure

WMD Weapons of Mass Destruction

# Appendix B: Definitions

Ante mortem: Prior to death.

Casualty: A person who is injured in a mass fatality incident but does not die.

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

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

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

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

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

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

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

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

Justice of the Peace: An elected county official whose duties include serving as the medico-legal authority in counties that do not maintain an Office of the Medical Examiner.

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

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

Mass Burial: A large plot of land used for burying multiple victims in partitioned, marked graves.

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

Mass Grave: A common grave containing multiple, usually unidentified human corpses.

Mass Interment: Burial of large numbers of identified or unidentified bodies.

Medico-legal: Of or pertaining to law as affected by medical facts.

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

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

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

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

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

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

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

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

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

Postmortem: After death.

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

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

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

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

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

# Appendix C: Policies

## Temporary Storage Policy

Temporary storage of remains or unassociated tissue may be the choice rather than immediate burial. Consideration in the decision would include: time between death and the identification and return of the remains to the family, possibility of identification, inability to locate or determine the next of kin, and legal considerations. The choice is the responsibility of the Medical Examiner. If the decision is temporary storage, remains should be thoroughly preserved and disinfected.

Once the remains have been properly prepared, pouched and/or casketed, they shall be returned to the Coroner/Medical Examiner for storage.

## Next of Kin

The *Right to Control and Duty of the Disposition of the Body* Minnesota law clearly identifies who is in charge of the disposition of the body. The right to control a dead human body, including the location and conditions of final disposition, vests in, and the duty of final disposition of the body devolves upon, the following in the order of priority listed:

1. A person may plan for their own final disposition and have those wishes carried out; (These arrangements made in advance of need must be in writing, dated and witnessed.)
2. The person or persons appointed in a dated written instrument signed by the decedent. By definition, a written instrument includes, but is not limited to, a health care directive executed under chapter 145C. If there is a dispute involving more than one written instrument, a written instrument that is witnessed or notarized prevails over a written instrument that is not witnessed or notarized. However, a written instrument does not include a durable or nondurable power of attorney which terminates on the death of the principal pursuant to sections 523.08 and 523.09;
3. The spouse of the decedent;
4. The adult child or the majority of the adult children of the decedent. Keep in mind that, in the absence of actual knowledge to the contrary, a mortician may rely on instructions given by the child or children who represent that they are the sole surviving child, or that they constitute a majority of the surviving children;
5. The surviving parent or parents of the decedent, each having equal authority;
6. The adult sibling or the majority of the adult siblings of the decedent, provided that, in the absence of actual knowledge to the contrary, a mortician may rely on instructions given by the sibling or siblings who represent that they are the sole surviving sibling, or that they constitute a majority of the surviving siblings;
7. The adult grandchild or the majority of the adult grandchildren of the decedent. A mortician may rely on instructions given by a grandchild or grandchildren who represent that they are the only grandchild or grandchildren reasonably available to control final disposition of the decedent's remains or represent a majority of such grandchildren;
8. The grandparent or the grandparents of the decedent, each having equal authority;
9. The adult nieces and nephews of the decedent, or a majority of them, provided that, in the absence of actual knowledge to the contrary, a funeral director or mortician may rely on instructions given by a niece, nephew, or nieces or nephews who represent that they are the only niece, nephew, or nieces or nephews reasonably available to control final disposition of the decedent's remains or represent a majority of nieces and nephews reasonably available to control final disposition of the decedent's remains;
10. The person or persons who were acting as the guardians of the person of the decedent with authority to make health care decisions for the decedent at the time of death;
11. An adult who exhibited special care and concern for the decedent;
12. The person or persons respectively in the next degree of kinship in the order named by law to inherit the estate of the decedent;
13. The appropriate public or court authority, as required by law. You may review the regulations on controlling the final disposition of a body and who has the duty to pay for the funeral in MN Statutes 149A.80.

## Cameras and Recording Equipment Policy

The use of cameras and other recording equipment shall be prohibited without the written authorization of the Medical Examiner.

Any individual in possession of a camera or other recording equipment without the written authorization of the Medical Examiner shall have equipment confiscated and the individual will be personally escorted to Site Security.

Site Security will determine if an individual is authorized by the Medical Examiner to use cameras or other recording equipment. If Site Security believes an individual may have a valid need for the use of a camera or recording equipment, a recommendation may be forwarded to the Medical Examiner.

Any individual discovered at a site without appropriate authorization shall be removed from the disaster operation.

Any photographs or recording material used in the processing and identification of remains or personal effects will remain the property of the Medical Examiner.

The Coroner/Medical Examiner will make the final determination regarding the public release of any photograph or recording material of remains or personal effects.

The Medical Examiner will approve and contract with a photographic laboratory for the development of all photographic or recording material.

## Confidentiality Policy

All staff shall respect the rights of survivors, family members, and staff to privacy. Private information from survivors, family members and staff should not be solicited unless it is essential to providing services. Once private information is shared, standards of confidentiality apply.

All staff shall protect the confidentiality of all information obtained in the course of the mass fatalities operation, except for compelling professional reasons. The general expectation that information will be kept confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to an identifiable person or when laws or regulations require disclosure without an individual’s consent. In all instances, staff should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

All staff shall protect the confidentiality of survivors, victims, family members, and staff when responding to requests from representatives of the media.

When feasible, staff should inform survivors, family members, and staff members, to the extent possible, about the disclosure of confidential information and the potential consequences, before the disclosure is made. This applies whether the confidential information is disclosed on the basis of a legal requirement or with the individual’s consent.

Staff shall not discuss confidential information in any setting unless privacy can be ensured. Staff should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators and restaurants.

All staff shall protect the confidentiality of survivors, victims, family members, and staff written and electronic records and other sensitive information. Staff should take reasonable steps to ensure that records are stored in secure locations and that these records are not available to individuals who are not authorized to have access.

Staff should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

Mental Health Staff should discuss with survivors, family members, and staff the nature of confidentiality and limitations of individual right to confidentiality. Mental Health Staff should review with individuals the circumstances in which confidential information may be requested and in which disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the relationship and as needed throughout the course of the relationship.

Mental Health Staff should protect the confidentiality of individuals during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders Mental Health Staff to disclose confidential or privileged information without an individual’s consent and such disclosure could cause harm to the individual, Mental Health Staff should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

Mental Health Staff shall not disclose identifying information when discussing individuals for teaching or training purposes unless the individual has consented in writing to the disclosure of confidential information.

All staff shall protect the confidentiality of the deceased consistent with the preceding standards.

Upon closure of the mass fatalities response operation, all individual records should be transferred or disposed of in a manner that protects the individuals’ confidentiality and is consistent with state statutes governing records.

# Appendix D - Morgue Unit Leader Job Action Sheet

**Mission**:   Coordinate fatalities management operations. Report operational issues to the [Insert Appropriate HICS Position Title].

| Immediate (Operational Period 0-2 Hours) | Time | Initial |
| --- | --- | --- |
| Receive appointment, briefing, and appropriate materials from [Insert Appropriate HICS Position Title]. |   |   |
| Read this entire Job Action Sheet and review incident management team chart (HICS Form 207).  Put on position identification vest. |   |   |
| Notify your usual supervisor of your HICS assignment. |   |   |
| Establish Morgue Area. Temporary morgue is [Insert Location]. Phone #: [Insert Phone Number]. Coordinate with Emergency Department Supervisor and Patient Care Director. |   |   |
| Contact Environmental Services or Facilities to prepare temporary morgue (e.g., obtain hoyer lift, clear area of any equipment/supplies that are in storage, etc.) |   |   |
| Obtain assistance from the [Insert Appropriate HICS Position Title] for transporting deceased patients. |   |   |
| Assure all transporting devices are removed from under deceased patients and returned to the Triage Area. |   |   |
| Monitor critical equipment and supplies, and alert Incident Commander to potential shortages. |   |   |
| Document all activities on the Operational Log (Form 214).  Provide a copy of the Incident Message Form to the Documentation Manager. |   |   |

| Intermediate (Operational Period 2-12 Hours) | Time | Initial |
| --- | --- | --- |
| Advise [Insert Appropriate HICS Position Title] immediately of any operational issue you are not able to correct or resolve. |   |   |
| Ensure patient records and documentation are being prepared correctly and collected. |   |   |
| Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques. |   |   |
| Meet regularly with team members for status reports and report information to [Insert Appropriate HICS Position Title]. |   |   |

| Extended (Operational Period Beyond 12 Hours) | Time | Initial |
| --- | --- | --- |
| Maintain master list of deceased patients with time of arrival for Patient Tracking/Bed Management Leader and Patient Information Leader. |   |   |
| Assure all personal belongings are kept with deceased patients and are secured. |   |   |
| Assure all deceased patients in Morgue Areas are covered, tagged and identified where possible. |   |   |
| Keep Treatment Areas unit leaders apprised of number of deceased. |   |   |
| Contact the Security Officer for any morgue security needs. |   |   |
| Arrange for frequent rest and recovery periods, as well as relief for staff. |   |   |
| Schedule meetings with the Behavioral Health Unit Leader to allow for staff debriefing |   |   |
| Observe and assist any staff whom exhibits signs of stress or fatigue. Report any concerns to the Emergency Department Supervisor. |   |   |
| Review and approve the area documenter's recording of action/decisions in the Morgue Area. Send copy to the Emergency Department Supervisor. |   |   |
| Direct non-utilized personnel to Labor Pool/Personnel Staging Unit. |   |   |

| Demobilization/System Recovery | Time | Initial |
| --- | --- | --- |
| As needs decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner. |   |   |
| Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment. |   |   |
| Upon deactivation of your position, brief the Operations Chief on current problems, outstanding issues, and follow-up requirements. |   |   |
| Upon deactivation of your position, ensure all documentation and Operational Logs are submitted to Operations Chief. |   |   |
| Participate in stress management and after-action debriefings.  Participate in other briefings and meetings as required. |   |   |

| Documents/Tools |
| --- |
| * Incident Action Plan
* HICS Form 204 – Branch Assignment Sheet
* HICS Form 207 – Incident Management Team Chart
* HICS Form 214 – Operational Log
* HICS Form 254 – Disaster Victim /Patient Tracking Form
* Hospital Emergency Operations Plan
* Hospital Fatality Management Plan
* Community Fatality Management Plan
 |

# Appendix E – Transportation and Surge Morgue Sites

The following hospital transportation assets are available to support decedent transport.

|  |  |  |
| --- | --- | --- |
| Transport Description | Quantity | Location |
|  |  |  |
|  |  |  |
|  |  |  |

The following non-hospital transportation assets are available to support decedent transport.

|  |  |  |
| --- | --- | --- |
| Transport Description | Quantity | Location/Contact Info |
|  |  |  |
|  |  |  |
|  |  |  |

The following hospital morgue surge sites are available to support decedent storage.

|  |  |
| --- | --- |
| Location | Maximum # Decedents |
|  |  |
|  |  |
|  |  |

# Appendix F – Equipment & Supplies

The following resources will likely be needed and are currently available from the hospital to support the hospital’s fatality management operations:

|  |  |  |
| --- | --- | --- |
| Resource Description | Quantity | Location |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

The following resources might be needed and would need to be requested/purchased at time of need to support the hospital’s fatality management operations:

|  |  |  |
| --- | --- | --- |
| Resource Description | Quantity | Source |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# Appendix G – Key Contacts

The following are key contacts that may be necessary to support the hospital’s fatality management plan.

|  |  |  |  |
| --- | --- | --- | --- |
| Service/Function | Organization | Contact Name | Contact Phone # |
| [Funeral Home] |  |  |  |
| [Medical Examiner] |  |  |  |
| [EMA] |  |  |  |
| [Behavioral Health Support] |  |  |  |
| [Vendor (e.g., Refrigerated Trucks] |  |  |  |
| [Transportation Provider] |  |  |  |
| Medical Resource Support | SEMN Healthcare MACC | 24/7 ECC Dispatch | Primary 855.606.5458 Backup 507.255.2808 Backup radio ARMER “SE Hospital” Talkgroup |

# Appendix H – Decedent/Missing Person Information Form

Use this form following a mass fatality incident to collect family information regarding a missing person.

|  |  |
| --- | --- |
| **Facility Name:** |  |
| **Information Collected By:** |  |
| **Date:** |  |  Print Name & Title |
| **Time:** |  | **AM/PM** | **Phone:** |  | **Fax:**  |  |

**Information Given By**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Last Name:** |  | **First Name:** |  | **Middle Name:** |  |
| **Phone:** |  | **Email:** |  |
| **Relationship:** |  |
| **Address:** |  |
| **City:** |  | **State:** |  | **Zip Code**: |  |

**Contact Person for Missing Person** (If different from above)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Last Name:** |  | **First Name:** |  | **Middle Name:** |  |
| **Phone:** |  | **Email:** |  |
| **Relationship:** |  |
| **Address:** |  |
| **City:** |  | **State:** |  | **Zip Code:** |  |

**When was the last known contact with the missing person?**

**Missing Person Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Last Name:** |  | **First Name:** |  | **Middle Name:** |  |
| **Maiden Name:** |  | **Email:** |  |
| **Phone Number:** |  |
| **Relationship:** |  |
| **Marital Status:** |  | **Date of Birth:** |  | **Age:** |  |
| **Address:** |  |
| **City:** |  | **State:** |  | **Zip Code:** |  |
| **Does the person require any medications?** |
| **Does the person have any major medical or mental health issues?** |

**Legal Next of Kin**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Last Name:** |  | **First Name:** |  | **Middle Name:** |  |
| **Phone:** |  | **Email:** |  |
| **Relationship:** |  |
| **Address:** |  |
| **City:** |  | **State:** |  | **Zip Code:** |  |

**Physical Description**

Mark with an **X** the most appropriate response and add additional information in the space provided

|  |  |
| --- | --- |
| **Approximate Height** | **Approximate Weight** |
| **Sex** | Male Female Unknown   |
| **Age Group** | Infant Child Adolescent Adult: 20’s 30’s 40’s 50’s 60’s 70’s 80’s >80’          Unknown Other   |
| **Race/ Ethnicity** | White Black/African American Asian Native American Hispanic/Latino    Unknown Other   |
| **Skin Color** | Light Medium Tan Dark Freckles Unknown Other       |
| **Hair Color** | Blonde Brown Black Grey White Red Dyed      Unknown Other   |
| **Hair Length** | Short-chin level Medium – shoulder level Long – below shoulder Unknown Other    **** |
| **Hair Type** | Straight Curly Wavy Shaved Bald Pattern of Baldness     Unknown Other   |
| **Facial Hair** | None Beard Moustache Stubble Sideburns Goatee Unknown      Other  |
| **Eye Color** | Brown Blue Green Hazel Black Grey Unknown      Other  |
| **Eye Wear** | Contact Lenses Yes No  | Glasses Yes No Describe Frames: |
| **Dental Characteristics** | Dentures Yes No Partials Yes No  | Bridge Braces Crowns Missing   Chipped Gaps Other   |
| **Unique Features** | Shape of faceEyebrows:Nose:Chin:Hands:Feet: | Shape of EarsAttached Yes No Detached Yes No  |
| **Toenails** | Manicured Yes No Color: Decorated Yes No Describe:   | Other: |
| **Fingernails** | Manicured Yes No Color:  Decorated Yes No Describe:  | Other: |

**Distinguishing Body Marks**

Provide a brief description and location of the following distinguishing body marks and mark its location on the body sketch

|  |
| --- |
| **Tattoos** (description and location) |
| 1. |
| 2. |
| 3. |
| 4. |

|  |
| --- |
| Scars (Description & Location) |
| 1. |
| 2. |
| 3.  |
| 4. |

|  |
| --- |
| **Piercings (Description & Location)** |
| 1. |
| 2. |
| 3.  |
| 4. |

|  |
| --- |
| **Birthmarks** (description and location) |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

|  |
| --- |
| **Missing Organs/Amputations** (description and location) |
| 1. |
| 2. |
| 3. |
| 4. |

|  |
| --- |
| **List Prosthesis/Implants** (e.g. pacemaker, metal plates, screws, hearing aid) |
| 1. |
| 2. |
| 3. |
| 4. |



 Front Back

Mark on body sketch the presence of:

* **Scars S**
* **Tattoos T**
* **Piercings P**
* **Birthmarks B**
* **Amputations A**

**Place Patient Identification Sticker Here or Patient Tracking Unique Identifier**

**Photographs**

List and describe all photographs attached below (or attached to this form)

1.
2.
3.
4.

**Place Photo Here Place Photo Here**

**Place Photo Here Place Photo Here**

**Personal Effects**

**Description of clothing:** Describe type of clothes worn in as much detail as possible. Include **size, color, material and any inscription**.

1.

6.

2.

7.

3.

8.

4.

9.

5.

10.

**Description of Footwear:** Describe type of worn footwear in as much detail as possible. Include **size, material, color and any inscription**.

**What is his/her shoe size?** \_\_\_\_\_\_\_

**Description of Jewelry Items:** Describe the type, color, stone and any inscription in as much detail as possible. (e.g. yellow metal ring with clear stone)

**Worn at Time of Disaster: Jewelry Items “Always Worn”**

1.

5.

2.

6.

3.

7.

4.

8.

**Other Personal Items Found on Person:** Such as wallet, purse, keys, cell phone, contents of pockets, etc. Provide as much detail as possible

1.

5.

2.

6.

3.

7.

4.

8.

|  |
| --- |
| **Additional Comments:** |

# Appendix I – Decedent Tracking Log

|  |  |
| --- | --- |
| **DATE/TIME PREPARED:** | **OPERATIONAL PERIOD DATE/TIME:** |
| **NAME** | **SEX** | **DOB** | **NOK NOTIFIED YES/NO** | **ENTERED YES/NO** | **DECEDENT STORAGE AREA** |
| **NOTIFIED VIA PHONE** | **EDRS** | **LOCATION** | **IN DATE/ TIME** | **OUT DATE/ TIME** | **LOCATION** | **IN DATE/ TIME** | **OUT DATE/ TIME** |
|  |  |  |  |  |  |  |  |  |  |  |  |
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# Appendix J – Multi-cultural Planning

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.

| Religion/Culture | Preference | Other Comments |
| --- | --- | --- |
| Afghanistan / Islam | Rapid Burial |  |
| Amish / Mennonites | No Restrictions |  |
| Arab Cultures / Islam | Rapid Burial |  |
| Buddhist | No Restrictions |  |
| Chinese / Hindu | Cremation | Burial |
| Christian Scientist | No Restrictions | Cremation |
| Cuban / Roman Catholic | Burial |  |
| Eastern Orthodox | Burial |  |
| Filipino / Roman Catholic | Burial |  |
| Guatemalan / Roman Catholic | Burial |  |
| Hispanic/Latino (other) / Roman Catholic | Burial (Generally) |  |
| Indian / Hindu | Cremation |  |
| Japanese / Buddhist | No Restrictions |  |
| Jewish | Rapid Burial |  |
| Korean | Burial |  |
| LDS | Burial |  |
| Mexican / Roman Catholic | Burial |  |
| Native American | Burial |  |
| Pakistani | Rapid Burial | No coffin |
| Polynesian | Burial |  |
| Puerto Rican / Roman Catholic | Burial |  |
| Rastafarian | Don’t believe in burial | Ask for Preference |
| Sri Lanka / Buddhist | No Restrictions |  |