

DC Emergency Healthcare Coalition

Residential Healthcare Facility

Mass Fatality Procedures Template



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RESIDENTIAL HEALTHCARE FACILITY MASS FATALITY PROCEDURES TEMPLATE

Produced by the DC Emergency Healthcare Coalition

Introduction and purpose:

This template has been designed by the DC Emergency Healthcare Coalition (DC EHC) to provide guidance to member organizations that provide residential healthcare services (acute care, long and short term care). The guidance is focused upon effective management of mass fatality situations. It is formatted to be easily adapted by Coalition member organizations to either enhance existing mass fatality plans or to assist in the creation of new planning. Nothing in this template is prescriptive nor sets standards for participating organizations. A mass fatality incident is defined in this document to be consistent with the DC Office of the Chief Medical Examiner's (OMCE's) definition: fatalities that present a challenge or overwhelm a healthcare organization's capabilities due to increased numbers or other special factors (e.g. contamination).

To be concise and practical, this document provides both preparedness and response guidance. The entire document is formatted to provide the architecture of an annex that an organization might wish to establish for its Emergency Operations Plan (EOP). Relevant preparedness information is provided throughout the text and is highlighted where appropriate. Individual organizations are encouraged to review this entire template and consider how these issues would be addressed within their own organization.

It should be noted that this document has been designed utilizing several references (noted where applicable). Many general concepts were adapted from these references and incorporated in a manner that makes direct referencing difficult. Therefore, a reference list is provided at the end of this document in order to provide credit.

In addition, it is constructed based upon foundational emergency management and incident command system principles. It is not intended to provide overall management concepts for an organization but rather to focus on those issues relevant to the identification, tracking, storing, reporting, and transfer of the deceased in the District of Columbia. Concepts in this document should be considered for incorporation into an organization's EOP and overall emergency management program in a fashion consistent with other projects.

1.) Facility Mass Fatality Response Procedures Template:

The remaining sections of this document provide a template that a residential healthcare organization can utilize to document its respective mass fatality response processes and procedures. Bolded text indicates important sections worth considering for inclusion in the documented response procedures.

Statement of purpose of the plan: A brief statement of purpose of the procedures should delineate when and how the document should be applied. For example, it might

be worth delineating that the procedures can be utilized for a large number of fatalities or for fatalities that are difficult to process (e.g. contamination).

Goal and Objectives: Some organizations may wish to include a goal statement and objectives in this section of the response procedures. A candidate goal statement might be:

- Goal: To safely, efficiently, and respectfully process and store the deceased at the healthcare facility regardless of challenges posed.

Assumptions: Specific incident parameters should be listed that in the annex that would indicate the appropriate application of these procedures. In addition, exceptions that might impact the application of the procedures should be listed as well. *These incident assumptions must be evaluated at the time of response to ensure their validity and hence, appropriateness of utilizing these procedures.* Suggested assumptions for inclusion in a Mass Fatality Annex to an EOP include:

- The District of Columbia could be confronted with an incident that results in mass fatalities that severely challenge the regular capacity of the Office of the Chief Medical Examiner.
- Some of these fatalities may occur at healthcare-organizations after injured or ill patients arrive for treatment.
- In unusual incidents, the fatality numbers could severely challenge the capacity of the healthcare organizations and potentially compromise other emergency operations.
- Fatalities in the field will not be transported to healthcare organizations for further processing unless a special agreement exists between DC OCME and that individual healthcare organization.
- Due to incident parameters, positive identification of victims at healthcare organizations may be difficult to conclusively determine.
- As in past large-scale incidents, victims' families will search at healthcare organizations across the area to try to locate missing loved ones unless an alternative process is available. This can result in excessive commitment of valuable personnel time and other resources, and promote undue stress in personnel as well as families of missing persons.
- A slow or less-than-visibly competent healthcare organization response to assisting with locating deceased individuals may be perceived negatively by the media and the public.
- Some of the identification procedures utilized for mass fatalities could also be of assistance during a surge incident with multiple critically ill patients, unable to identify themselves. The process used should be consistent with available internal patient tracking systems.
- Processing and storage of remains at a healthcare organization could be complicated by chemical or radiological contamination of the victims.

- Processing and storage of remains at a healthcare organization could be complicated by unusual, highly infectious organism that caused the victim's demise.
- Storage of multiple fatalities at a healthcare organization must address respect for the deceased, privacy considerations, as well as forensic and mortuary physical storage requirements.
- Chain of custody may be necessary for storage of remains and their personal effects.
- Transfer of remains after a mass fatality incident will in most situations be to the responsibility of DC Office of the Medical Examiner (OCME) or their designated alternate facilities (e.g. DMORT)
- In some cases after a mass fatality incident, DC OCME may permit release of human remains directly from healthcare organizations to funeral homes and/or the deceased's family (i.e. in cases involving natural causes of death)
- In some incidents (e.g. terrorist incident, incident on DoD property), other organizations may have an interest/role in processing of deceased (e.g. FBI, Department of Defense or DoD). In these instances, healthcare organizations can expect DC OCME to coordinate the requests of these other organizations.

Systems Description: This section of the document should outline important functions that the facility may have to address during care of the deceased. This list of functions should be utilized to guide the establishment of an organizational structure and the subsequent assignment of personnel. It should be recognized that not every function will be needed for every incident.

This actual construct of how these functions are addressed should be based upon processes and procedures already outlined in a facility's all hazards Emergency Operations Plan (EOP). Therefore, *incident command (for the facility), Planning, Logistics, and Admin/Finance functions are not specifically mentioned here* (as they are assumed to be a part of a generic response plan). As an example, healthcare organizations should have consistent processes for documenting expenditures during emergency response in anticipation of being able to seek financial relief during recovery from the hazard impact.

Important functions to consider in assigning personnel include:

- **Liaisons:** Liaison positions for the facility may be required to interface with several external entities. The usual senior liaison position(s) could interface with:
 - OCME who will have ultimate say on whether the deceased qualify to be a Medical Examiner case or may be released to a family/funeral home. Even if the healthcare facility feels the latter case applies, all deaths are to be reported immediately to DC OCME. In addition, there may be reporting requirements to any Family Assistance Center (FAC).
 - Funeral homes

- DC Fire and EMS as indicated
 - DC Emergency Healthcare Coalition (and its Healthcare Coalition Response Team or HCRT) to assist with information needs and coordination with jurisdictional response
 - DC Department of Health (DOH) as indicated
 - DC Homeland Security and Emergency Management Agency (HSEMA), as indicated
 - DC Metropolitan Police Department (MPD), and as indicated, other law enforcement organizations such as the FBI
 - Other healthcare facilities responding to or requesting assistance through mutual aid.
- Safety Officer(s): Safety Officers monitor for and intervene when unsafe practices or conditions arise that could potentially impact staff, visitors, or patients during the facility response. There are several potential activities safety officers could be required to oversee/ensure are being properly addressed:
 - Infection control for those handling the deceased (see **attachment 1**, risks posed by the deceased).
 - Ensuring isolation of contaminated remains or decedents who expired from an unusual, highly infectious disease (see **attachment 2**)
 - Addressing mental health concerns for workers handling excessive or disfigured human remains.
 - Public Information officer(s): This important position/function provides public messaging through the media and assists with internal communication of messages relevant to staff, visitors, and patients. Media messaging should include relevant information regarding how to locate a loved one (e.g. jurisdictional phone numbers) or location of the Family Assistance Center. As with any incident response, this position monitors media messaging for inaccurate or critical information regarding the healthcare organization's response to the mass fatality incident.
 - Operations: Personnel assigned to the Operations Section are involved with tasks designed to meet the facility's response objectives. Though this section can be organized and sub-divided in different fashions, the core critical functions during response to mass fatalities include:
 - Patient identification: Residential healthcare facilities (acute care) should be prepared for situations in which multiple patients present critically ill or injured and then die. Procedures for working with the jurisdiction to establish patient identity and proper disposition of the patient can be critical for bringing closure to grieving families and in some instances, hasten the issuance of a death certificate. Timely closure can also have important financial implications for benefactors of the patient.

On a day-to-day basis, acute care healthcare facilities are confronted with this on a regular basis. There are three essential elements that are repeated here as they are germane to mass fatalities as well:

- Patient is not disfigured
- Photo identification with patient
- Family member (who can verify their identity) positively identifies the deceased

When one of these three elements is not available on a day to day basis, the patient is typically declared a medical examiner case where positive identification can then take place.

The challenge with this day-to-day approach during a mass fatality incident is that DC OCME may be challenged itself with response to the incident (e.g. field decedents take priority). Identification of decedents at healthcare organizations, therefore, is likely not to be the immediate priority and so the usual OCME actions may be significantly delayed. This can be problematic for families and for the impacted healthcare organizations, and so the healthcare organizations may institute relatively simple procedures to facilitate the identification process.

Healthcare facilities are therefore encouraged to utilize **attachment 3** when reporting **unidentified** deceased individuals to the DC OCME during a mass fatality incident (note: the same form can be utilized to report to DC DOH unidentified critically ill/injured patients). The purpose of this form is to gather easily documented, visible information from the human remains to increase the efficiency of patient identification. A standardized process is promoted for healthcare facilities as well as individuals reporting missing persons.

Note: Healthcare organizations only assume the role of body identification when this is a straightforward process (i.e., photo identification present with the body, the human remains are not disfigured or decomposed, a close family member positively identifies the patient by direct visualization). Otherwise, information in attachment 3 is provided to DC OCME to assist in their determination of victim identification. The method for sending the form will be determined by OCME at the time of the incident.

- Patient tracking: Tracking of the deceased within a healthcare facility must occur. As these patients will typically have been admitted, facilities are encouraged to utilize their regular surge tracking mechanisms with designators that indicate the patient is deceased. Facilities may wish to include other elements in their tracking mechanisms including specific locations (e.g. space 1 row 2, floor of morgue)

In addition, healthcare facilities will have to establish a method for tracking the deceased individual's personal effects. Simple tagging methods that link the belongings to the deceased are usually sufficient. The important point here is that a method for documenting chain of custody should be established for security of the belongings as well as the situation where the deceased may be implicated in criminal activity.

This tracking function will necessarily have to be tightly linked with the patient family assistance functions that most healthcare organizations typically establish (e.g. to provide confirmation to families when inquiries are made about the presence of the patient).

- Patient information management: Though the facility liaison may be assigned with the actual reporting of cases to DC OCME, several operations section activities related to reporting the deceased may need to occur internally:
 - Discovering information that will assist in the determination that the patient should be a medical examiner case: During a mass fatality incident, DC OCME may require more information regarding a patient to ascertain whether or not it is a medical examiner case. This can entail research, discussions with family members as well as other activities all of which are most appropriately located under the operations section.
 - Death certificates: In cases in which a natural cause has led to the patient's demise and DC OCME has released jurisdiction a physician licensed in the District of Columbia should complete the death certificate (see attachment 4, death certificates). An example might be during a highly lethal influenza incident.¹ This issue may be addressed by the healthcare facility's Incident Management Team (IMT) by assigning personnel to oversee responsible physicians are completing the appropriate paperwork (which includes the ability to complete this information on-line). Work could include ensuring that certificates are filled out correctly and processed for submission (thereby preventing any delays in release of the human remains to the family).
 - Patient family assistance functions:
 - Tracking and responding to family inquiries about the potential presence of a specific victim at the facility: For acute care facilities during a sudden onset incident, this can be a significant activity that relates both to live and deceased patients. This patient family assistance function must have pre-established personnel who have been trained on the facility's procedures. Important concepts could include:
 - A well publicized telephone number that is known internal to the facility (e.g. switchboard operators). This will prevent the transfer of calls to clinical areas that may be overwhelmed.
 - Multiple roll-over lines dedicated to the same destination so that during the initial stages of an

¹ Note: This type of incident should be distinguished from a intentional contagious disease outbreak in which case, at least initially, all cases could be deemed OCME cases.

incident, callers do not receive busy signals or generic voicemail messages.²

- If there is an EMR in use, then personnel operating this inquiries function must have access to it in addition to the ability to discuss specific cases directly with clinical staff.
 - Access to the ED/IT connectivity program if that is relevant to the incident (e.g. acute onset, presenting to acute care facilities).
 - A scripted message that is standardized for responding to callers. This can promote consistency and enhance effectiveness.
 - A simple tool that tracks caller information including contact methods (see **attachment 5**). This may be helpful in the event a patient presents later in the incident, after the facility has received the inquiry
- If the deceased have positively identified next of kin who are available, healthcare organization personnel may be required and assigned to:
 - Prepare and accompany individuals to view the relatives/loved ones body
 - Facilitate patient families as they seek arrangements for final disposition of the deceased (i.e. if not a medical examiner case).
 - Provide any behavioral health assistance
 - Storage of human remains: This function would oversee the regular and any surge capacity or capability requirements for storage of the deceased. In addition to the operations personnel assigned to this operations function, logistics personnel would be required to support these activities. As the logistics function is not addressed separately in this document, logistical considerations are listed here as well.³ It is important to note that some of the following concepts should be examined for their impact on preparedness activities (e.g. selection of any surge site) or during response activities (e.g. when surge sites, selecting additional sites):

² Unfortunately, HIPAA prohibits simple processes such as those that occur in many countries overseas when a large scale disaster occurs: hospitals publish lists of patients in a very public fashion to decrease the need for assigning healthcare facility personnel to handling multiple calls.

³ Many of these concepts were adopted from “Mass Fatality Incident Management: Guidance for Hospitals and Other Healthcare Entities.” Developed by the following Los Angeles County partners: Department of Coroner, Department of Health Services/Emergency Medical Services Agency, and Department of Public Health. August, 2008. Available at <http://ems.dhs.lacounty.gov/ManualsProtocols/MFIM/MFIGuidanceForHospitals808.pdf> accessed March 13, 2010.

- Environment: The environment can have an obvious and significant impact on body decomposition. The two most important factors are temperature and humidity.
 - Temperature: Contrary to popular belief, freezing bodies is usually discouraged for many reasons (change appearance of body, can increase tissue fragility, and can cause freezing injuries that could confuse post-mortem examinations, etc.). The ideal temperature is 38-42° F. This merely delays the decomposition process. In severe situations, temperature controlled rooms that do not reach this level may be acceptable.
 - Humidity: Low levels of humidity are generally encouraged to slow the decomposition process. As an example, high levels can increase the potential for mold formation.
 - In addition, other considerations such as preventing access to the bodies by scavengers (insect, rodent, etc) can be critical for avoiding rapid tissue decomposition that can impact families when identifying victims and conducting funeral rituals.
 - Ventilation of the space is important. External ventilation of the space is desirable.
 - Wood or other porous surfaces are generally not recommended as these can be hard to clean post-incident.
- Security considerations are paramount. Being able to prevent unwanted individuals (both external and internal to the organization) from accessing the site is important and could require posting personnel to monitor the site. In addition, placement of these facilities ideally will avoid highly visible public areas. This would include transport routes from clinical areas to the morgue facility, plus the loading areas for transfer to final disposition.
- If appropriate tracking and documenting methods are established, it may not be necessary to store personal belongings with the bodies (thus freeing up space for more bodies).
- Placement of patients should be considered in designating storage space. For example, it is typically NOT acceptable to stack bodies (out of respect, disfigures the bodies, etc.).
 - Bodies should be placed in body bags or similar devices to contain any effluent.
 - Bodies MAY be positioned to conserve space such as placing the body #1 between the legs of another (body #2) with the head of #1 resting on the abdomen of #2.

- It is generally ill advised to store bodies at a level above the waistline with shelving systems. This can present a transfer and safety problem.
- Bodies should be placed so that there is easy access to all of them in the storage facility (i.e. aisles or corridors through the bodies to permit easy access).
- Selection of sites and alternate care facilities: Considerations of what the potential storage space is utilized for on a day to day basis become paramount. Once the space is utilized for storing human remains, there may be very negative emotional reactions about utilizing the space for its original function. An example would be the predictable response to cafeteria operations after utilizing walk in refrigerators to store human remains.
- Mobile containers: There is the possibility of obtaining mobile containers such as refrigerated trucks (“reefers”). If this is a part of the planned response, the facility may wish to examine emergency contracts with vendors. Ascertaining the dimensions (e.g. height, width, length) of any pre-planned container is necessary to ensure any pre-planned staging area is adequate for placement of the container. In addition, healthcare organization emergency managers should consider associated maintenance requirements that may be necessary for some mobile containers and how these would be supported (e.g. maintaining cooling mechanisms deployed with associated mobile container).
- Security procedures should be preplanned and implemented regardless of selected location for storage of the deceased. This should include examination of locking mechanisms, staffing requirements as well as other factors deemed necessary to ensure unwanted entry into the area.
- Patient transfer: This function addresses the administrative arrangements for transferring patients either to DC OCME or to funeral homes. Activities will include:
 - Identifying available patient destinations (in coordination with the Patient Family Assistance function)
 - Identifying transport methods and estimated time of arrival (at times could be in conjunction with the liaison function)
 - Coordination with patient tracking when body final disposition is made
 - Transfer of patients to appropriate loading areas.⁴

⁴ Most healthcare facilities have loading areas that are protected from on lookers for loading the deceased during day to day operations. These loading areas may become compromised during a mass fatality

- Ensuring appropriate paperwork and personal affects accompany the body
- Completion of any procedures for documenting chain of custody

Concept of Operations: The Concept of Operations provides generic processes that should be addressed throughout different stages of the incident.

- **Incident recognition**

- Incident recognition for both the healthcare organizations or for DC OCME could occur in several fashions. Two of the more likely scenarios would be:
 - Acute, sudden onset incidents: Examples include transportation sector incidents or large fires. In these incidents, there may be a relatively quick identification of the need for additional fatality care resources or specialized procedures.
 - Prolonged, slowly evolving incidents: A prime example would be a highly contagious and lethal disease outbreak in which both acute and long term care facilities are challenged in a gradual fashion by numbers of deceased in their facilities. The challenge here with disposition of the deceased may not be with DC OCME but rather funeral homes delaying pick up of the deceased.
- For individual residential healthcare organizations, incident recognition is establishing the point in time in which something other than day to day procedures are needed for handling fatalities within the facility.

- **Initial notification/activation**

- Initiation of the facility's mass fatality procedures is not expected to typically require special activation procedures as it is anticipated that the facility's EOP will already be activated in most instances. It is also likely that specialized fatality procedures may not be the highest priority response objective during initial stages of most responses. There could, however, be rare situations in which the organization must deal with an incident that is isolated to a surge in fatalities
- Initial notifications for activation of specialized fatality procedures should focus on the operations and logistics personnel that have been identified during preparedness to assist with these activities. In addition, providing a broader notification to healthcare facility regarding the activation should occur (e.g. through incident action planning if appropriate).
- Initial notification procedures should include both DC OCME and/or DC EHC even if no identified need for external support has been identified as of yet.

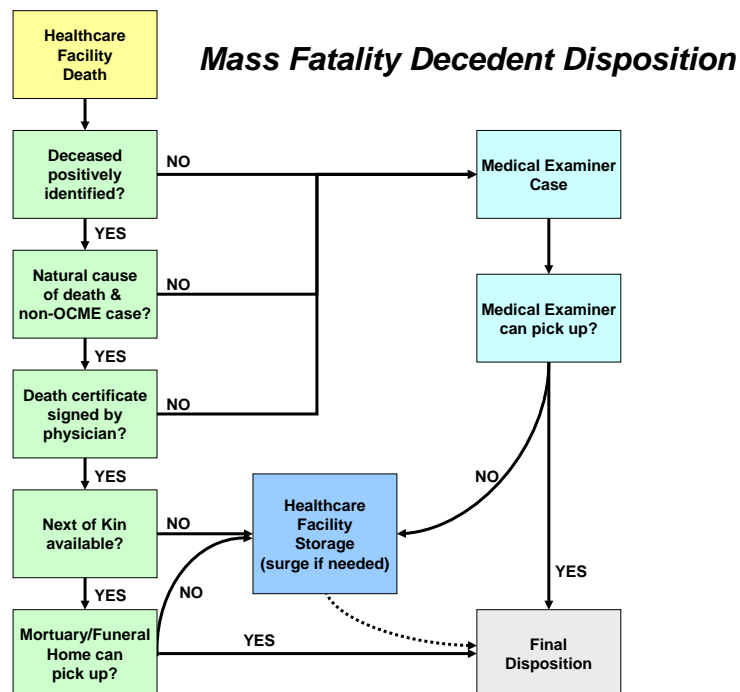
incident (higher priority needs for loading area, too many victims for loading area, etc.). Organizations are encouraged to examine alternate methods for loading the deceased for transport from the facility.

- **Mobilization**

- A variety of mobilization procedures may be necessary depending upon the incident parameters. Important considerations include:
 - Facilities: Executing any checklist driven guidance to set up or establish additional space for storage of the deceased. This can include the implementation of emergency contracts for outside vendor assistance.
 - Personnel: Assembling personnel responsible for special fatality procedures and providing assignments/briefings
 - Equipment and supplies: Obtaining pre-identified or newly identified equipment as required based upon initial incident parameters.

- **Incident operations**

- Incident operations are expected to focus on the 5 main activities/functions listed above (patient identification, patient tracking, patient reporting, storage, and transfer).
- A template process to assist facilities with processing the deceased is provided in the figure below. It is worth noting that this does not deviate significantly with day-to-day practice other than the potential for increased storage capacity.



- Regulatory variance: The DC Department of Consumer and Regulatory Affairs has a 30 day limit on the storage of the deceased at healthcare organizations (after which the facility is potential liable for fines). If OCME operations are challenged by field operations, there is a potential to exceed this limit. Seeking early variance from this regulation may be necessary (e.g. through the DC Emergency Healthcare Coalition if activated or through DC Department of Health).
- Depending upon incident parameters, healthcare organizations may need to staff the above required functions to varying degrees. Some functions (e.g. identification) may demobilize earlier than others (e.g. storage).

- **Demobilization and transition to recovery**

- Healthcare organizations should consider collating and filing expenditures related to the mass fatality incident (typically tracked by a Finance/Admin section during the incident). There may be a possibility of reimbursement for extraordinary expenditures.
- Facilities: Surge spaces utilized to store remains may require rehabilitation and/or cleaning. The following concepts should be considered:
 - In most instances, it may be advantageous to utilize contractors that are specifically qualified to conduct such services. These organizations should provide:
 - Before cleaning: process to be utilized to clean space
 - After cleaning: some certification that verifies the space is free of pathogens, offensive odors, as well as chemical products utilized in the cleaning process.
 - If contractors are cost prohibitive, healthcare organizations should consider obtaining additional assistance with guidance for procedures (e.g. from DOH) and should recognize that all activities must be conducted in accordance with OSHA, EPA, and local regulations.
- Personnel: All personnel involved in mass fatality procedures should be demobilized according to the organization's regular procedures. Consideration should be given to the need for any mental health debriefing and for providing access to mental health professionals if this is needed.
- Equipment: Durable equipment may require rehabilitation and expendables should be noted for potential re-ordering.
- Personnel involved in the mass fatality response should be encouraged to capture information for any potential After Action Review as per the home organization's regular policies.

Attachment 1: Infection control for the handling of the deceased

A critical message to convey to staff is that there is no infectious disease risk from merely being in the vicinity of the deceased. A corollary is that a deceased individual poses much less of an infectious risk to providers than a live patient. The following concepts are provided and should be considered for dissemination to staff working with or in the vicinity of the deceased:

- For individuals merely handling bodies (not performing post-mortems), there is no risk for catching a respiratory transmitted illness.
- The risk of transmission of disease by exposure to body fluids from the deceased decreases significantly over time (i.e. as time goes on post-mortem, the living organisms within the patient begin to diminish in virility and quantity).
- A risk for transmission of disease exists for an extended period after time of death through exposure to a puncture wound from bone.
- Standard precautions are recommended for handling the remains of the deceased:
 - Universal precautions should be implemented to prevent exposure to body and enteric fluids.
 - Masks may be utilized to assist with diminishing the effects of odors though they are not required.
 - Consider barrier protection (e.g. gowns, sleeve protectors, booties) when lifting or moving bodies
- The deceased should be stored in body bags or other water impermeable containment devices to decrease the chance of exposure
- Post-exposure protocols:
 - Initiate home organization post-exposure protocols for significant exposures
 - Testing of the deceased may require coordination with DC OCME as to where to send to sample tissue for the potential presence of pathogens (i.e. some healthcare organization's labs may be reluctant to test samples from the deceased for the presence or absence of pathogens)

Highly contagious diseases

- Standard precautions are generally acceptable (as noted above) for the simple process of handling the decedents for most infectious diseases.
- Considerations to upgrade PPE may be made when indicated by public health guidance.

Attachment 2: Processing contaminated remains

Chemical contamination and radiological contamination/incorporation

- It is generally assumed that chemical and radiological contamination on patients arriving at acute care healthcare facilities for treatment should be removed prior to entrance to the facility. The discussion regarding how this is to occur is beyond the scope of this guide. However, some patients could potentially expire at the healthcare facility prior to the full decontamination process.
- In addition, patients with radiological materials incorporated into their bodies (e.g. ingested/inhaled) may survive initial injury and illness and then expire later in the acute care healthcare organization.
- The two most important considerations for healthcare organizations related to these types of decedents are:
 - Storage space:
 - Once decedents are placed in water impermeable body bags, the chance of transfer of the toxin on a body is decreased substantially provided that the chemical does not react with the body bag itself causing a breach.
 - Chemically contaminated patients or those with surface radiological contamination should generally not be stored in usual morgue spaces. In addition, any contained environment (e.g. reefers) may be contraindicated due to the potential for buildup of off-gassing materials. Though difficult to address, outdoor storage with visual barriers may need to be temporarily erected.
 - The healthcare organization should generally NOT consider decontaminating the decedent (the health risk posed to healthcare responders may in most instances outweigh the benefit). If a healthcare organization does feel it has the capability to perform decontamination of the deceased:
 - This should take a lower precedent than decontamination and care of the living
 - **This effort should be coordinated with OCME and relevant law enforcement authorities to ensure that the contaminant is not being considered forensic evidence (as appropriate).**
 - PPE: As long as responders are not in a zone of release and are not interacting with contaminated remains in an enclosed environment,

regular decontamination PPE may be worn (generally accepted to be Level C though there is some controversy on this).

- Radiological monitoring may occur for the deceased contaminated or with incorporated radiological materials. In many instances, the latter will not pose a risk to responders and these remains may be stored in the usual fashion.

Attachment 3: Physical attributes to report on unidentified patients

Attachment 4: Information on death certificates in the District of Columbia

- Legal record that is used to register the patient's death with Vital Records
 - Are also used for public health purposes to track diseases
- Contains but not inclusive:
 - Name , date of birth, date of death
 - Location of death
 - Parents names
 - Usual occupation
 - Disposition of remains
 - Cause of death (see below)
 - Manner of death (see below)
- Cause
 - The listed cause of death must be etiologically specific
 - The first line designates the immediate cause of death (e.g. renal failure). Only one cause may be listed. Cardiac arrest or respiratory failure may be the final terminal mechanism but DO NOT reflect the specific disease process.
 - The subsequent lines provide an etiological explanation of the order of events resulting in death (e.g. sepsis, bacterial pneumonia, influenza). Note these lines are separated by the statements "due to or as a consequence of"
 - Not a laundry list but report each disease or abnormality that the physician believes adversely affected the decedent. A condition can be listed as "probable" if not definitively diagnosed.
 - If an organ system failure such as congestive heart disease, hepatic failure, or renal failure is listed as a cause of death, always report its etiology on the line(s) beneath (for example, renal failure, due to Type I diabetes mellitus).
 - Not mechanism of death, not respiratory failure or cardiopulmonary arrest/failure
 - Certain things cannot stand alone i.e. pneumonia, sepsis, heart disease – they have a reason

- The disease or injury, or combination of disease and injury which are responsible for the fatality
- Represents the physician's best medical opinion
- The processing of the deceased and filing of the death certificate may be delayed if this is not properly addressed by the certifying physician.

Example:

- ☐ Septic shock
 - ☐ Due to or as a consequence of infected decubitus ulcers
 - ☐ Due to or as a consequence of complications from cerebral infarction
 - ☐ Due to or as a consequence of cerebral artery atherosclerosis
 - ☐ Complicating factors: insulin dependent diabetes mellitus
- Manner
 - Natural
 - Accident
 - Suicide
 - Homicide
 - Undetermined
- *THE HEALTHCARE ORGANIZATION CAN ONLY ISSUE A DEATH CERTIFICATE THAT LISTS A NATURAL MANNER. ALL OTHERS, BY DEFAULT, MUST BE OCME CASES AND THUS THE DEATH CERTIFICATE IS NOT THE RESPONSIBILITY OF THE HEALTHCARE ORGANIZATION.*
 - Death certificates are now electronic and the component filled out by the healthcare organization is on-line.
 - Healthcare organizations typically already have pre-designated personnel with access to the system. Ensuring their availability during a mass fatality incident is of paramount importance.
 - Physicians do not have to be licensed in the District of Columbia to sign a death certificate.
 - Once the healthcare organization completes its portion of the death certificate, another portion is to be completed

by the funeral home before the entire certificate is filed with Vital Records.

See below for a copy of the portion of the certificate that healthcare organizations are responsible for:

include sample certificate

Attachment 5: Caller tracking form

DATE: _____

PAGE: ____ of ____

Name of caller	Time called	Name of patient seeking information on	Age and gender of patient	Contact information for caller	Was patient at facility or other comments (e.g. pt referred to...)

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