

Tips for Healthcare Facilities: Assisting Families and Loved Ones after a Mass Casualty Incident

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Overview

Mass casualty incidents (MCI) can be human-caused or a result of a natural or technological disaster, and may overwhelm local healthcare systems, communications, and other services. Understandably, MCIs cause great concern among the loved ones of the wounded, missing, or deceased, who may rush to healthcare facilities, reunification centers, or the incident site to seek information and reunification. In the immediate aftermath of a mass casualty incident (MCI), those affected will have four fundamental concerns or needs:

1. Determining if their loved one was involved in the MCI;
2. Determining their loved one's whereabouts and injury status;
3. Obtaining information regarding the MCI and receiving available immediate support (e.g., food, shelter, clothing, and aid); and
4. Receiving their loved one's personal effects.

This [ASPR TRACIE](#) resource sheet summarizes family support strategies for **hospitals and healthcare providers** following an MCI and examines the collaboration between hospital support systems and jurisdictional family support initiatives.

This document highlights promising practices and strategies for addressing these concerns. MCIs highlight the importance of the early establishment of processes for family reunification, notification, assistance, and recovery support. Rapid activation of pre-designated family support locations; electronic systems for information sharing, patient tracking, and reunification; and adequately trained regional personnel to support logistics are critical to reducing the emotional and physical distress of patients and loved ones, and to ease the demands on 911, hospitals, and other overwhelmed systems. Equally important is linking all family support locations to facilitate communication, maintain situational awareness, allocate resources, and coordinate services and tracking, so loved ones do not have to visit multiple locations for assistance.

There is a significant level of anxiety associated with searching for a missing loved one. Several variables can contribute to delays in locating missing people, including:

Hospitals should integrate their MCI planning and response specific to family support with their healthcare coalitions, emergency management, and local authorities in the event of a large MCI.

- Lockdown situations and ongoing threats or hazards;
- The time it takes to safely evacuate a scene;
- The loss of access or inability to respond to communication devices (for both survivors and those critically injured or deceased);
- Difficulty identifying, registering and tracking patients during hospital surges; and
- Delays in patient/victim identification by hospitals and law enforcement.

Hospitals usually have small family notification rooms within their emergency departments and may be able to expand this service to conference/meeting rooms, or cafeterias. For a larger-scale incident that results in many casualties, however, on-site space will likely be insufficient.

The lead agency (typically law enforcement) may have to concentrate on death notification or investigation support and may be unable to allocate sufficient resources to activate a family reception center (FRC) and/or family assistance center (FAC). This is where healthcare and community partners, including healthcare coalitions (HCCs) and non-government organizations (NGOs), can assist. People will seek information from social media, traditional media sources, emergency hotlines and call centers, hospitals, law enforcement, fire and emergency medical services, public health, shelters, and the morgue/medical examiner/coroner. All these issues underscore the importance of involving community partners in hospital family support center (FSC), FRC, and FAC disaster response planning. This [ASPR TRACIE](#) resource provides an overview of commonly used terms and highlights roles and planning considerations for FRCs and FACs.

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Definitions of Commonly Used Terms (Listed in Order of Activation)

This section lists various types of post-disaster family assistance based on location and function. Though many facilities and jurisdictions use these acronyms interchangeably, for the purposes of this document, hospital assistance centers will be referred to as FSCs and the community-wide assistance

centers will be referred to as FRCs and FACs. From a state and regional planning perspective, it is important to use common terminology and define the types of services provided by each type of location.

Family Reception Center (FRC): A centralized, *temporary* location set up in the immediate hours after an MCI for families and friends seeking vetted/legitimate information about loved ones or to directly reunite loved ones (for example after a school bus accident to reunite students and parents). This center is a jurisdictional responsibility, and the lead agency may vary by event type and according to local policy. The FRC may only be open for a few hours following an incident and may not have services/resources available for families. Healthcare systems may send representatives to the FRC to centralize and expedite information sharing, saving loved ones from traveling to and possibly overwhelming area hospitals. The FRC will then transition to a FAC. Some localities will use the term “Family Reunification Center” and the National Transportation Safety Board (NTSB) uses the term “Friends and Relatives Center.”

Hospital Family Support Center (FSC): A healthcare facility-based location that provides initial information specific to admitted patients, and assists with reunification, notification, and providing information and support to patients’ loved ones. These operations are the responsibility of the healthcare facility. As soon as the community FRC or FAC (defined next) is opened, most family support functions should be transferred to that location. FSCs may need to continue to be open and provide support even if an FRC or FAC is activated. Law enforcement interviews may take place at the FSC in addition to the FAC. Please note that some hospitals may also use the terms “Hospital Family Reunification Center,” “Family Staging Area,” “Family Assistance Area,” or “Family Meeting Area” to refer to FSCs.

Family Assistance Center (FAC): A secure location established to provide information about missing or unaccounted persons and the deceased, and to provide a “one-stop shop” of services for victims and their loved ones. FACs may also help with mental health, spiritual care, and a variety of short-term and longer-term needs of affected loved ones. Depending on the incident, different agencies may be responsible for activation based on pre-established plans. Law enforcement investigations, including interviews and evidence investigations, may also take place at the FAC. If the incident was the result of a crime, and where applicable, victims should receive information from experienced staff about their rights, crime victim compensation, and victim assistance. FACs may not be established until 24-48 hours after an incident (and may be located in the same place as the FRC was).

Hospital FSC Planning

In the minutes and hours during and after an MCI, people will flock to local hospitals (particularly trauma centers and hospitals closest to the incident), desperate to locate their loved ones. Distraught, they will hope for an immediate status update and may not understand the complex process of patient identification and the need for law enforcement and medical examiner/coroner

investigations. People will also call those hospitals seeking information, particularly when the MCI affects non-residents (e.g., sporting and entertainment venues, university campus events). This may overload the hospital switchboards until, and even if, a community/centralized phone number can be established and staffed.

Hospitals benefit from developing an operational plan that interfaces with an HCC and community response to support family members immediately after an incident, but before community resources are made available. Having a solid, exercised family support plan in place will allow a smoother transition to community resources when these are activated. Plans need to be scalable, flexible, and adaptable, and include key triggers for activation. FSC operations can be organized into three phases:

1. Immediate (establish FSC, receive patients and loved ones, notification, identification, reunification);
2. Intermediate (concurrent operations with FRC or FAC when majority of patients remain admitted, and bulk of loved ones are present in the health-care facility); and
3. Recovery (majority of patients have been discharged; ensure plans address assistance with admitted long-term patients).

Children may present *with patients* or unaccompanied *as patients*. A supervised, pediatric-safe area will need to be designated. This area should ideally be separate from the command-type area where children may hear unsettling information. Ensure there is also a process for release of minors to an appropriate caregiver.

The specifics of this planning are beyond the scope of this document; the ASPR TRACIE [Family Reunification and Support Topic Collection](#) includes links to helpful resources.

Coordinating certain functions and resources during the planning process can ensure an efficient, secure, and trauma-informed check-in and notification process at the FSC. The following section highlights the hospital's incident command considerations and positions. It is important to set aside spaces that are shielded from the media for these non-patient care actions and may be conducive to different types of incidents (e.g., a location somewhere else on the hospital's campus if the hospital is on lockdown). Note: more detailed information is provided in the [Los Angeles County Family Assistance Center Planning Guide for Facilities](#).

Key Considerations and Actions:

- **Conduct an initial intake of loved ones and the patient(s) they are looking for.** Include contact information for loved ones, identifying characteristics of the patient (e.g., hair color, eye color, build, skin color, tattoos, birthmarks, clothing, and jewelry), and nicknames. Sometimes families discover that their loved one did not have a means to communicate or went to a location other than their home. The check-in/verification process should consider a way to check for, and reconcile, potential duplicate entries for the same person.

- It is important to plan **to determine a loved one's relationship to the patient/victim** as many loved ones who will be seeking information may not be family or next of kin. For area residents, this may be performed with the support of law enforcement, school districts, and child protective services. For international visitors or citizens, this may be accomplished with the support of embassies/consulates.
- Establish a **badging/security process** for staff and loved ones to protect site security and prevent unwanted media attention.
- Provide **timely patient lists/access to the electronic health records** to the FSC coordinator and ideally with operators or a designated virtual support team that can share information with callers or via social media to those seeking loved ones.
- Dedicate multiple phone lines to the FSC and ensure the **coordinator has access** to any jurisdictional patient tracking/incident information system.
- Have a **process for sharing updates with victims' families first, followed by the public** (e.g., message boards, regular verbal announcements, social media). These should occur at defined intervals and include situational and hospital information as well as how many unidentified patients remain at the facility and status of a larger family assistance operation. It is important that individuals providing this information are trained to do this emotionally challenging work.
- Have a process for tracking completion of information requests/reunification, ideally with a time and actions taken section that can be archived. This will keep the "active list" as short as possible.
- Gather **contact information for those seeking patient information**. This may be done online, via telephone, and/or email and should take into consideration translation or other special services. If the patient is located, physically or virtually advise the primary point of contact of their status and location, then facilitate reunification within the facility as appropriate. Note that hospital restrictions may preclude all loved ones from visiting at once.
- If a patient is located but is deceased, **take loved ones to a private area that can accommodate the size of the group (aim for space that can accommodate 10)**.
 - Those providing this information should be trained, authorized, and experienced professionals in death notification. Try to take into account any cultural and religious sensitivities and know that some loved ones may have access and functional needs and/or disabilities. If the incident is the result of a criminal act, law enforcement, medical examiners, or coroners may perform this function.
 - Be prepared to accommodate viewing requests and understand any limitations on physical contact with the decedent and/or release of belongings as directed by law enforcement/medical examiner/coroner
- Establish a **process for reconciling unidentified patients** and ensure that it interfaces with the process used by other area hospitals, local law enforcement, and the medical examiner/coroner.

- **Provide healthy snacks and water** for people in the waiting areas.
- **Provide a clinician to the room to help anyone that may be in physical distress.**
- Provide access to **telephones, outlets, phone chargers, and internet access** as practical. Internet access may need to be monitored and limited to ensure systems are not overwhelmed. Plan for providing minimal financial support to purchase necessities such as phone chargers.
- Have a process in place for working with foreign nationals and patients that are international visitors (e.g., designating medical proxies, translations services, etc.).

Orlando Health's white paper on [supporting non-resident/foreign citizen patients](#) and [Family Reunification Toolkit](#) can help healthcare facility emergency planners plan for and better support patients in general and after an MCI.

Hospital Incident Command Activation, Operations, and Roles

Activation of the [Hospital Incident Command System \(HICS\)](#) or other hospital incident command structure is vital to the management of a surge of patients and concerned family members. Under HICS the **Patient Family Assistance Branch Director** position, which coordinates family support operations, should be activated as early as possible. The [Patient Family Assistance Branch Director job action sheet \(JAS\)](#) requires significant customization by the facility.

The **Hospital Liaison Officer** communicates with HCCs and other community partners about their status and updates emergency management platforms indicating bed availability and sharing other information and needs. The sharing of survivor/deceased patient tracking information needs to remain [HIPAA compliant](#), released in collaboration with applicable hospitals, and with approval of local authorities such as law enforcement and the medical examiner as directed. Note, however, that HIPAA has broad permissions allowing the exchange of information necessary for family reunification. If there are issues or concerns with the proposed information exchange, those should be worked out prior to the incident. Some states have additional patient privacy laws beyond HIPAA that require consideration. Embassies and consulates can assist with foreign national identification and overseas death notifications.

One role of the **Hospital Public Information Officer (PIO)** is to share call center numbers and the location of the FRC and/or FAC with loved ones. PIOs can also assure people who have missing loved ones that the FRC and/or FAC will have updates for them with more information, and that they are communicating with other hospitals. They will coordinate any hospital press conferences and public information releases regarding patient updates and hospital response efforts. The hospital PIO should also coordinate communications with law enforcement/investigative, fire rescue, and

Helpful Resources:

- [HIPAA and Disasters: What Emergency Professionals Need to Know](#)
- [EMTALA and Disasters](#)
- [1135 Waivers](#)

emergency management PIOs to ensure consistent messaging.

Due to the physical and emotional stress experienced by staff/responders who work as a part of FSC, FRC, and FAC operations, healthcare entities should proactively plan for, staff, and support the [Employee Health and Well-Being Unit Leader](#) position.

Emergency Medical Services (EMS) should be a part of the Incident Command/Unified Command structure. Initial patient and destination information may be available via their dispatch or operations center and can be shared to facilitate reunification.

- EMS or fire agencies should declare an MCI according to local policies and request hospitals be notified immediately. This is critical to allow staff and supplies to be mobilized and capacity increased within the emergency department, operating rooms, and intensive care units and for incident command activation including initiation of FSC activities. Once notified, they should keep the hospital informed of updates so that they know how to continue or modify their response tactics.
- The EMS dispatch center should have a checklist of notifications which should include supervisory/chief staff, municipal or county emergency managers, public information officer, emergency relief services/partners (e.g., the American Red Cross [ARC]), victim and witness specialists, local and state health departments, and other partners. Dispatch can continue to provide situational awareness as the incident progresses. They should also have standard operating procedures (e.g., providing high-level just-in-time training) for how the calls from the community seeking patient information should be handled (e.g., acceptable terminology, pre-scripted templates, and guidance to direct callers to more appropriate resources).

Key Considerations and Actions:

- Prior to an incident:
 - Customize the Family Assistance Branch Chief JAS to meet the needs and logistics of the facility and develop any relevant additional quick reference materials.
 - Determine the location(s) for family support activities based on the incident needs and define any flow, security, communications, or other support that will be needed to operationalize the location
 - Identify the supplies needed for operation of the FSC and locate these in a designated area along with “quick start” guides for initiation of services.
 - Plan how phone support for callers seeking patient information will be handled and how updated information will be relayed to operators.
 - Determine the process for collecting identifying information from family members and the process for how information from unidentified patients will be shared at the facility and across the HCC/jurisdiction.

- Conduct planning sessions with hospital general counsel to discuss questions, concerns, and protocols (particularly for MCI) for sharing patient information and handling protected health information.
- Create a list of local resources such as hotels, transportation, etc. to share with out of town loved ones.
- Have contact information available for potential translation services.
- Include [Risk Management Ethicists](#) in pre-planning and response assistance.
- Upon notification of an MCI, hospitals should activate and operationalize their hospital incident command center as soon as possible (no longer than 10-15 minutes or as soon as it is feasible and safe to do so), even if starting with minimal command elements such as initial notifications and assigning an incident commander.
- As soon as possible, transition hospital-provided family support services to the inpatient units where patients are located or to the community FRC or FAC once operational. HICS should continue to support the response effort as required.
- The jurisdictional emergency operations center (EOC) should be activated in large MCIs.
 - A healthcare or HCC representative should have a physical or virtual presence in the EOC to gather and share hospital patient information.

FRC and FAC Planning

Note: FRCs and FACs have distinct roles (noted in the previous definitions section) and once the FRC transitions to an FAC, the FRC ceases to operate. For the purposes of this document, FRCs and FACs are included in the same section since some planning considerations overlap, but key distinctions are made as appropriate.

After an MCI, FRCs and/or FACs (or similar temporary locations and call centers) must be established rapidly with reunification and investigatory support as their primary purposes. Providing death notifications and family support are additional key functions.

Local emergency planners and the county/city manager should have either one centrally pre-identified site or multiple geographically dispersed sites that can serve as FRCs and/or FACs and provide an initial, private, safe gathering place for the loved ones of unaccounted family members. The location, scale, and number of sites will depend on the location and magnitude of the incident. Having just one site is preferred because more than one can pose staffing and communication challenges. Memoranda of Agreements with such facilities should be completed prior to an incident and these potential sites made known to local HCC members including hospitals, emergency medical service providers, law enforcement, and emergency relief services/partners.

Key Considerations and Actions:

- **Identify sites with potential immediate availability ahead of time** (e.g., municipal park and recreation centers, community centers, hotels, and convention centers). Such venues may be chosen if they are close to—but not within direct view of—the incident site. Ideally, this location would be easily accessible and able to provide sufficient space and services for a significant number of people. Some venues may not be appropriate due to residents’ religious and cultural sensitivities; consider those ahead of time.
 - Knowing which facilities have sufficient capacity and capabilities, are compliant with the Americans with Disabilities Act, and have pre-identified 24/7 contact numbers and available staff can help create a “turnkey” operation.
 - Emergency planners usually already have relationships with owners of major venues, which can facilitate the identification of sites and development of formal agreements in the planning phase.
- Aim to have staff slated to operationalize an FRC and FAC at a designated site **within 60 minutes of notification**.
- Have **an alternate site with additional capacity available** in the event services need to be increased. It may be necessary to support an FAC for one to four weeks or longer. To avoid confusion and the disruption associated with relocating because of a need for more space, it is best to operate within a larger space from the beginning.
- Once an FRC/FAC is opened, the **planning for demobilization** should also begin. This enables a smooth transition back for the facility and staff.
- Local emergency management should have a process in place to **rapidly request pre-designated law enforcement, victim/witness specialists, social services, and other personnel** to the FRC/FAC to initiate services and secure the venue. Develop a decision matrix to outline who is authorized to open and manage the FRC/FAC.
- Center personnel should have access to radio and phone communications, internet, patient lists, local staff contact lists, and other related information.
- Establish a way to **validate details** about the incident and any decedent-specific information before it is released by credible authorities.
- **Law enforcement should:** coordinate investigation of missing person reports and information (and limit asking the same questions multiple times to victims and loved ones to prevent re-traumatization); provide security (or coordinate with partners) by setting up perimeters to control access to the location of the FRC and FAC, conduct crowd control, direct traffic, and control media access; and share resources with the public that support reunification and identification.

Planning Tip: Consider using a “1 to 10 ratio” rule: for every victim, there can be up to 10 people looking for them. This can help in planning how large of a site may be needed.

- Law enforcement (in coordination with partners) will **maintain security** from the activation of the FRC, to the transition to the FAC, and throughout the demobilization process.

People who manage high density locations (e.g., schools, hospitals, stadiums, and entertainment or business centers) should work with local responders to determine an appropriate and accessible nearby “meet-up” site that can be used in the event of an MCI.

FRC and FAC Activation and Operations

Incident command for the FRC and FAC site is critical to controlling the “organized chaos” that typically follows an MCI and coordinating with other organizational structures such as the NTSB’s [Joint Family Support Operations Center](#) (JFSOC). The JFSOC is a central location where participating organizations monitor, plan, coordinate, and initiate the family assistance operation, maximizing the utilization of all available resources and minimizing duplication of services.

An Incident Commander and Command Team should be designated by the lead response agency. This facilitates FRC and FAC security liaison capability with Unified Command and community partners and provides a PIO who can communicate with the Joint Information Center (JIC), and support for operations, logistics, planning, and financial/administrative issues.

Key Considerations and Actions:

- The first thing staff will do once an FRC and FAC is opened is **set up a registration area** for family members.
 - Badges can be issued to identify FRC and FAC staff and family members. Planning for credentialing and badging should be done in advance of an incident.
 - Have a process in place to handle spontaneous volunteers and the media; include a staging area for both of these groups separate from the FRC/FAC operations.
 - Provide assistance for those that may need translation services, and other individuals with specific needs (e.g., nursing mothers and older adults). Ideally this would be in-person, but virtual support options (phone/tablet) should also be available.
 - Ensure all sites managing patient information are connected to a real-time intranet/tracking system.
- Consider having behavioral health professionals staff the entrances and registration areas to provide psychological support at the beginning of and throughout the process.
- Behavioral health and spiritual care providers are essential team members and should be pre-identified, able to report to the FRC/FAC, and have defined scope of interventions and duties (e.g., help address cultural and religious considerations).
- Law enforcement and/or the medical examiner/coroner will likely set up a separate area for

The activation, management, and demobilization of an FRC and FAC are not typically the responsibility of a hospital or HCC. The lead agency can be local police, fire, or emergency management or a federal agency such as the Federal Bureau of Investigation or National Transportation Safety Board. The American Red Cross often supports the lead agency in establishing a FAC.

witnesses and/or loved ones to be interviewed.

- There may also be a detective, family liaison/coordinator, or victim specialist or specialist assigned to each family unit.
- **Provide healthy snacks and water** for people in the waiting areas.
 - Only accept food, snacks, and water from known and trusted sources.
 - Snacks should be individually packaged and should not be temperature sensitive (i.e., no hot or cold foods)
 - Consider culturally and situationally appropriate food and beverages.
- **Provide access to telephones, outlets, phone chargers, and the internet** as practical.
- Family members who are unable to locate their loved ones should be able to provide photos and given a form to complete that includes **identifying characteristics** of the patient (e.g., hair color, eye color, height/build, skin color, tattoos, piercings, clothing, and unique/special jewelry).
- Families who have not located their loved ones may be paired with a trained victim specialist or community advocate if the incident is not a criminal act. This advocate remain with them, if possible (or at least be accessible), until final notifications are made, as staffing and resources allow.
 - A liaison/companion may also be assigned to families who come to a FAC to access services well after death notifications have been made.
- Ensure the family liaison(s) is clearly visible to center visitors and known by staff so they can quickly direct people to further assistance.
 - Determine where in the facility and at what point in the process are most important for them to be present if staffing/resources are limited.
 - Ensure the personnel are visible/identifiable.
 - Consider animal therapy if available through community partners. Ensure that the animals are kept in a designated area for voluntary interaction as certain animals/breeds may provoke anxiety for some individuals.
- Official family briefing sessions should be held regularly (at least once a day, ideally twice a day or more frequently as needed). These are held privately within the FRC and/or FAC and are not intended for media or external partners. Families/loved ones should be notified of any updates before information is shared with the media and public.
- Media briefings should be held separate from the FRC /FAC to minimize re-traumatization. A PIO should be designated for the FRC/FAC.
- The FRC will need to **remain open 24/7** during the initial period after the incident. FACs may also initially be open 24/7, but after a full transition from the FRC to FAC, hours may be shortened.

Lessons learned from previous incidents indicate that it may take 48 hours or longer for families to be able to process what they have experienced. Some may experience shock and continue searching for their loved ones despite the information they have been given.

- FRC and/or FAC staff are typically assigned **12-hour shifts** to support continuity of operations which are then shortened accordingly to accommodate FAC operating hours.
- **Death notifications** are made by bringing each family unit (next of kin and those with the next of kin) into a private, secure room that can hold a minimum of 10 people. This process is typically managed by the coroner/medical examiner and/or law enforcement and may be supported by a mental health provider, spiritual care advisor, caseworker, and/or nurse.
- A **pre-established exit route** needs to be in place so that FRC and/or FAC staff can escort and protect family members from the media and other onlookers after such notifications.
- Each decedent's family should be provided with a point of contact that they can reach out to for information about ongoing needs, preferably a trained, pre-identified victim advocate/specialist. Alternatively, each organization represented at the FAC may create and share a mechanism (e.g., an email address, on-line form, or toll-free line) families can use to request contact information or actual services.
- The FRC and/or FAC should **coordinate family services** with a multitude of agencies, including air and ground transportation, emergency relief services/partners, agencies such as Voluntary Organizations Active in Disasters (VOAD), child and family services, healthcare, consulates, translation services, legal aid, lodging, and senior services necessary to meet the support needs generated by the incident.
- **Donations** to an FRC and/or FAC can come from the immediate community and beyond and may become overwhelming. A donation manager may need to be assigned within the hospital command structure.
 - The PIO should be ready to communicate what types of donations are needed and where to send these if there is such need. They should also work with FRC and/or FAC PIOs to determine if there is an official fund for financial donations and, if so, the preferred process.
 - Note that certain foods are not appropriate from a food safety perspective (e.g., foods that must be kept at a certain temperature). Furthermore, some foods are not appropriate to serve (e.g., meat on the bone and red sauces) because they may conjure negative images of the incident for some people. Cultural and faith observance needs should be considered when choosing foods for the FRC/FAC.
 - Discourage the public from donating home-cooked foods and do not allow staff to eat them.
 - Discourage donations at the FRC/FAC location. Communicate a donation management site to the public and be specific about needs, hours, etc. Relevant donations can then

All who serve in an FRC and FAC are expected to follow a **code of conduct** respecting the need for privacy for family members, confidentiality of information, and appropriate behavior. This includes refraining from sharing information about their work on social media. Entities involved in response may wish to consider having a social media policy for staff and volunteers.

be directed to the FRC/FAC or information about the donated materials can be made available to family members/partners.

- Provide a wish list for needed items to vetted commercial vendors who want to donate food or water or supplies.
- Ensure there is a specified schedule and convenient location for requested deliveries.
- Other communities who have suffered tragedies may extend valuable offers to support response operations. You may wish to accept assistance from local community services first then reach out to other communities if necessary (note that communities that recently experienced tragedies may wish to assist but may not have recovered to the extent that they can assist in a healthy way).

Planning Tip: Anticipate that for every casualty, at least three family members will call for information.

A virtual or mobile FAC may be used to support those who cannot get to the designated center. The mobile unit could be deployed to a hospitalized victim or to a family member who is homebound or does not have the technological tools needed to maintain situational awareness.

As the need for services decreases in the days and weeks after an MCI, the FAC will hold a final family briefing to explain transitional services and plans (demobilization of a FAC operation should be communicated to families in advance of this briefing). This can include referral to a virtual FAC for callers requesting resources. Note that in some instances, and depending on resources and the incident type, the FAC may need to be predominantly virtual. During the COVID-19 pandemic, for example, [the American Red Cross set up a virtual FAC](#) for families who lost loved ones, connecting them to resources and community support.

Communication Planning

In today's quick-paced environment, social media updates often occur at the same time 911 calls are being made. Community members can see and hear the tragedy unfold unfiltered through firsthand accounts, driving the need for a robust, rapid informational response by the jurisdiction. In some areas, an internet-based system may be used to provide updates to hospitals and emergency management. In others, radio communication, phone (landline, VOIP, cell), or paging may be used. Some HCCs have sophisticated web-based systems that can respond to patient name-based queries and provide matches



Figure 1. Comfort dogs “Comfort Dogs” consoled Desert Springs Hospital (NV) patients, visitors, and staff after an MCI.

with those names at area hospitals. Though this may currently be beyond the capabilities of many systems, it is a valuable asset to be considered. Be aware that communication platforms can be overloaded or otherwise inaccessible just after an MCI. Some large incidents can actually “take down” communications or authorities may need to interrupt communication technology for security reasons. If power is out or the incident is protracted, cell phone batteries may be drained. Plan accordingly and determine how you will communicate with staff, other community partners, and survivors. Establish a plan to initiate 24/7 communication resources after initial information is known to authorities, ideally within the first 30 minutes of an MCI.

Key Considerations and Actions:

- Planners should review their Communications Plan/Annex to initiate call downs, manage systems, and activate [priority telecommunications services](#) if applicable.
- Communications staff should be trained to work in crisis situations.
- **A Joint Information System (JIS) should be initiated** by the Emergency Operations Center and official information channels established through social and traditional media.
- The hospitals receiving patients may encourage loved ones to text each other (or use social media to communicate) and to designate a single individual as a point of contact for reunification. Going directly to/calling hospitals or 911 for information should be discouraged.
- **A toll-free hotline/call center** should be set up and staffed as practical for community members seeking specific information.
 - Operators should be aware of available resources and how to recommend them to callers.
 - Consider using 311 as a gateway depending on your community.
 - Consider using a local disaster community hotline number or reverse 911 system to share initial information and regularly updated messaging.
 - Hotline staff should receive updated patient lists from the hospitals (or HCCs or other entities) and be able to direct family members to the appropriate hospital, FRC, or FAC.
 - Interpreters and accessibility devices should be available.
- **Include communications planning** that enables staff to be available within the first hour of an MCI and surge up to handle a large number of calls. This will be especially helpful to out-of-area, out-of-state, or international callers who are searching for loved ones.

Federal and Private Partner FRC and FAC Support

Many local, state, and regional agencies have potential roles and responsibilities related to family assistance after an MCI. Healthcare facilities should work with their local law enforcement partners to ensure a seamless investigation and victim advocate process for patients and their loved ones. It may become necessary for the healthcare facility to have a senior law enforcement and fire department representative at the hospital command center or FRC during the response phase of the incident to assist with messaging, operations, and logistics. In any type of incident, roles may overlap. In criminal cases, local law enforcement or the FBI may be the lead agency for the FRC and/or FAC. In other cases, local emergency management or another local agency may be responsible. In an aviation or rail accident, the FAC is established by the airline or rail carrier and managed by the National Transportation Safety Board's (NTSB) Transportation Disaster Assistance Division. While the ARC does not typically lead FRCs or FACs, they do play a significant support role including leadership to support FAC operations and potentially mobilizing their Disaster Mental Health, Disaster Health Services, and/or Disaster Spiritual Care teams. They may also mobilize volunteers to assist with feeding and supporting family members and first responders as necessary. ARC and other non-governmental organization roles and responsibilities to an FRC/FAC should be pre-planned. These volunteers should be accountable to the same code of conduct as all workers and their engagement with the media managed through the PIO. Table 1 illustrates the roles played by potential lead agency/organization depending on the type of disaster.

Public figures (e.g., the mayor, county commissioners, the governor, legislators, and even the President), celebrities, and athletes may wish to demonstrate their support. Plan for these VIP visits, as they may consume significant resources that are in short supply. Note that it may not always be appropriate for public figures to participate in visits with victims and loved ones.

Table 1. Incidents and the Role of Lead Agencies and Organizations

Type of Incident/Disaster	Potential Lead Agency/Organization	Description
Legislated Aviation and Rail Accidents ¹	National Transportation Safety Board (NTSB) in coordination with the ARC and the affected domestic or foreign air carrier or rail passenger carrier	Following a legislated ¹ aviation or rail passenger accident, the NTSB is responsible for coordinating federal government resources to support local and state governments, disaster relief organizations, and the affected air or rail carrier to meet the needs of victims and their families. The ARC has specific obligations focused on the provision of disaster mental health services to victims and their families. Legislated air carriers and rail passenger carriers also have specific family assistance obligations. ² They have designated family assistance teams that exercise regularly for such incidents. They also have pre-identified venues that can be used as an FRC and/or FAC. The NTSB Transportation Disaster Assistance (TDA) works closely with federal, state, local, volunteer agencies, and the transportation carrier to meet the needs of disaster victims and their families. Information sharing, counseling, victim identification and forensic services, communicating with foreign governments, and translation services are a few of the services that can be coordinated.

¹ Aviation and rail accidents are classified as “legislated” by the NTSB if they meet the following criteria established per 49 USC 1136 (aviation) and 49 USC 1139 (passenger rail):

1. Accident occurred in the U.S. or its territories;
2. Accident resulted in a major loss of life; and
3. Accident involving a domestic or foreign air carrier that has economic authority to operate in the U.S issued by the US Department of Transportation (DOT). A list of domestic certificated air carriers is available on the [DOT website](#). With only a few exceptions, all foreign air carriers operating within the U.S. hold economic authority; or
4. Accident involving an interstate intercity rail passenger carrier (i.e., Amtrak) or an interstate or intrastate high-speed rail operator.

² Family assistance obligations are set forth in:

- 49 USC 41113: domestic air carrier obligations
- 49 USC 41313: foreign air carrier obligations
- 49 USC 24316: rail passenger carrier obligations

Type of Incident/Disaster	Potential Lead Agency/Organization	Description
Other transportation accidents investigated by the NTSB , but not covered by federal family assistance legislation (e.g., general aviation, commuter rail, highway, marine and pipeline)	Jurisdiction that has experienced the MCI	The jurisdiction that has experienced the MCI is responsible for coordinating services in support of accident survivors and family members. The NTSB will strive to support the family assistance operation and will serve as the primary point of contact for accident survivors and family members regarding the federal safety investigation. The NTSB will also coordinate with the affected transportation operator if one exists.
Criminal	DOJ, FBI DOJ, Office for Victims of Crime (OVC)	In criminal incidents the FBI has a Terrorism Task Force and Victim Assistance Teams which will support an FRC and/or FAC. The OVC has a definition of criminal mass violence or terrorism. For incidents that meet OVC's definition of criminal mass violence or terrorism, OVC will offer the state or jurisdiction on-the-ground technical assistance, typically through experienced consultants or OVC staff. This support is designed to help victims and may include assistance in implementing best practices in response, sharing of available resources, conducting a victim needs assessment, victim service mapping, or supplemental funding for victims' needs through the Antiterrorism and Emergency Assistance Program (AEAP.) States and jurisdictions can also request training and mass violence planning assistance from OVC.
Other	Lead City or County Government Agency	For multi-casualty incidents or other disasters that are not covered under the Aviation Family Assistance Act of 1996, a local city or county may take the lead to set up and manage a FAC, in coordination with other government and non-government partners including the ARC.

Recovery/Demobilization

Demobilization of the FRC is dependent on when there can be a transition to a FAC. Law enforcement should maintain security throughout the demobilization process. Final family briefings to explain transitional services should be part of the demobilization process and can include referrals to the FAC or virtual FAC if applicable.

Check out ASPR TRACIE's [Disaster Behavioral Health Resources Page](#) for related articles, plans, tools, and templates.

The recovery process needs to include continuous provision of behavioral health services, spiritual care, or other casework services to support survivors, their loved ones, law enforcement, EMS, hospital staff, and the staff of the FRC and/or FAC as everyone will be affected. It is important that responders and those who staffed the centers receive a trauma debrief and information on available employee assistance programs.

Authorities in London established a “Family Resiliency Center” after the 2005 London Underground bombings, acknowledging that many might need emotional support over a longer period. Similar centers were established in Las Vegas, Orlando, and Boston. Multiple coordinated pathways to healing for all involved can help ensure community resilience. It is not unusual for community, family, and responder support to continue for years after an MCI through support groups, memorials, and anniversary recognitions. Family members may also engage in advocacy efforts with the goal of preventing similar tragedies. Providing short- and long-term support to families and staff following a large incident can help promote recovery from a tragedy and overall community resilience.

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