

APPENDIX - A
Acronym Reference List

AAR	After Action Report
ADFAA	Aviation Disaster Family Assistance Act of 1996
AFDIL	Armed Forces DNA Identification Laboratory
AFIP	Armed Forces Institute of Pathology
AFME	Office of Armed Forces Medical Examiner (also OAFME)
CFR	Code of Federal Regulations
DHLS	Division of Homeland Security (State of Utah)
DHS	Department of Homeland Security (Federal)
DMORT	Disaster Mortuary Operational Response Team
DPMU	DMORT Portable Morgue Unit
DPS	Department of Public Safety (State of Utah)
DNA	Deoxyribonucleic Acid
DCC	Department Coordination Center (UDOH)
DOD	Department of Defense
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ERT	Evidence Response Team (part of FBI)
FAA	Federal Aviation Administration
FAC	Family Assistance Center
FACT	Family Assistance Center Team (specialty team of DMORT)
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
HAZMAT	Hazardous Materials
HIPAA	Health Insurance Portability and Accountability Act of 1996
IA	Interagency Agreement
IIC	Investigator-In-Charge
IRC	Information Resource Center (part of DMORT team)
MFI	Mass Fatality Incident
MRN	Morgue Reference Number
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NTSB	National Transportation Safety Board
OME	Office of Medical Examiner (Utah)
SOG	Standard Operating Guidelines
TDA	Office of Transportation Disaster Assistance (NTSB)
UDOH	Utah Department of Health
UFDA	Utah Funeral Directors Association
VIP	Victim Information Profile, or Victim Identification Program

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Riverton, UT 84065
(PH) (801) 253-2795 (FAX) (801) 446-7079
Greg Ballard

BRANCH--VALLEY VIEW FUNERAL HOME

4335 W. 4100 S.
West Valley City, UT 84120
(PH) (801) 969-1081 (FAX) (801) 969-7198
David Bartholomew

WHEELER MORTUARY

211 E. 200 S.
Springville, UT 84663
(PH) (801) 489-6021
E-mail: wheelermortuary@msn.com

Paul B. Wheeler

Curtis Wilkey

WING MORTUARY

118 East Main St.
Lehi, UT 84043
(PH) (801) 768-9514 (FAX) (801) 768-3534
E-mail: wingmortuary@mac.com

Lenard A. Wing

Quinn A. Wing

Christopher Wing (Intern)

APPENDIX C – Pan Flue Protective Info

Appendix D – Hospital Planning Template

[FACILITY] MASS FATALITY MANAGEMENT PLAN

Purpose:

A mass casualty event, whether man-made, a natural disaster or a pandemic disease, may potentially cause an overwhelming number of fatalities. In these situations, THE FACILITY may find it necessary to provide short term storage of the deceased at the facility until such time that local funeral directors or the Office of the Medical Examiner can take possession of the bodies. The purpose of this document is to insure the safety of our employees and that bodies are taken care of in a manner that will maintain both the sanitary conditions of the remains as well as the dignity they rightfully deserve.

This document relates only to those victims dying at the facility. It is not intended that this facility become a temporary morgue site for the entire community.

Planning:

Mass fatalities may occur as the result of a variety of events, including natural disasters, disease outbreaks, transportation accidents, or as the result of the intentional use of a chemical, biological, radiological, or explosive agent. Since a Mass Fatalities Incident (MFI) is likely to result from a major incident, responsibility for managing the incident response and recovery will require a UNIFIED effort by all agencies, jurisdictions and entities involved. This plan has been developed in conjunction with the following local partners:

Local Health Department

Local Emergency Management

Local Funeral Directors

Local Deputy Medical Examiner

Local Law Enforcement

Determinations:

The following area (s) has been chosen as this facility's short term over flow morgue:

The following person/position will act as the Liaison upon activation of the emergency command center:

-
- A mortality tracking/documentation system for those remains not immediately removed from the facility has been developed and is available at:

Plan Activation:

Once a disaster has occurred the Liaison will make contact with the nursing supervisor to determine their current morgue status. Once the morgue reaches its capacity, activation of the mass fatality plan will become operational.

The Liaison Officer will notify the Incident Commander of the situation:

- A briefing of the events will take place
- The Nursing Supervisors will work with the funeral homes to have the decedent removed from the facility as soon as possible unless the event requires approval from state or federal agencies, due to the cause of the mass fatality.
- Temporary storage of decedents should be in the pre-determined cool-dry location that is locked and secure.

Documentation of the patient's death:

Medical Facility personnel will be required to maintain appropriate documentation of the patient's death.

Deceased Patient Identification:

Time of Death _____ A.M. _____ P.M.

Patient's Home Address _____

Relative Responsible _____

Relative's Address _____

Relative's Telephone No. _____

Procedure:

The Medical Facility will be required, at the time of death to:

- Certify the death via the State Electronic Death Entry Network (EDEN).
- Utilize mortality tracking/documentation system for those remains not immediately removed from the facility.
- Notify Family in an appropriate manner.
- Release remains only to a licensed Funeral Director or other authorized official.

- Maintain documentation of decedent’s temporary/staging location and obtain signature of release to Funeral Director/Authority.

Procedures for Electronic Death Entry – Facility medical records director will be in charge

Electronic Death Entry Network (EDEN)

- Death Certificate must be filed with local registrar within 5 days of death.
- By statute, funeral directors are responsible for death registration.
- Certifying physician or ME completes medical section within 72 hours from time of death.
- Physicians can sign on EDEN for complete death certificate if they have signed up to use this service. The URL is health.utah.gov/eden (you must be using Internet Explorer and Windows 2000 or XP – Contact Margaret Bowen at 538-6012 for assistance)

Location of Body bags and Personal Protective Equipment (PPE) Supplies

- During a disaster, body bags are located: _____
- PPE is located in the: _____
- Other supplies (ie. ID tags, gloves) located: _____

Proper care of the Decedent: (Please refer to the attached flow charts)

Some Mass Fatality Incidents may actually be classified as **Crime Scenes** (such as a bomb explosion). Utah Law (26-4-7) requires that certain deaths be reported to the State Medical Examiner’s office. Those cases are:

1. Deaths by violence, gunshot, suicide or accident, except highway accidents;
2. Sudden death while in apparent health;
3. Unattended deaths except that an autopsy may only be performed in accordance with the provisions of subsection 26-4-9(3);
4. Deaths under suspicious or unusual circumstances;
5. Deaths resulting from poisoning or overdose of drugs;
6. Deaths resulting from diseases that may constitute a threat to the public health;
7. Deaths resulting from disease, injury, toxic effect or unusual exertion incurred within the scope of the deceased’s employment;
8. Deaths due to sudden infant death syndrome;
9. Deaths resulting while the deceased was in prison, jail, in police custody, in the state hospital, or in a detention or medical facility operated for the treatment of the mentally ill or emotionally disturbed or delinquent persons;
10. Deaths associated with diagnostic and therapeutic procedures.

Along with the reporting of these special cases, evidence collection and preservation by the Hospital personnel is essential to the medical examiner responsible for making an accurate and timely determination of the cause of death.

Hospital personnel will cooperate with the police in collecting and preserving evidence, pursuant to proper search and/or seizure procedures.

Hospital personnel should perform according to the guidelines that follow:

Clothing

1. When removing clothing, do not cut through any exit / entrance wounds caused by weapons (guns, knives, etc).
2. Do not cut through any stains or markings in the clothing.
3. Do not cut through knots of any ligatures (ropes, cords, etc) tied around extremities or neck.
4. Do not put any moist clothing item in plastic bags - allow to air dry and package in paper bags.
5. If a sexual assault or homicide is suspected, remove clothing items without shaking. Collect all clothing, shoes, sanitary napkins, tampons, and handkerchiefs / tissues which may have been used to clean the genital area of the male or female, or which may have been used to wipe blood.

Gunshot Victims

1. Place paper bags on hands and secure with tape (to preserve gun powder residue from possible self-inflicted wound).

Wounds

1. Chart the location, size, and appearance of wounds. Note presence and diameter of powder/stippling discoloration around gunshot wounds.
2. Chart the location of surgically imposed wounds as well as chest tubes, IV's, etc., so they will not be confused with other wounds on the patient. Circle all IV attempts. Leave admission tubes and lines in body.
3. Chart any cleaning or debridement of wounds.
4. If death occurs due to an assault or criminal activity, do not clean the body. Preserve clothing as outlined and do not release clothing and property to family.
5. ED record and paramedic record should be copied and sent with body to ME's office.

Handling of Evidence

1. Any items which may have to be used as evidence and dusted for fingerprints should not be touched with your hands or with anything that may smear the prints (paper towels, wash cloths, etc.). Evidentiary items may be picked up with hemostat's and properly packaged.

2. It is expected the nurse will assist with proper evidence collection as requested by the investigating officer.

Packaging Evidence

1. If "wet", air dry and place in paper bags.
2. Other evidence can be placed in plastic bags or other containers.
3. Seal the container by taping the opening closed and initialing the tape. Date and time sealed needs to be written on the tape.
4. If you have questions about packaging evidence, refer to a police officer and follow their instructions.

Pan Flu Body Preparation:

During normal operations, our facility provides care services to the decedent's remains. These services maintain both the sanitary conditions of the remains as well as the dignity they rightfully deserve. This may include, but not be limited to: washing and cleaning of the remains, the dressing or removing of hospital clothing, wrapping them in clean sheets and/or placing the remains in a body pouch. During a Pan Flu, there may not be the personnel or resources available to provide this care nor would it be prudent to unnecessarily expose staff.

Process:

Upon declaration of a Pan Flu emergency by the Utah Department of Health, this facility will provide only the following care for remains:

- 1) Leave remains in existing clothing. Do not remove clothing or re-dress them.
- 2) Do not remove wrist band, toe tag, or other medical apparatus or appliances (i.e. IV's trach tubes, monitor patches, etc.)
- 3) Do not clean or bathe the decedent.
- 4) Wrap the remains in the existing bedding (sheets) upon which they are lying, if any. Do not wrap them in a clean sheet.
- 5) Carefully place the remains in a zippered body pouch. This would include their existing clothing and their bedding that they are wrapped in. Contact local public health or emergency management for additional body pouches if necessary.
- 6) Identify the remains on the outside of the pouch so that the body can be easily identified without having to open the pouch. This is critical. It is imperative that no confusing of the remains take place. At this point, the facility is responsible for proper identification of the deceased. Funeral Directors will only open the pouch slightly in order to read the wrist band or toe tag to verify identity.
- 7) Caregivers will use appropriate PPE while taking care of the body, following donning protocol.
- 8) Remains and the decedent's personal effects are then to be wheeled on a gurney to an appropriate location to await arrival of the Funeral Home Director. The location of the decedent and personal effects are to be documented carefully on the facility's mortality tracking documents.

- 9) It is the facility's option to allow family visitation immediately following the death of the patient. This is discouraged however, due to the need of social distancing and infection control measures. This is only to be allowed in the patient care room and is not to be allowed in the storage area.
- 10) Proper verification and documentation of the decedent in the storage area is critical. It is imperative that no confusion as to the decedents' identity take place.

Temporary Care of the decedents – storage while awaiting the funeral home.

1. The incident commander will utilize the identified location for temporary holding.
 - Temporary storage should be no longer than 24-48 hours
2. If unable to secure a location on site, a call will be made to the _____County's Emergency Manager to assist in procuring a refrigerated trailer for use at the facility.
3. If unable to secure a trailer, the _____County Emergency Manager will assist in transportation and storage of remains.

Transfer of remains to a funeral home

1. Verification of decedent must be documented by the funeral home.
2. Upon arrival of the funeral home personnel at the medical facility, hospital security or designee will identify the location of the decedent in the temporary storage area. Hospital staff will don proper PPE and will accompany the funeral home personnel to verify the identity of the decedent.
3. The funeral home personnel will sign the facility's mortality tracking documents before decedent removal.

Psychosocial Considerations

This type of event is very stressful for staff. A close watch on staff should be conducted by managers, supervisors and administrators. As needed arrange for critical stress debriefing for staff by contacting the Employee's Assistant Program at _____ or the Utah Critical Incident Stress team at 1-866-364-8824.

Contact List

Disaster Hotline

(Surge Capacity and Resources)
1-866-DOH-UTAH (364-8824)

State of Utah Division of Epidemiology and laboratory Services

288 North 1460 West
Salt Lake City, UT
24-Hour Hotline – 1-888-374-8824 (EPI UTAH)
24-Hour Hotline – 538-6194 (local)

_____ **County's EOC** - _____

Medical Examiner - Utah Department of Health
48 North Medical Drive, Salt Lake City, UT 84113
801-584-8410; Fax 801-584-8435

EDEN Jeff Duncan
801-538-7023
<http://health.utah.gov/vitalrecords>

Appendix E - Law Enforcement Plan

7.0 Local Law Enforcement / Deputy Investigator's Plan

Principle

Once a Public Health Emergency for Utah has been declared, it is advised that all Law Enforcement Agencies and/or Deputy OME Investigators implement an action plan which will enable the jurisdictional agency to provide a continuation of services to the community, while protecting its most valuable resource, the workforce. A template for Pan Flu Continuity of Operations and Response is necessary for each agency. Local LE and Deputy Investigators are encouraged to adopt in whole or in part that is included as Appendix E, or to use the appendix as a template to modify for use within their jurisdictional boundaries.

7.0 Notification/Activation

Principle:

Once the local LE/Deputy Investigators have been notified that a Public Health emergency/pandemic is imminent or is occurring in the greater Utah area, this plan shall be activated. Notification will most likely be made to the local agencies by the local public health district, emergency management, or the OME. The point of contact will likely be the Emergency Management Director and/or local health emergency co-ordinator, Sheriff or OME.

Procedure:

Once notified, the local agency should activate some level of crisis management team for their department which will be the official source of health information to employees. Any new directives regarding operational assignments, or calls for service such as guarding hospitals, facilities or patients will be reviewed, and where appropriate responded to as directed by the local crisis management team.

The decision to close any local government facilities and any changes of shifts will be communicated through the departmental crisis management team (CMT) The CMT will meet as appropriate during the event at 0800 and 2000 hrs (twice daily suggested). These meetings may be accomplished as face to face meetings. If it is determined that face to face meetings would significantly increase the chances of further spread of the disease agent, alternate means such as conference calling, radio channels, or establishing a virtual command/operations center through Web-EOC or other similar programs, or even the use of e-mail, may be implemented.

7.0.1 Liaison with Public Health Agencies

Principle:

Close co-ordination, communication and information sharing is necessary between local Law Enforcement agencies and OME Deputy Investigators to support the community's response to the Pandemic.

Procedure:

If possible, a Supervisor from the department (Corrections, Patrol Bureau, Deputy Investigator) shall be assigned by the CMT as an Agency Rep to the local EOC (City/County/Local Public Health). The Agency Rep shall participate in the EOC process to provide the agency with the best possible health information coming from the area. The CMT shall provide the Agency Rep with daily updates of health related law enforcement / OME issues. These personnel shall be available 24 hours a day for each day the disaster remains in effect or as required during the operational hours of the local EOC. If providing an Agency Rep is not possible, close communications between the agency and the EOC will be maintained throughout the incident.

The Agency Rep shall be the point of contact for information during the hours that the CMT staff may be off duty. If the need arises the Agency Rep may request to call CMT staff back to duty. The Emergency Management/Homeland Security unit may also be tasked to provide staff to the agency CMT and/or local EOC during the scheduled hours of operation if at all practicable.

7.0.2 Plan Maintenance

Principle:

Emergency plans are necessarily updated each year for development and maintenance.

Procedure:

The local Emergency Management/Homeland Security agency and the local health district emergency co-ordinator will be responsible for the development and maintenance of this plan.

7.1 Warehouse and Materials Management

Principle:

Agencies will need sufficient additional supplies in order to staff positions during a Pandemic, especially those supplies and materials which will help protect the workforce from the disease.

Procedure:

If the local agency maintains warehousing staff (such as Sheriff's Correctional Facility Warehouse) the agency can/shall procure and keep custody of health protective supplies to include masks, medical examination gloves, bio-hazard protection suites and a suitable supply of hand wash agent. Consultation with local or State health to implement proper PPE is recommended.

7.2 Entry to Law Enforcement (LE) Facilities (Upon Notification of a Pandemic)

Principle:

During a Pandemic, infection control measures must be implemented to protect the public and the workforce.

Procedure:

No person shall enter a local LE facility until they have completed the attached health questionnaire, have complied with the hand washing/disinfectant protocol and donned a surgical mask. A hand sanitizing and surgical mask distribution station shall be made available at each designated point of access in each local LE facility. (*Health questionnaire may be found at the end of this section*).

The local LE main facility shall secure perimeter fences, if any. Other than incidents which require emergency access to the facility, the main entry gate shall be the single access point. Initial screening and disinfectant protocols for visitors, arresting officers, and detainees shall occur prior to entry to the facility. Only individuals having official LE/Sheriff's Office/OME business shall be allowed into the facility.

Access to the facility for visitors shall only occur through the main lobby door.

Employees reporting for duty shall enter the alternate/employee entrance. In the breezeway/doorway of this entrance employees will complete the health questionnaire, execute the disinfectant protocol and don an N95 or full face APR mask.

All visitors shall complete the hand washing/disinfectant protocol and don a surgical mask prior to being allowed entry.

7.3 Daily Staff Reporting

Principle:

Due to loss of workforce from sickness, daily staffing could become severely impacted, thus affecting the agency's ability to deliver services to the community. Daily staffing levels are critical to addressing the agency's response capability.

Procedure:

Each Division /Bureau shall report twice daily, or as directed, all sick notifications, current strengths and tasking availability to the departmental CMT/EOC by internal e-mail or Phone. Staff reports shall be forwarded no later than one hour prior to daily CMT/EOC meetings.

7.3.1 Duty Restriction of Agency Staff

Principle:

Staff should be screened daily to lessen the likelihood of spreading the infection to other staff or the public. Staff that are symptomatic should be restricted from duty.

Procedure:

Agency members who report for duty showing signs of obvious illness or who fail the medical questionnaire shall be immediately barred entry to agency facilities and referred to medical staff or their private health provider for final determination on duty restrictions. It will be assumed by

the Agency that staff showing illness requiring restriction from duty is a result of occupational contact (this is at the sole discretion of the agency).

Agency staff who are under direction to be restricted from duty, will be placed on administrative leave and compensated during their regular scheduled shifts via administrative leave, sick leave, or other catastrophic sick leave policies implemented by the agency, in accordance with agency policy. Staff may be restricted by their Medical Provider or by the agency. All members who have been informed that a medical practitioner has restricted them shall immediately report this information to their supervisor.

7.4 Personal Hygiene/Social Distancing

Principle:

The best possible defence to a flu virus is personal hygiene and social distancing. All staff members should follow approved methods for infection control including social distancing as a defence to the disease.

Procedure:

All staff should thoroughly wash their hands after every contact, before touching food, after using the washroom, after sneezing, coughing or blowing your nose, after touching pets, after touch door handles, or handling garbage. It is recommended that members should obtain a yearly flu vaccination.

Social Distancing is a critical key to maintaining the health of staff during an epidemic/pandemic event. Unfortunately procedures of social distancing may be perceived by the public as cold or impersonal and may heighten fears of individuals who come in contact with your officers.

The distribution of accurate and timely information to the public regarding social distancing procedures will alleviate these perceptions. The Agency shall post “What to expect” information to better prepare and educate the public regarding a deputy’s/officer’s appearance and expectations during a response. See Section 7.7.5, Citizen Information Sheet “What to Expect.”

For additional information regarding social distancing, please refer to Section 7.7.4 Infection Control Guidelines.

7.5 Policing Challenges for Public Health Emergencies

Principle:

The basic mission of the LE/Sheriffs Office is to protect life and property through professional and innovative services. This is accomplished in partnership with citizens and communities within the jurisdiction’s boundaries. A pandemic event offers the challenge of providing basic services in addition to responding to the consequences of the pandemic with the possibility of severe impact to the agency’s staffing levels. By identifying pandemic specific tasks and pre-planning for those tasks, the agency will be better prepared to successfully accomplish its stated mission. Potential pandemic specific tasks are identified below.

7.5.1 Enforcing Orders of Restriction

Principle:

During a public health emergency the UDOH or Chief Executive of the local public health department may order the restriction of a person or group of persons under Utah Public Health Law. As part of this authority, local Law Enforcement Officers with jurisdiction where the individual(s) can be located, shall assist with enforcing the Order of Restriction. However, due to anticipated resource and manpower shortages the local law enforcement agency will not have the personnel sufficient to support such actions.

Procedure:

Local law enforcement agencies prefer and request that the local health officers utilize alternate methods such as voluntary isolation, etc., prior to the issuance of formal orders of restriction or quarantine.

7.5.2 Transportation of Restricted Individuals

Principle:

Transportation of an individual subject to an order of restriction to court, or to a place for examination, quarantine, isolation, or treatment pursuant to a temporary order issued by a public health department or court order, should, where practicable, be conducted by the local LE/County Sheriff where the individual is located, as required by state law.

Procedure:

Full protective measures must be implemented to protect the employees involved in assisting with the transportation of the restricted individuals.

7.5.3 Guarding stock piles of medical supplies /Crowd control at SNS distribution areas

Principle:

The (local facility designated as an SNS Point of Distribution – POD) has been designated as the distribution/warehousing site for SNS medical supplies . Due to the need to maintain a secure nature of the facility, it is anticipated that (minimal/additional) security will be required while supplies are stockpiled at this site. While the National Guard may be tasked by UDOH, local LE should be aware and if need be, made available to assist in this important task.

Procedure:

Responding to specific incidents which may interfere with the security or orderly distribution of medical supplies or vaccines is considered critical in safeguarding the lives and safety of the citizens of the jurisdiction, and all reasonable steps shall be taken by the agency to ensure the security of medical supplies.

All requests for this service shall be directed to the agency's CMT via the City/County EOC.

7.5.4 Hospital Security – Critical Facility Protection

Principle:

Medical Facilities are designated critical infrastructure sites within the State of Utah. Sustaining operational medical facilities is critical during a public health emergency.

Procedure:

Providing staff to assist and supplement Hospital Security in controlling crowds during a patient surge is considered a high priority for maintaining adequate medical services.

The staffing of long term, static security posts is viewed as a low priority for the agency. This function is recommended duty for private security.

7.5.5 Calls for Service While at Reduced Staffing**Principle:**

During a panflu event, it is expected that staffing numbers will be reduced up to 40% due to illness. Therefore, service delivery will require modification and calls for service will need to be prioritized.

Procedure:

In consultation with the agency's executive staff, a determination will be made at the beginning of each shift based upon the demands for service, staffing levels, and tasking availability, the specific call types which the agency will respond to. This may involve a suspension of the agency's attendance at low priority calls for service or routine traffic enforcement. The agency will provide alternate means for citizens to file a police report such as phone in systems, and web based reporting systems. Information regarding alternate means shall be communicated to Dispatch by the agency's CMT. Strategies for service delivery may include:

1. Placing all uniform staff on 12 hour shifts;
2. Suspending select administrative functions and reassigning those staff members to uniform operations;
3. Temporary assignment of Corrections and /or Court Security Officers/Deputies to event specific field duties;
4. Termination of pre-approved vacation and training leave;
5. Re-assign Investigations staff into Uniform operations;
6. Utilize Recruits (if any available) for Administrative Support duties;
7. Cancel all non-emergency calls for service;
8. Utilize Search and Rescue, Auxiliary, or VIPS, if appropriate and if available.

7.6 Unattended Death Response

A high hazard duty for Law Enforcement/Deputy Investigator during any public health event involving a contagious disease is responding to calls of unattended deaths. As stated, the assumptions for a panflu event anticipate severe shortages of resources and personnel. Therefore a measured response involving the strategies of social distancing and situational Triage protocols

will be used while responding to “Unattended Death” or “Delta” response medical calls. (Delta is defined as a critical response involving immediate danger to life.)

When dispatch receives a call requesting a response for an unattended death, the receiving dispatcher shall engage the caller in a series of pre-scripted questions as a means of determining if this death may be related to the disease. If it is believed that the death may be disease related, the call should be dispatched as an “Unattended Death – Possible Flu Related” or as a “Delta Medical Response - Flu Related” call. Upon receiving a flu related call the primary Officer/Deputy dispatched shall acknowledge the call with dispatch and proceed to the location. Upon arrival, the primary Officer/Deputy dispatched shall;

1. Sign out at the location and don PPE prior to entering the scene;
2. Initially only the primary Officer/Deputy assigned shall enter the scene;
3. If the Officer/Deputy arrives prior to EMS, they shall initiate an assessment of the victim (Can use the “START Triage” protocol for mass casualty.);
4. Once an assessment/triage has been completed by the Officer/Deputy or EMS and the individual is deceased, the Officer/Deputy shall engage the witnesses on scene in a secondary scripted assessment for pan flu. See Section 7.7.7;
5. The Officer/Deputy shall also assess the scene and determine if any suspicious circumstances exist. If the circumstances do not appear to be pan flu related they shall declare a crime scene and standard protocols will occur based upon agency protocols;
6. If the Officer/Deputy finds circumstances appear to be related to pan flu, they shall notify their supervisor and also determine if the deceased individual’s physician will sign a certificate of death. If the physician will sign a certificate of death, the Officer/Deputy may offer to assist in contacting a funeral home and clear the call. The Officer/Deputy will also need to document the attending physician’s willingness to sign a certificate of death;
7. If there is no primary physician, or if that physician refuses to sign the certificate the Officer/Deputy may then contact the Deputy Investigator or if unavailable the OME’s office in SLC, and relay any findings.
8. If the Deputy Investigator agrees with the Officer’s/Deputy’s findings, the Deputy Investigator will contact the OME office. The Deputy Investigator will explore and pursue the most appropriate option ie a terminated case, an absentia case, or a regular case. (Before the body is released, arrangements will be made to ensure the death shall be properly certified.
9. The Officer/Deputy shall inform the family or witnesses that the Deputy investigator will arrive and that the body should not be moved or touched and that individuals should isolate themselves from the area where the body is. The Officer/Deputy may then clear with supervisory approval.

7.7 Operation of the Agency’s Correctional Facility

The agency anticipates that an epidemic/pandemic event will significantly impact normal

operations of its jail/correctional facilities. While the inmate population of the facility represents a cross section of the population of the County as a whole, a large number of offenders could be considered “at risk” for contracting contagious diseases. The agency correctional facility houses multiple inmates who fall into the following categories:

1. Legal and Illegal immigrants who have recently travelled from foreign countries;
2. Socio-economically depressed individuals who receive limited preventative medical care;
3. Immuno-suppressed individuals, who because of other illness (HIV, Hepatitis, Tuberculosis, etc) and/or drug and alcohol addiction are more likely to contract a communicable disease.

Because of these population dynamics and the close living conditions common to correctional facilities an epidemic/pandemic agent could spread very quickly with catastrophic results if introduced into the inmate population. Courses of action for the agency to prevent this are, but not limited to the following options:

1. Temporary suspension of inmate visiting, Temporary suspension of inmate programs and congregate services;
2. Suspension of community work details and programs;
3. Suspension of alternate sentencing programs such as weekend sentences, work search, etc.
4. Temporary lock-down of inmate populations;
5. Temporary release of low risk offenders;
6. Extended time of new offenders in R&O housing;
7. Additional medical screening procedures at time of booking;
8. Requests for Law Enforcement Agencies throughout the County to implement “cite and release” procedures unless there is obvious risk to the community if the offender remains free.

The agency Chief Executive Officer/Designee, in consultation with the agency CMT and local or state health will determine and implement the best course of action to ensure the safety and orderly operation of the correctional/jail facility. The agency CMT will be responsible to communicate any restrictions of the facility to the EOC and/or health department.

7.7.1 Quarantine of Prisoners

Prisoners who are exhibiting signs of illness or persons arrested under a Court Ordered Health Restriction shall be isolated at the facility or taken to the nearest hospital by the arresting agency for admittance. All prisoners requiring isolation/quarantine within the facility shall be TRO’d (Temporary Restriction Order) to a “Special Management” status and restricted per medical staff recommendations.

In the event of wide spread infection within the facility the Corrections Chief Deputy/Designee

may order emergency redesignations of inmate classification levels to better safeguard the health of inmates and staff.

7.7.2 Prisoner Screening

All new custody intakes, including those at Courts, shall be screened regarding health concerns. Possible symptoms are:

- ❖ High Fever – over 101.3 degrees Fahrenheit
- ❖ Muscle pain, aching body pain

Coupled with the above, any one of the following will trigger isolation procedures:

- ❖ Presence of Pneumonia
- ❖ Have recently travelled to any of the countries or areas where a level 4 epidemic/pandemic alert has been declared by the World Health Organization or other public health agency in the previous 2 weeks.

7.7.2.1 Personal Protection Equipment (PPE)

In circumstances where the health status of an offender is not known, members shall initiate universal precaution including the use of the following protective devices and measures:

- ❖ Wearing a protective N95 APR, or a Full-Face APR mask;
- ❖ Latex free medical examination gloves;
- ❖ Infection control gowns or biohazard suits shall be worn where there is potential exposure to blood or body fluids;
- ❖ Antibacterial wash solution.

7.7.2.2 Employee and Visitor Screening

Principle:

Once secured, the facility should not allow entry without screening the individuals.

EMPLOYEE/VISITOR MEDICAL SCREENING SHEET

<p>VISITORS/EMPLOYEES</p> <p>STOP!!! – DO NOT ENTER THIS FACILITY UNTIL YOU HAVE COMPLIED WITH THIS SCREENING DIRECTIVE.</p>		
<p>HAVING COMPLIED WITH THIS DIRECTIVE THE VISITOR / EMPLOYEE SHALL SANITIZE THEIR HANDS AND DONN A MASK BEFORE ENTERING THE FACILITY.</p>		
<p>To be completed by staff member or other authorized person. Name of person conducting this screening:</p>		
<p>SYMPTOMS: Are you experiencing any of the following symptoms?</p>		
Myalgia (muscle aches)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Malaise (severe fatigue or unwell)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Severe headache (worse than usual)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Shortness of breath	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Difficulty breathing	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<p>If the employee or visitor answers yes to two or more of the above there will be no entrance allowed to the facility</p>		
<p>CIRCUMSTANCES: Please answer the following questions.</p>		
Have you had contact with a person with or under investigation for FLU in the last (incubation period) days?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you been to (focus of outbreak) in the last (incubation period) days? If yes, please identify the date and the area?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Date/Area:		
<p>Any yes answer to one or more of the above there will be no entrance to the facility</p>		
<p>Employees of the agency are required to complete the following section</p>		
<p>Temperature: _____ <i>If temp. is above 101.3 do not enter the facility and immediately notify your supervisor</i></p>		

7.7.3 Crisis Management Team

Principle:

Once a health emergency is declared, the agency should activate some form of Crisis Management Team/Emergency Operations Team (in accordance with existing Emergency Operations Plans) to help direct and coordinate the agency's actions. Standardized checklists can help guide managers in the decision making process.

AGENCY RESPONSE TEAM PAN-FLU CHECKLIST

Pandemic period - Phase 6- Outside Utah (or other trigger point)

- Obtain briefing From Local Health District or UDOH:
 - Nature of Event? Geographic Scope? Size/Complexity?
 - Location of Outbreak
 - Anticipated impact on employees
- Notifications
 - Post informational materials.
 - Begin Public Information notifications.
- Incident Course and Threat:
 - Begin Social Distancing Protocols?
- Begin building isolation procedures?
 - Begin illness monitoring inside Correctional Facility?
 - Begin illness monitoring for visitors and staff?
- Staffing:
 - Review current staffing levels Enforcement/Corrections
 - Create emergency shift schedules based on current staff
- Evaluate Resources:
 - Adequate N95 masks on hand for staff?
 - Adequate Surgical masks on hand for visitors?
 - Adequate hand wash supplies and Gloves?
 - Address shortfalls.
- Begin Action Planning:Options?
 - Estimate Potential Outcomes. Resources Needed.
 - Plan for reduction in service calls?
 - Plan for modification of jail intake procedures?
 - Plan for Public Health specific tasking.

Pandemic period - Phase 6 - Inside Utah (or other trigger point)

- Obtain briefing From Local Health District or UDOH:
 - Nature of Event? Geographic Scope? Size/Complexity?
 - Location of Outbreak
 - Anticipated impact on employees
- Notifications
 - Post informational materials.
 - Begin Public Information notifications.
 - Assign Agency Rep to local health or EOC.
 - Public Information (inform community of service modifications)
- Operational Responses:
 - Implement emergency staffing plan.
 - Secure Facilities.
 - Implement facility entry protocols.
 - Implement remote briefing via Mobile Data technology.
 - Request allied agencies to begin “cite and release” policies.
 - Implement web/phone reporting protocols.
 - Prioritize service call response.
- Review Resource Status:
 - What Resources are Being Used, Where, Doing What?
 - Additional Needs Based on Situation.
 - Consider reassignment of sworn staff to event tasking.
 - Suspend leave for vacation/training.
 - Mobilize recruits, VIPS, S&R if available.
- Incident Action Planning
 - Identify Key Functions or Strategic Goals and Tactical Objectives of the Response:(See Applicable Incident Action Planning Worksheet.)
- Identify Resources Needed and Their Sources.
- Identify Any Necessary Tactical Methodologies:
 - How will the Assignments be Carried Out.
 - Make the Tactical Assignments to Specific Resources.
- Define Operational Period, Schedule Next Planning Meeting.
- Conduct Operations
 - Create Operations Section.
- Coordinate with local health, EOC, other agencies as necessary

7.7.4 Infection Control Guidelines

INFECTION CONTROL CHECKLIST

General Infection Control Checklist

- ❖ Post visual alerts (in appropriate languages) at the entrance to facilities instructing persons to inform personnel of symptoms of a respiratory infection.

- ❖ Emphasize covering nose/mouth when coughing and sneezing and the cleaning of hands.
- ❖ Use “Ask for a Mask” campaign materials (or other materials) to demonstrate the sequences for donning and removing personal protective equipment.
- ❖ Require appropriate respiratory protection for specific employees (mask or respirator based on job function).
- ❖ Provide tissues and no-touch receptacles for used tissue disposal and require employees and visitors to use tissues to contain respiratory secretions.
- ❖ Place hand hygiene cleaning stations (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic hand wash) at strategic locations (doorways, entrances, phones, etc.). Ensure that supplies for hand washing are consistently available.
- ❖ Require use of waterless hand cleaner after each employee/customer contact.
- ❖ Provide masks and hand cleaning supplies in waiting area for clients and visitors.
- ❖ Require persons who are coughing to wear a provided mask, or go home.
- ❖ Encourage coughing persons to isolate themselves from others.
- ❖ Maximize the distance between employees and clients. Minimize exposure to others.
- ❖ Implement social distancing protocols including but not limited to:
 - a) Canceling large public gathering such as concerts, formations, sporting events, etc.
 - b) Utilize telecommunications capabilities; expand online and self-service options for customers and business partners.
 - c) If job description allows, work offsite while ill.
 - d) Hold conference calls instead of meetings.
 - e) Encourage employees to get the annual flu shot and pneumococcal vaccine.
 - f) Communicate to employees the importance of staying home if ill (concern about lost wages is the largest deterrent to self-quarantine). If job description allows, work offsite or telecommunicate while ill.
 - g) Move work stations further apart and stagger shifts.
 - h) Determine which outside activities are critical to maintaining operations and develop alternatives.

7.7.5 Public Information Release for Change of Agency Protocols

CITIZEN INFORMATION SHEET “WHAT TO EXPECT”

To the Citizens of (City/County):

Due to the recent Public Health Emergency, the (Agency) Office will modify the manner in which we serve you, the community. This letter is being written to assist both the (LE Agency) (County Sheriff's) (OME) and you in ensuring that the presence of our staff will not increase the risk of this illness spreading.

Social Distancing

During an event such as this the ability to distance oneself from others is a key component to maintaining personal health. If (Officers/Deputies) are responding to your location we would ask you to do the following.

1. Meet the (Officer/Deputy) in an open area, outside if possible.
2. Maintain a distance of at least ten (10) feet from the (Officer/Deputy) or their equipment unless asked to move closer.
3. If you have a surgical or other type of face mask please put it on. Please wash your hands before the (Officer/Deputy) arrives (If there is an item of evidence, blood or other substances that may be destroyed as a result of hand washing DO NOT WASH your hands).

Protective Equipment (PPE)

When (Officers/Deputies) arrive at your location they may be wearing PPE. While their appearance may seem unusual do not be alarmed. This is intended to ensure the good health of the (Officer/Deputy) as well as you. Items (Officers/Deputies) may be wearing are;

1. Surgical or chemical/biological protective masks;
2. Chemical/Biological protective suits;
3. Surgical or chemical/biological resistant gloves and boots.

Calls for Service

Because of this emergency event there may be some limitations to the service we are able to provide you. As a result, if you call for service you may be asked to phone your complaint in to the LE/Sheriffs Office or be referred to our website. We realize that this may seem an impersonal way of serving your needs but again it is intended to ensure your good health and ours. Please know that we intend to provide service that is still the best that is practicable throughout this trying time.

Thank you, (Chief/Sheriff/OME)

7.7.6 Public Information Posters for Infection Control

INFORMATIONAL POSTERS

- Refer to State Pan flu website for access to posters and flyers information:
<http://www.pandemicflu.utah.gov/index.htm>
- Refer to Appendix C for 8.5 X 11 examples of posters and flyers.

7.7.7

Dispatch Center and First Responder Protocols (example)

DISPATCH/FIRST RESPONDER SCREENING

Initial Screening Questions

For use when a Medical Priority Dispatch card is unavailable. To be used in assessing health needs of caller.

1. Are you having difficulty breathing? (Yes = possible flu)
2. Do you have a fever of 102 or higher? (yes = more likely flu)
3. Have you experienced uncontrollable coughing? (yes = very likely flu)
4. Are other persons in the home showing similar symptoms? (Yes = probable flu)
5. Have you had these symptoms for greater than 7 days? (Yes = lesser chance of flu)
6. Are you experiencing nausea, vomiting, diarrhea ? (unlikely flu)
7. Have you been exposed to anyone with the flu?

Secondary Screening Questions

For use in preliminary assessment of establishing circumstances surrounding death of subject. Can be used by Dispatch and/or first responding officer/Deputy/OME Deputy Investigator.

1. Has the individual been under the care of a Doctor recently?
2. Has the individual been diagnosed with the flu?
3. Has the individual been diagnosed with any other significant health problems?
4. What is the name of the individual's Doctor?
5. What symptoms has the individual exhibited over the past few hours/days?

Appendix F

On-Scene and Morgue Standard Operating Guidelines for Mass Fatalities Incidents

1.0 Introduction and Overview

1.1 Victim Identification in Mass Disasters

These guidelines are to be used for Response Team operations when activated under the State Emergency Operations Plan. They are designed to provide responders (Pathologists, death investigators, crime scene investigators, Odontologists, Anthropologists, funeral directors, and other medicolegal authorities) an interoperable response methodology to operate effectively and efficiently at a mass fatality incident involving a number of fatalities that exceed the responsible jurisdiction's resources and/or capabilities.

The Department of Health, Medical Examiner, and emergency management officials understand that expectations of family members of victims (and by extension the general public, public officials, and the media) concerning identification and morgue operations are high. Non-scientific identification methods, which can lead to misidentifications, are not acceptable. Medical examiners are expected to rely upon acceptable forensic techniques (fingerprinting, dental, anthropological/radiological, DNA, etc) for positive identification. While the cost associated with accepted forensic identification methods should be considered, it should not be the only consideration in making timely and accurate identifications.

The victim identification process should be thorough, efficient, and devised to minimize errors. These procedures are based on years of experience by other response teams. Slight variance from the procedures in morgue organization is expected based on the particulars of the event, e.g. condition of remains and availability of ante mortem information. However, since the ultimate goal of the process is identification of the victim, accepted standards for the processes of forensic identification must be maintained.

For the family and friends of the victims of mass disasters, an important measure of comfort awarded them is in the process of identifying the remains of the deceased. Because this process happens without their direct involvement and oversight, the medicolegal and mortuary responders are granted a fragile trust. Society and families hold responders to the high expectation that the victim's remains will be identified and returned to them in a most expedient manner. They demand that they be kept informed of the entire identification process. Forensic science, as a profession, must provide accurate, concise and honest information to families admitting to and providing an explanation of mistakes when they occur. It is also their responsibility to institute standards and quality control measures in order to reduce errors, ultimately giving families and society a confidence in the process they need during their recovery from loss. For family members and society, the trust placed in the forensic professional to accurately, quickly and with respect identify victim's remains can be easily compromised if an attention to detail is not maintained.

These guidelines were created to give structure to any response team that may assist the Utah Medical Examiner's Office. The legal responsibility of the Utah State Medical Examiner to certify the cause and manner of death and to identify disaster victims is well established in state statute, and remains unchanged when a mass fatality incident occurs. The system as outlined in this plan allows for disaster victim identification to be managed in a consistent manner statewide.

1.2 Jurisdictional Responsibility

The Utah Medical Examiner's Office is legally mandated to conduct victim identification (or assist the lead investigative agency to complete victim identification), determine cause and manner of death, manage death certification, and is responsible for other medicolegal activities. In the event of a mass disaster, Medical

Examiner's Office maintains these responsibilities. Although the response teams provide support to the Medical Examiner's Office to accomplish decedent identification, they cannot speak for the Medical Examiner's Office, nor assume the legal responsibilities unless specifically requested to do so, and then only with subject matter and approval of the release by the Medical Examiner's Office.

1.3 Using State, Local and Federal Response Teams

Utah supports the use of response teams that work under the authority of the Utah Medical Examiner's Office. Any of these teams should have standard operating procedures equivalent to those listed herein. Local and Federal resources can augment the Medical Examiner's response to a mass fatality event. To ensure that these teams can work effectively together, a pre-operational meeting will occur between a representative of the Medical Examiner's Office and any other response team leadership, as appropriate. Team leadership should also meet and brief during each operational period.

Since the focus for all involved is the efficient, accurate, and timely identification of the deceased, the highest standards for morgue operations, decedent identification, and data management will be maintained.

1.4 Assisting Response Teams' Role in Family Briefings

Representatives from assisting response teams will be available to assist the Medical Examiner's Office in briefings that are held for family members if requested. Typically, the Medical Examiner's role at these briefings entails providing information about the following questions:

1. Why is recovery taking so long?
2. How will families be notified if their loved ones are recovered and identified?
3. When will the personal effects be returned to the family?
4. What methods are used to identify the families' loved ones?
5. Will DNA be used in identification?
6. What is the condition of the body?
7. Will an autopsy be performed?
8. How do families know that the information they receive is accurate?
9. How may families obtain copies of the medical examiner's report?
10. Why are the identifications taking so long?

For an overview how medical examiner's offices in two cities (Oklahoma City and Miami) managed family concerns following two mass fatality disasters, see Attachment 1.

1.5 Fatality Management Considerations

Five factors impact the processing of remains and identification of decedents:

- ❖ Number of fatalities
- ❖ Decedent population (open or closed)
- ❖ Availability of ante mortem information
- ❖ Condition of remains (complete or fragmentary remains)
- ❖ Nature of the event (Chemical, Biological, Explosion, etc.)

These factors drive the personnel needed, how long identification will take, and the methods used to care for the victim's remains and make identifications.

Number of fatalities

The number of dead in a disaster is a significant driver in the amount of resources needed to search, recover, and identify the dead. For most transportation disasters, the number of dead will be limited (i.e. no more than several hundred). In addition, aviation accidents are a closed population (see below), and in essence provide an

accurate number of fatalities and their personal identifiers. In general terms, as the number of decedents increases, the resources needed to manage and care for them increases.

Decedent population

In general, there are two types of decedent groups – closed and open populations. In a “closed population”, the number of victims and their names are known. The singular example of a closed population is an aircraft accident, where positive identification checks, ticket purchasing procedures, and airport security allow forensic responders to trust the accuracy of the flight manifest and its associated passenger name record. Passenger names and contact information should be available to the authorities within a matter of hours following an incident, and the collection of ante mortem information can begin within the same time period.

Conversely, an “open population” is one in which neither the number of victims nor their names are known. As such, response personnel must sort those who are **reported** missing from those who are **actually** missing. This sorting process takes time. Once a person is known to be missing with a reasonable certainty, the process of obtaining and cataloging ante mortem data can begin. An example of this is the World Trade Center disaster. Initial media reports indicated as many as 10,000 dead or missing. In subsequent days, the number of reported missing fluctuated between 3958 and 6453 (Simpson and Stehr, 2003, “Victim Management and Identification after the World Trade Center Collapse,” in *Beyond September 11th: An Account of Post-Disaster Research*, http://www.colorado.edu/hazards/sp/sp39/sept11book_ch4_simpson.pdf). The total number of missing was 2749 and total identified was 1591 (as of June 2005). In an open population, since the number and names of dead are not known, all remains should be profiled for DNA if practical so that entirety of the decedent profiles is available.

Transportation accidents may involve open or closed populations. The details of obtaining passenger lists and missing person information will be coordinated with the Medical Examiner’s Office and the responsible/investigating agency.

Ante mortem information

Identification requires comparing postmortem and ante mortem data. Collecting the postmortem information is accomplished in the incident morgue as the remains themselves are analyzed when they become available from the scene. However, locating and obtaining accurate and useful ante mortem data is more time consuming and complex. Factors such as the age, socioeconomic status, cultural practices, and religious beliefs of the decedent and their families impact ante mortem record availability considerably.

Because the backgrounds of victims are so varied, some may not have had dental care, and subsequently no ante mortem dental records exist. Many people have never been fingerprinted, or were printed through a process that may or may not allow for their prints to be stored and retrieved. Certain religions believe that is not important to provide a final disposition for remains, and as such family members may be unwilling to provide DNA samples for identification. Another consideration is the proximity of the incident to the location of the decedents’ ante mortem records. For example, if the majority of decedents are from the city where the incident occurs, then access to records will be more rapid because of the proximity of both families and dentists/doctors. Conversely, the ante mortem record availability in an incident where no decedent is local (including foreign victims), the access to families, and thus ante mortem records, is slowed.

It has been shown, that there is a direct correlation between the timely collection of ante mortem records and the completion of the identification process. ***The same level of attention and resources provided to the postmortem data collections processes should be awarded to the ante mortem data collection process.***

Condition of remains

Whole bodies or those that are mostly intact are much easier to process and, with adequate ante mortem information, can be identified quickly. A victim is considered identified and accounted for, when an identification is made using an accepted method (fingerprint, dental, etc.). Fragmented remains present more complex issues. Certain body parts may contain these unique identifiers (e.g. dental work or fingers) and these parts can be identified. In this case, there is proof of the person having died, and proof that they have been identified. However, the process of identification does not stop at that point. DNA analysis may be used to identify body parts that have no unique physical identifier. However, DNA analysis does have limitations - not all DNA analyses result in a DNA profile.

In a closed population, high-fragmentation incident, forensic investigators work to identify all the victims, with an understanding that not all remains will be identified because of the technological limitations of current identification processes. In an open population, high-fragmentation event, the focus must be on identifying all remains as the number and names of decedent is not known. In both cases, frequently not all body parts can be identified. Because not all fragmented remains are identifiable, the Medical Examiner must decide, in conjunction with the families, about the final disposition of these remains, often referred to as common tissue. Families are informed of the presence of these unidentifiable remains early in the incident, and preferably work as a group to decide upon the final disposition. If families cannot decide, the medicolegal authority takes action under the jurisdiction's laws to dispose of the remains. If this occurs, families will be notified of the process and timing for final disposition.

The decision about what to analyze for identification is done at the morgue triage station based on guidelines set forth by the Medical Examiner. These guidelines should be based upon the degree of fragmentation and/or burning of the remains, the availability of ante-mortem information, and other particulars of the disaster. Remains that have a high potential for identification are put through the morgue process, where those with a low or no potential are held as common tissue.

The interplay of these five areas: 1) Number of fatalities, 2) Condition of remains, 3) Decedent population, and 4) Ante mortem record availability 5) Nature of the event - reveals the potential for positive identifications and how they will be conducted. Forensic and morgue personnel must understand the interplay of these factors so that the morgue operation can proceed accordingly.

1.6 Family/Next of Kin Considerations for Decedent Information

The nature of the victim identification process requires the involvement of the next-of-kin (NOK) in decisions about certain aspects of issues regarding decedent remains. The Medical Examiner is responsible for the coordination of, interviews, liaisons with, and the overall interaction with victim's families. Some of these aspects are outlined as follows.

1.6.1 Death Notification/Notification of Identification

The Medical Examiner or his designee will notify the NOK when the decedent has been identified. This notification can be done via telephone (if the NOK have stayed home and not traveled to the incident city), at the Family Assistance Center (FAC), or another location as agreed to between the NOK and the incident command.

In the case of complete or nearly complete remains, the decedent is often identified in a relatively short period of time using conventional identification methods (dental, fingerprints, medical devices, etc). For such remains, notification of identification should be followed fairly quickly by release to the designated funeral home. However, it is understood that other factors (incident investigation, etc.) may necessitate the remains being held after identification is made.

In event that a significant portion of a victim's remains is identified, families should be asked if they wish to have those remains (e.g. 80% complete) released to them and forgo future DNA identification of fragmented remains, or if they want DNA to be used if possible to re-associate any additional remains. The latter choice will delay the release of remains until the DNA testing is completed and the additional remains are identified. Families should NOT be faced with the trauma of having their loved one's remains released, only to find out weeks or months later that additional remains have been identified. Families should be well advised and informed of this situation as early as possible in the incident.

In the case of fragmented remains, identifications usually take time to complete. DNA will be the primary method for identification, and remains will need to be re-associated based on the DNA analyses. Families should be notified the first time remains from the decedent are identified. At this point, the NOK choose when and if they are notified of additional identifications. They can be notified each time remains are identified, once all identifications are complete, or receive no further notification of identification. Consideration should be given to fragmented remains being retained at the morgue until all remains have been identified. This reduces error and can allow for more remains to be identified.

The Medical Examiner should brief families about the general condition of the remains. When remains are fragmented, the families should be advised that identification process will take time, and that no whole bodies may be recovered. Care should be taken as to how this information should be presented to the families and will be done by the Medical Examiner or his designee only.

1.6.2 Identification of Decedents vs. Identification of Remains

The Medical Examiner is responsible for deciding upon the primary goal for the identification efforts: whether to identify each decedent or to identify all remains. This decision will have a significant impact on the scope of the identification process. In the case of an incident where not all decedents are known (open population) and remains are fragmented, all remains must be analyzed for DNA so that profiles on all decedents can be obtained. DNA testing may not result in positive results for all remains tested, and the work must proceed so that all obtainable profiles are available for identification. In a closed population where the victim's information is known (such as an aviation accident with a flight manifest), focus should be placed on identifying the as many body parts for each decedent as possible. However, each disaster poses unique concerns and the circumstances should be thoroughly considered before identification efforts begin.

1.6.3 Use of DNA

In mass fatalities and/or in cases of highly fragmented remains, DNA analysis is an essential component of the identification process. Like any forensic technique, DNA analysis has benefits and limitations. An awareness of these factors, how they impact issues related to the identification of the deceased, and a how they impact working with family members critical.

DNA analysis can (1) Identify the victims, (2) Associate fragmented remains, and (3) Assist in ongoing medical and legal investigations. However, there are limits to DNA technology. DNA analysis takes time. The collection of ante-mortem reference samples from certain family members is required depending on the type of DNA being analyzed. Despite its liberal application, DNA analysis may not yield useful information. As a destructive test, very small remains may be destroyed entirely in the process, thus leaving nothing to return to the NOK.

At some point, the Medical Examiner must decide to end further DNA testing of remains. This is particularly important if additional remains from the accident site are recovered after the formal search and recovery period has ended.

1.7 Records Management and Long-Term Support

The Medical Examiner will be provided all the original records from any assisting response team, including postmortem forms, ante-mortem records, and any associated documentation. They are also provided a copy of the data entered into the Victim Identification Program (VIP) database. The VIP will be discussed in detail later in this plan.

1.8 Federal Disaster Portable Morgue Unit (DPMU)

The NDMS Section of the US Department of Health and Human Services, has three (3) fully equipped Disaster Portable Morgue Units (DPMUs). DPMUs have the equipment necessary for morgue operations. Disaster-specific needs dictate how and where the morgue will be set up to best accomplish the mission. DPMUs are deployed rapidly, along with logistical specialists to establish and manage the DPMU.

All NDMS field response operations are established using the National Incident Management System (NIMS), Incident Command System (ICS). This resource will interface with local, State, and Federal agencies and volunteer organizations necessary and appropriate by the Medical Examiner.

1.9 Training and Licensure

The importance of joint training and exercise is recognized and every effort will be made to conduct joint trainings. It is expected that any special licensures or certifications required by a member of a response team will be current and in good standing.

2.0 Incident Site Operations

2.1 Search and Recovery

Principle:

The search for and recovery of remains and other pertinent items from incident sites requires a standardized approach to ensure that the process is in accordance with standard rules of evidence and is properly documented.

Procedure:

For some transportation accidents, the FBI Evidence Response Team (ERT) provides personnel and management for the search and recovery of human remains, personal effects, and accident-related wreckage per an agreement with the NTSB. The local jurisdiction may be asked to augment the FBI ERT response, based on the particulars of the event. The FBI ERT provides standard methods to document the accident scene and in the handling of materials at the scene.

Remains recovered by the FBI ERT will be documented at a level required by the NTSB to conduct their investigation. The Medical Examiner may ask for additional information to be collected to accommodate a specific need.

Assisting response team personnel can assist with the search and recovery effort as well as other scene issues that could impact morgue operations. This may include anthropologists, dentists, medicolegal investigators, or other suitably qualified specialists.

For incidents not involving FBI ERT and NTSB, search and recovery efforts may fall totally on the Medical Examiner and assisting response team resources. The Medical Examiner and the investigative law enforcement agency will determine the level of documentation required at the scene.

2.2 Field Safety Briefing

Principle:

Working at a mass fatalities disaster site is hazardous and site workers must be made aware of the hazards and take steps to maintain their health and safety.

Procedure:

A Search and Recovery Safety Officer will be designated to conduct a briefing before the beginning of each operational period. Local hazmat teams may also be involved in this briefing. Other specialized personnel may also be called upon to assist. The Safety Officer will develop a Site Safety Plan and constantly review safety procedures and the work site for additional hazardous conditions or procedures.

2.3 Decontamination of Remains

Principle:

Standard medico-legal investigation teams are not equipped or trained to process chemically contaminated remains. Chemically contaminated remains are unsafe to process in the incident morgue and must be decontaminated before removal to the incident morgue to avoid cross contamination of other areas and people.

If the threat of contaminated remains, personnel effects, and other items of evidence exists, the Medical Examiner and all supporting agencies must determine the best approach for mitigating the hazardous agent while preserving all items of interest during the decontamination process.

If necessary, the US Department of Health and Human Services, NDMS Section DMORT-Weapons of Mass Destruction Team (DMORT-WMD) may be deployed to clean and decontaminate human remains.

Procedure:

During the initial planning phase, the Unified Command must specifically address who is completing which task, the order of tasks included in the decontamination process, and why the details must be carried out in a specific manner for each phase of the operation. There are essentially two (2) options: 1) Include forensic operations in the decon line, or 2) Conduct decon only, and deliver “clean” remains to the morgue for forensic operations. The process will include the following decisions and processes:

1. Determine if decontamination of remains is required for the incident.
2. Determine the personnel skill level and personal protective equipment (PPE) necessary to safely complete the decon operation.
3. Determine if typical morgue processes such as photography, triage, and documentation of personal effects and evidence should be part of the decontamination process or remain in the morgue.
4. Determine the size and composition of the Decontamination Team which may include:
 - Hazardous Materials Ops Level or Technician Level Responders
 - Forensic Pathologists
 - Forensic Anthropologists
 - Forensic Odontologists
 - Forensic Photographers
 - Medicolegal Investigators and/or Law Enforcement Staff
 - Fire Service Professionals
 - Medical Support Staff for the Decontamination Team

5. If removal of personnel effects and/or evidence is completed on the decontamination line, all items shall be documented by photography and written means. All items removed from the remains will be labeled with the same number as the remains and be packaged for safe handling.
6. If necessary, and only if requested, forensic examination of the remains may be completed on the decontamination line for unusual cases.
7. Remains are cleaned utilizing the best cleaning compounds for the particular chemical agent.
8. Remains are chemically monitored for the agent to determine if the remains are “clean”.
9. If necessary, repeat the decontamination processes up to three times until the remains are safe to handle in the morgue. If the remains cannot be “cleaned” after three attempts, the HAZMAT team will report to the local Medicolegal Authorities for determination of disposition of the remains.
10. Remains will be placed in the proper receptacle and forwarded to a clean refrigerated area or incident morgue

2.4 Temporary/Staging Morgue

Principle:

In some disasters, an area will be designated as the temporary or holding morgue. This morgue is where remains are held until transport to the incident morgue can be arranged. Some initial examination and documentation of remains may take place in this morgue but for the most part, this “Temporary” or “Staging Morgue” will only be used to “stage” or “hold” the remains as they await transport to the Incident Morgue.

Procedure:

The temporary morgue should be a permanent or semi-permanent structure close to the incident site. In some cases, a tent or vehicle may be used, particularly in rural areas. When the remains are removed from the incident site, they will be placed in body bags or a similar appropriate container. This container/bag will be marked with the site recovery number pertaining to the remains. The container/bag will be placed in the temporary morgue and will be logged into the inventory system in the morgue. Once removed from the morgue, the remains will again be logged as such.

2.5 Transportation of Remains to Incident Morgue

Principle:

The incident morgue is the location where the remains are processed by forensic specialists to make an identification, to conduct a medicolegal exam for determination of cause and manner of death and any other documentation that may be required. Transportation of remains from the incident site or temporary morgue to the morgue site will be accomplished in a professional and dignified manner. Care should be taken to ensure all remains are properly bagged, tagged, inventoried and placed in a refrigerated or other appropriate vehicle for transportation to the morgue. Transportation logs will be maintained to ensure accountability of all remains throughout this process.

Procedure:

1. A log sheet will be maintained indicating the following:
 - Assigned remains number for each remain being transported
 - Number of remains being transported in the vehicle
 - The license number of the transporting vehicle
 - The name of the driver of the vehicle
 - Signature of driver accepting responsibility for remains
 - Date and time vehicle leaves incident site/staging morgue for morgue
2. Enclosed professional vehicles or refrigerated vehicles should be used.

3. Remains will not be stacked.
4. Remains will be placed face up, zipper sides up.
5. Determine the number of refrigerated trailers needed for transport (approximately 20 adult whole bodies per 40-foot trailer).
6. Place vehicles in a secure area near accident site with easy access to load remains.
7. Once bagged, tagged and placed on a litter, the remains will be carried to the vehicle and loaded. Remains will never be “tossed.”
8. Use sufficient personnel to carry each litter to reduce lifting injuries.
9. Trailer doors will be locked and remain locked while human remains are inside.
10. Vehicle driver will deliver the door key to morgue refrigerator storage supervisor.
11. Vehicle driver will be provided the route and will proceed directly to the morgue with no deviations or stops.
12. Police escort should be arranged with the local or state law enforcement if it will not create a “spectacle.”
13. Security should be present at the entrance to the incident site at all times.

3.0 Incident Morgue Operations

3.1 Site Selection and Requirements

Principle:

The incident morgue facility must meet certain requirements for size, layout, and support infrastructure. These requirements are listed below. In general, places such as airplane hangars and unused warehouses have served well as incident morgues. Facilities such as school gymnasiums, public auditoriums, ice rinks, or similar facilities used by the general public after the disaster will NOT be used. The facility should not have adjacent occupied office or work space. If needed, a large banquet style tent may be used, but it will require configuration for sufficient flooring, HVAC, electrical, waste and water requirements. A portable tent unit with adequate flooring, heating, and air conditioning may be available through contract.

Procedure:

Site Selection

If at all possible, existing morgue facilities should be used. However, if the size and scope of the incident does not allow for the use of existing facilities, then pre-determined facilities or expediently acquired facilities need to be secured. When securing a site, consideration should be given to ingress and egress.

Site Requirements

- A. Structure Type
 - Hard, weather tight roofed structure
 - Separate accessible office space for Information Resource Center
 - Separate space for administrative needs/personnel
 - Re-supply and supply storage area, suggest 5,000 square feet
 - Non-porous floors, preferably concrete
 - Floors capable of being decontaminated (hardwood and tile floors are porous and as such, are not suitable)
- B. Size
 - Minimal size of 9,000 - 12,000 square feet
 - More square footage may be necessary for casket storage or other mission-specific needs
- C. Accessibility
 - Tractor trailer accessible
 - 10-foot by 10-foot door (loading dock access preferred)

- D. Electrical
 - Electrical equipment utilizes standard household current (110 – 120 volts)
 - Power obtained from accessible on site distribution panel (200-amp draw)
 - Electrical connections to distribution panels made by local licensed electricians
 - Consider 125K generator and a separate 70K generator for Admin and IR sections
- E. Water
 - Single source of cold water with standard hose bib connection
 - Water hoses, hot water heaters, sinks, and connectors
- F. Communications Access
 - Five existing telephone lines for telephone/fax capabilities
 - Expansion of telephone lines may occur as the mission dictates
 - Broadband Internet connectivity
 - If additional telephone lines are needed, only authorized personnel will complete any expansion and/or connections
- G. Sanitation/Drainage
 - Pre-existing rest rooms within the facility are preferable
 - Gray water will be disposed of utilizing existing drainage
 - Biological hazardous waste, liquid or dry, produced as a result of morgue operations, will be disposed of according to local/state requirements
- H. Special Equipment Needs
 - Local authority should provide a forklift capable of lifting eight thousand pounds, with six-foot forks, or fork extensions to safely off-load pallets
 - A smaller forklift, of minimal lifting capacity, is needed to move heavy equipment, caskets, etc., within the morgue during set-up
- I. Miscellaneous Requirements
 - Consider the placement of refrigerated trailers for easy access
 - The number of decedents dictates the number of refrigerated trailers
 - Separate processed remains from unprocessed remains in different trailers
 - Obtain a yard tractor to move trailers around morgue

3.2 Establishing the Incident Morgue

Principle:

Exact placement of the morgue within the facility is determined by electrical source location, water source location, morgue accessibility by personnel, placement of refrigerated trailers, the morgue flow plan, and security concerns. The Morgue Branch Director along with the Ops Chief and Logistics Chief will determine morgue placement within the facility after consultation with the Medical Examiner.

The morgue flow plan and any specific needs of the Medical Examiner will determine the basic floor plan of the morgue. Morgue sections, or workstations, may include:

Triage	Pathology	Anthropology	Dental
Admitting	Fingerprints	DNA	Embalming
Personal Effects	Radiology	Casketing	Storage and Release
Photography	PPE donning and doffing station		

Proximity to electrical and water sources reduces the hose and power cord size. Flexibility allows for variably sized work stations/areas. The morgue floor plan can be modified to support the specific needs of the workstation.

Morgue floor space can be added or deleted, as the needs of the mission change, or the specific needs or requirements of the Medical Examiner.

Consideration must be given to the additional floor space required for the radiology (x-ray) section, and either the utilization of an existing space or office that is light proof, or the construction of a dark room for radiology film development if digital processing is not used.

Procedure:

The set up procedure will normally be under the guidance and management of the Morgue Branch Director.

Floor Preparation

The floor of the morgue should be covered with 6 mil plastic sheathing (20' X 100') in sufficient quantity to initially protect all flooring that the morgue will encompass. A basic floor plan will consist of two rolls of 6 ml plastic secured to each other side by side with duct tape. Care must be taken to minimize the overlap of the two pieces to eliminate plastic on plastic "slippage". All leading edges of the plastic will also be taped to prevent tripping and to maintain the integrity of the floor. This provides an approximate 40' X 100' footprint (4,000 square feet). Additional floor coverage may extend beyond this basic floor plan to accommodate radiology.

Basic Layout

By this point, a morgue flow plan should have been established and specific needs and morgue requirements have been decided upon by the incident command. Once the floor is covered and secured, the basic lay out of the morgue commences. Assisting members will break out and assemble partitions (suggest PVC poles in bases and blue tarps).

If PVC poles with attached threaded tailpieces are used for the morgue walls, then all PVC poles should be of the same size and length to facilitate the layout. Once the bases and poles are placed appropriately creating the basic layout, the horizontal top rail is assembled utilizing PVC poles and appropriate connector pieces (90 degree elbows, tee's, straight connectors, etc.), and attached to the upright poles and bases. This will create the sectioning of the individual workstations, and the basic structure to which the partitioning drop curtains will be attached. Drop curtains **are not** attached at this time in order to facilitate the movement of equipment into the individual workstations.

Electrical and Water Distribution Systems

After electrical and water sources have been determined, appropriate water hose and power cords are laid out in accordance with the morgue layout. The water distribution system should include sinks & hot water heaters. The electrical distribution system must be of sufficient quantity to supply each workstation and should be assembled by qualified electricians. It is preferred to have all water hose and power cords to run on the outside perimeter of the morgue. If crossing the morgue floor with water hose and/or power cords is necessary, cable protectors will be used. Tripping hazards must be kept at a minimum as these will endanger the morgue workers, and also interfere with the free movement of morgue tables.

Drainage and Liquid Waste Disposal

Prior to the commencement of morgue operations, a disposal procedure for liquid waste generated by the morgue needs to be determined in accordance with local and/or state laws. Some local regulations allow direct disposal into existing sewer systems. If this practice is not permitted, arrangements need to be made with Logistics to have bulk disposal tanks delivered to the incident morgue site facility and properly disposed of by a bio-hazard removal contractor.

Equipment Dispersal

Simultaneously with the set up of the electrical and water distributions systems, equipment can also be placed into the respective morgue workstations. Each station should be labeled to identify the appropriate forensic principle it is assigned. (PAT/pathology; ANT/anthropology; DEN/dental; ADM/admitting; FPT/fingerprinting; XR/x-ray; EMB/embalming; etc). The individual workstations are identified with placards attached to the horizontal top rail to facilitate identification of the workstation to which equipment can be placed.

X-Ray Film Processing Darkroom

If an existing room is not available in the facility that can be utilized as, or converted to, a dark room for film processing, then by using available PVC poles, bases, and black 6 mil plastic sheeting, one can be constructed. Typically a 12-foot by 12 foot (approximate) dark room is sufficient to house two film processors, all associated chemical tanks and a designated water source. As in the case of generated liquid waste from the morgue, disposal of used chemicals must be done in accordance with local and/or state laws. Safe lighting and ventilation systems for the darkroom must also be installed.

Work Station Set-Up

Once equipment is placed into a workstation, and prior to morgue operations commencing, each section leader will have the opportunity to arrange their assigned workstation for their specific needs and liking. It is also at this time that the drop curtains are attached to the PVC poles/top rail to further define individual workstations. Any additional equipment needs not already provided can be requested through the Morgue Branch Director by the Group Supervisor.

Safety Briefing

Prior to the commencement of morgue operations, the Morgue Branch Director (AKA Morgue Manager) or designee, along with the Safety Officer (Command Staff) or designee will identify a Morgue Safety Officer and conduct a safety and operational briefing. The safety briefing will consist of instruction in the use of fire extinguishers and the eyewash station. The operational briefing will include the information that the Morgue Branch Director considers essential and consistent with the mission.

Morgue Supply

Upon completion of the morgue set up, the area adjacent to the morgue containing the staged supplies will be off limits to morgue workers. Only Logistics or Supply Personnel will be allowed into the supply area. This will ensure safety of the team members, and will allow an accurate re-supply inventory that will be on going through out the mission by the Logistics personnel.

Inventory and Re-Supply

At the end of the first day of morgue operations, inventory and re-supply issues must be addressed to ensure an adequate supply of any one item is available for the next operational period. Inventory lists will be supplied to each Station Leader and it becomes their responsibility to continuously track that particular station's inventory, anticipate future requirements, and to ensure a timely re-supply. Re-supply requests will go directly to the Logistics Section. Any request for procurement of a non-standard item must be approved by the Morgue Manager, and be accompanied with a justification for the request. Upon conclusion of morgue operations at the end of the mission, a complete inventory of supplies used by the Morgue will be prepared and forwarded to the Logistics Chief for appropriate review and action.

3.3 Morgue Security

Principle:

Any morgue site established by the Medical Examiner will be considered under State control for the duration of morgue operations. For liability, safety, and security concerns, access to the morgue is closely controlled. The

Medical Examiner will work with state and local authorities to ensure only authorized personnel can access the morgue.

Procedure:

A list of personnel authorized to access the morgue will be provided to the Security Branch. The Security Branch will arrange with local, state, and federal law enforcement agencies to provide 24-hour security in and around the facility. Law enforcement personnel will check the credentials to ensure that authorized personnel only are allowed access in or around the incident morgue. Unique identification badges may be issued to ensure that access is restricted to authorized personnel. Each person entering the area of the morgue will sign in and will sign out upon departure.

3.4 Personal Protective Equipment (PPE)

Principle:

All individuals directly involved with human remains and biological hazards need protection from blood-borne and aerosol-transmissible pathogens.

Procedure:

To protect the eyes, skin, and mucous membranes, all individuals present during the handling and examination of remains should wear the appropriate protective equipment.

Minimum protection includes:

- Impervious gown or long-sleeved Tyvek suit with impervious apron
- Disposable surgical cap
- Disposable surgical mask
- Eye protection (goggles or face shield)
- Disposable shoe covers
- Disposable surgical gloves (double gloves)

The complete set of PPE must be worn at all times while examining remains. NO food, drink or chewing gum is allowed in the morgue at any time. Eye wash stations will be readily accessible in the morgue. A donning and doffing station with supplies will be provided.

Reference: Nolte, Taylor, and Richmond. Biosafety Considerations for Autopsy. *American Journal of Forensic Medicine and Pathology* 23(2):107-122, 2002.

3.5 Photography Policy

Principle:

For the purpose of security and privacy, taking photographs within the morgue is restricted. For historical and training purposes, certain candid photographs will be allowed. A candid photograph is any photograph taken within the secured morgue/storage area for any purpose other than being a part of the identification process and filed in a folder with an associated Morgue Reference Number (MRN).

Procedure:

No candid photographs may be taken in the morgue between the time that the first remains enter and the last remains exit. The single exception is a designated photographer(s) approved by the Medical Examiner who will take photographs for historical documentation. These photographer(s) will wear a distinctive and conspicuous

means of identification and will be named by the Morgue Manager with the consent of any other agencies involved with the response (ie NTSB.)

Photographs will remain in the custody of the photographer. The Medical Examiner following a review, will coordinate distribution. This distribution may be restricted to certain individuals/organizations including assisting teams. The Medical Examiner will decide on the disposition of any photographs that are not authorized for distribution.

Individuals assigned as photographers within the morgue stations (i.e., taking photographs of remains) are prohibited from taking candid photographs.

With the advent of cellular phone/camera technology, cellular phone use in the morgue is prohibited. No cell phone may be removed from its holder while in the morgue. The only exception is the use of cellular telephones which do not contain cameras.

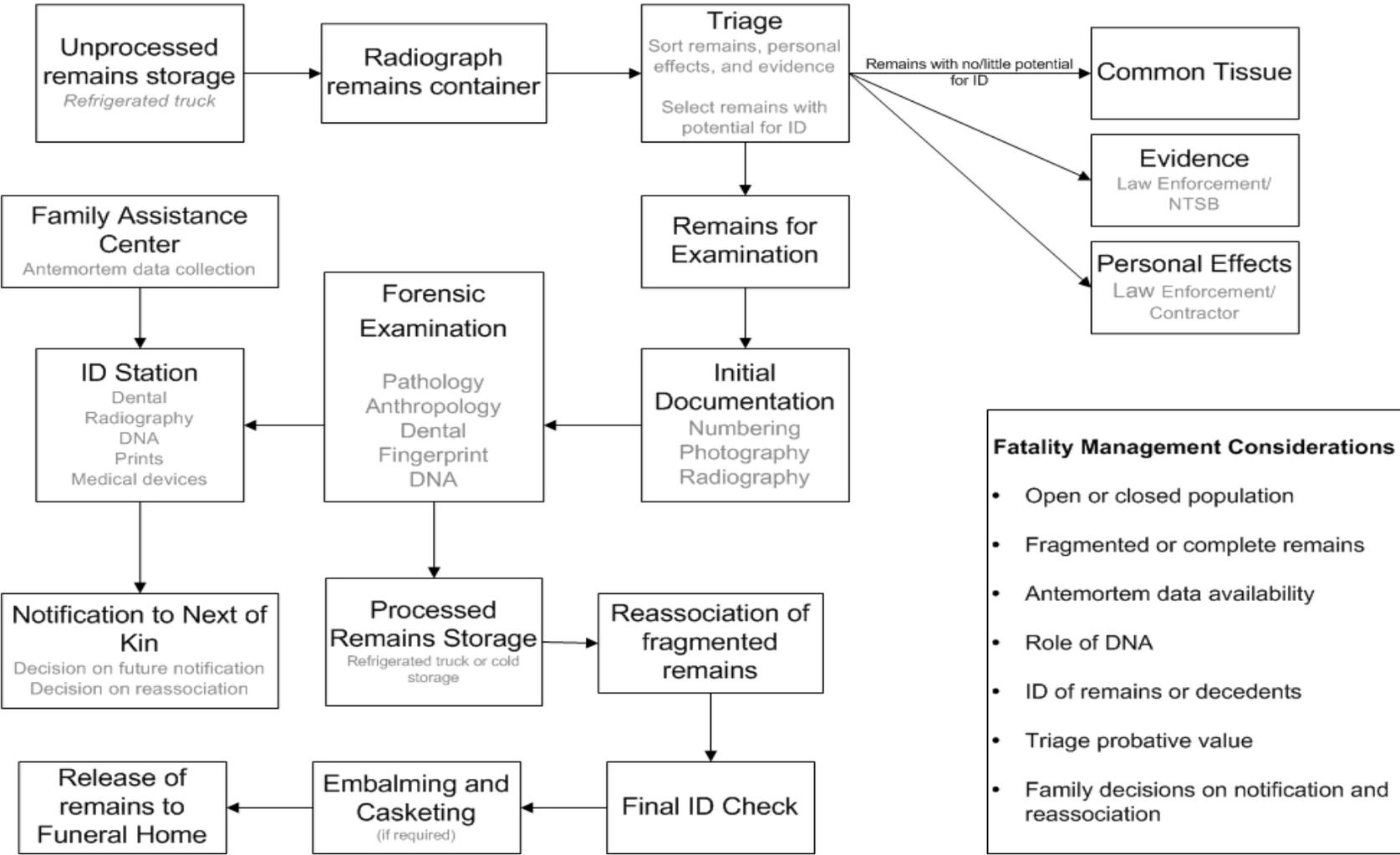
4.0 Documentation and Analysis of Remains

4.1 Morgue Flow Chart

The flow of remains and personnel through the incident morgue is dictated by the physical structure of the facility, the number of morgue personnel, the condition of the remains, and the concerns of the medicolegal process for the event. In general, however, the flow of remains through the morgue is done according to the following diagram. Typical incident morgue operational periods are 12 hours per day. The number of remains will dictate whether a second shift is warranted.

The chart indicates a typical approach to the flow of remains and information through the incident morgue. The nature of the event may result in modifications to the flow, and such changes should be documented in the morgue protocol for the specific event and in the after action report.

Mass Fatality Morgue Operational Plan



4.2 Radiography of Remains Container

Principle:

In certain situations, particularly those involving fragmentary remains, it may be necessary to radiograph the bag or container holding the remains before the triage process. The resulting radiographs are used to assess the contents of the bag so that more effective sorting can be completed at triage and any associated hazardous materials (knives, guns, bomb parts, etc.) collected with the remains can be safely managed.

Procedure:

The entire, unopened container will be radiographed and the film read by a pathologist or anthropologist with augmentation from other appropriate staff such as bomb team members, etc., prior to proceeding to the triage. The digital radiograph should be labeled with the field number that has been assigned by the search and recovery team. Care should be taken to make certain that the container is not opened at this point as morgue numbers have not yet been assigned. These radiographs will be stored electronically on storage devices (computers). All electronic storage devices will be kept secure.

4.3 Triage of Remains and Evidence

Principle:

Triage is an interdisciplinary section consisting of a pathologist, anthropologist, and odontologist. The role of triage is to sort materials brought from the site in order to:

1. Separate human tissues from other material evidence.
2. Identify associated remains from non-associated remains.
3. Assign probative value to fragmented remains in order to first process those remains most likely to yield evidence of personal identity. Triage will initially separate out tissues that are less likely to yield evidence of personal identity and place those remains in a common tissue container for later analysis or disposition.
4. Enter remains into admitting for assignment of a morgue number.

Procedure:

The triage team members are expected to:

1. Open bags delivered from scene.
2. Utilizing radiographs of bags taken prior to triage, sort through bags to separate diagnostic human tissue from material evidence and debris.
3. If deemed necessary, the triage section may apply appropriate protection to oral, facial, skeletal or other structures to insure integrity of those structures.
4. Route material evidence to the appropriate law enforcement agency if warranted.
5. Isolated personal effects are routed to the local jurisdiction
6. Log bag number and other information into triage log sheet.
7. Bag remains with a high probative index (i.e. those remains with the highest likelihood for identification) and attach a Victim Processing Record (VPR).
8. Identify the stations where the specimen should be routed and make that notation on the VPR (all specimens go to photography, radiography and DNA).

The triage scribe signs and dates the Victim Processing Record, and then the specimen is routed on through the Admitting Group.

In the pathology section, when human remains are associated with personal effects, the personal effect is removed from the human remains as long as removal will not damage or compromise the remains. Notation about the clothing is entered into the comments section of the Victim Processing Record and the clothing is turned over to an organization with experience in dealing with personal effects, such as a personal effects contracting company. If the human remains are suitable for further analysis, they are processed through these stations.

For remains in which the personal effect cannot be removed without possible damage, notify the Medical Examiner or his designee, and leave effects associated with tissue. Mark ME in red marker on the Victim Processing Record, and send specimen through procedures described above. The Medical Examiner will receive the specimen after all other relevant stations have signed off and then coordinate removal of the personal effect. These specimens may also be expedited through the system at the request of the Medical Examiner and/or the protocol may allow for immediate removal upon approval of the Medical Examiner.

4.3.1 Chain-of-Custody

Principle:

Establishing and maintaining a chain-of-custody for remains, personal effects and other pertinent materials verifies the integrity of the evidence. Remains/evidence processing teams should maintain the chain-of-custody throughout the recovery and morgue processes.

Procedure:

Throughout the processing of human remains, those responsible for preserving the chain-of-custody should:

During the removal of personal effects care should be given to fully documenting and describing those removed personal effects. Once removed there should be full documentation showing the morgue reference number referring to the case. Descriptions should be made in generic terms such as yellow metal, clear stones, etc.

Fully document, photograph, and turn over to the appropriate law enforcement agency, anything suspected of having evidentiary nature, using the chain of custody forms. Documentation must include the date, time of location, and the name of the person making the discovery.

Sign chain of custody forms whenever “evidence” or personal effects are released from one individual or section. This form should include the signature of the person relinquishing control as well as the signature of the person receiving control. The form should also document the date and time that the transfer of custody was made.

4.3.2 Personal Effects

Principle:

As with human remains, personal effects must be handled with the same care and consideration.

Typically, personal effects removed from remains will be managed by the local jurisdiction under their procedures.

Procedure:

The Unit Leader (Personal Effects) shall assure that a standard personal effects process is adhered to and personal effects are tagged and a log maintained

The Unit Leader shall be responsible for the custody and security of all items and for obtaining signatures on the proper release or chain of custody forms when transferring personal effects within the morgue sections. Under certain conditions, this Unit will be responsible for cleaning and sanitizing the personal effects before release

Clothing or jewelry found on a victim will be photographed and documented. Designated personnel in the morgue will handle removal of these personal effects.

Removed items will be given to the Personal Effects Unit (may be a contractor) for processing. No attempt will be made to repair any associated or unassociated jewelry that is found damaged.

If personal effects are found on a victim after being processed, the items will be returned to the admitting station, logged in, and released to the Personal Effects Unit.

4.4 Admitting and Numbering of Remains

Principle:

The system used to number remains entering the morgue process should be simple and use whole numbers. Complex numbering systems lead to confusion and errors. Following identification, the Medical Examiner will be able to use their office case number to account for decedent remains.

Procedure:

After triage, the individual remains or fragments shall proceed to admission where they will be assigned a Morgue Reference Number (MRN) and Escort (or tracker). Every body or fragment thereof will be assigned a simple, ascending number. The first body or fragment thereof will be assigned "1", and the numbers will ascend accordingly until the last set of remains is processed. As individual bodies are identified the Medical Examiner can now re-incorporate his/her internal tracking number and the release can be made using this number. Disaster Victim Packets (DVP) are assigned at this time.

Ideally a bar code system that will allow for the tracking of bodies or fragments through the morgue stations could be utilized. When instituted, this system will allow for numbering of bodies, as detailed above. At the admitting station the body will be assigned a number and given a bar code with a corresponding number. The admitting station will print corresponding sheets of bar code stickers to be included in the DVP. As the body proceeds through the stations the Escort will be responsible for attaching a unique bar code to that body and to all x-rays and papers generated through the process.

4.5 Escorts

Principle:

Escorts accompany human remains through the mortuary process and ensure proper documentation is complete and attached at each morgue station. Escorts are responsible for the collection and safe keeping of all papers and examination records kept in the DVP. (Note:

Staffing for escorts may vary according to the particular disaster. It is strongly suggested that persons who do not have morgue experience should not be used.)

Procedure:

The Escort Unit Leader assures that each Escort is briefed concerning their duties and maintains a log of the Escort names, date and time of duty.

If personnel are not available to serve as Escorts, volunteers from a state funeral director disaster team or local or state law enforcement can be used. Be sure to be attentive to the psychological and physical responses of inexperienced support personnel from local teams.

The Escort Unit Leader shall assign at least one Escort to each container, pouch or evidence bag containing human remains before it begins processing through the morgue system. When the human remains have been processed through all appropriate morgue sections, the Escort shall return the DVP to the Unit Leader.

The Escort Unit Leader shall assure that all forms in the DVP have been accurately completed before releasing or reassigning the Escort.

The escort transports the remains through the various morgue sections and stays with the body until all processing aspects are completed.

Escorts will ensure station personnel complete, sign, and insert completed forms in the DVP. The Escort Unit Leader is responsible for returning the DVP to the Admitting/Processing Group Supervisor.

Escorts must stay with assigned remains at all times and will not wander through the morgue.

Religious customs concerning the handling of remains will be considered and every reasonable effort will be made to comply with these customs. The Medical Examiner will make the final determination on how religious and cultural issues are addressed.

4.6 Photography of Remains

Principle:

Photography of remains is an essential and standard process for forensic examination. Each body or numbered fragment will be photographed. Local jurisdiction medicolegal or law enforcement personnel including crime-scene technicians are good candidates to take photographs. Volunteer professional photographers with no death or crime scene experience should not be considered.

Procedure

1. For complete bodies, standard autopsy-type photographs will be taken (anatomical position)
2. Where possible, full-face identification photographs will be taken.
3. All photographs will contain the morgue reference number as well as a reference scale where applicable.
4. Photography station personnel will maintain a photo log.
5. Photographs of all personal effects will be taken prior to removal.

6. Digital cameras are part of the standard process.
7. Digital image files will be provided to the IR section for inclusion into VIP.
8. Hard copies of digital photographs will be placed in the DVP when available if desired by the Medical Examiner.

4.7 Radiology

Principle:

The Radiologist/X-ray technologist conducts radiographic examinations to detect evidence; provides postmortem radiographs for comparison with ante mortem clinical radiographs; and assists pathologists, anthropologists, and odontologists in the interpretation of radiographs. It is recommended that ALL remains have radiographs completed to ensure physical items (personal effects, evidence, etc.) are not missed in the processing of remains.

Procedure:

The radiology section shall be established in an area of the morgue that is secluded from the other processing sections. The section shall contain a portable x-ray unit and appropriate protective equipment. Digital radiography equipment is strongly suggested.

The Radiology Team Leader will:

1. Address radiation safety issues such as shielding.
2. Monitor radiation dosage of team members via dosimeters and assign dosimeters to other morgue personnel as appropriate considering location and shielding of the x-ray unit.
3. Identify sources of equipment or additional facilities as needed.
4. Maintain control and accountability of all individual radiograph jackets.

The Radiology Team will:

1. Radiograph all remains entering the morgue unit.
2. Keep a log of all radiographs taken, including:
 3. Morgue reference number.
 4. Date/time remain received.
 5. Radiograph number.
 6. Number of radiographs taken.
 7. Initials of X-ray technician.
8. Mark each radiograph with the corresponding morgue reference number.
9. Insert x-rays into file jackets and file numerically.
10. Conduct additional radiographs as requested by forensic specialists.
11. Evaluate circumstances in which additional images may be required (e.g. making radiographs of the hands and feet of flight crew) as they relate to the incident.
12. Assist other forensic specialists with the comparison of ante mortem and postmortem radiographs.
13. Ensure and document that a qualified forensic specialist has read each radiograph. A description of the findings will be recorded in VIP

Radiographs will become the property of the Medical Examiner and will be a permanent record of the decedent. No radiographs will be removed from the morgue without the written permission of the Medical Examiner.

Additional Procedures for Radiology

To examine a radiograph away from the radiology section, using conventional means, the requesting section must sign for the release of the radiograph. When the radiograph is returned, the radiology section will annotate in their records the date the radiograph was returned and by whom.

Whenever possible the remains should be positioned so that standard and conventional views are obtained for ease of comparison with ante-mortem films. When dealing with fragmented remains, this may require the assistance of an anthropologist or pathologist.

Complete radiographs of the abdomen and chest region will be taken.

Anterior Position (AP) and lateral radiographs of the skull must include a clear view of the sinuses.

Radiographs of the extremities will be taken as needed.

After the radiograph is developed, it will be placed in a radiograph file jacket. The jacket will be annotated with the MRN, radiograph number, and number of radiographs.

If digital radiographs are being taken, the image files will be provided to the IR section for inclusion into VIP.

Radiograph file jackets shall be arranged in sequence according to radiograph reference number.

4.7.2 Radiographic Identification

Radiographs should be examined for pathological and medical conditions by a radiologist (if available locally). If a radiologist is unavailable, an anthropologist or pathologist experienced in radiographic interpretations for identification purposes will review radiographs.

A written description of the points of similarity leading to the identification will be provided to the identification section for review. The identification section may review the radiographs to assist in understanding the identification. The Medical Examiner should review the documentation and radiographs leading to the identification.

4.8 Odontology

Principle:

The Dental Team Leader is responsible for the dental team. The team leader or other team members may provide support to other agencies (e.g., NTSB, FBI) and other forensic identification disciplines (e.g., forensic anthropology, fingerprints, radiology). The Odontology Station (AKA Dental Station) is comprised of the ante-mortem section, the postmortem section, and the dental comparison section. Dental personnel may also be asked to support search and recovery of dental evidence at the incident scene.

4.8.1 Scene Dental Evidence Collection

Principle:

The Dental Team may provide remains recovery assistance to the search and recovery teams. At the scene, the dental team can recognize craniofacial structures and dental prosthetic devices, and

may recommend procedures for the protection and preservation of dental evidence prior to transporting decedents to the temporary morgue from the disaster site.

Procedure:

1. Identify, collect, and preserve dental evidence.
2. Protect craniofacial remains by wrapping.
3. Assist with site searching for dental remains.

4.8.2 Dental Ante-mortem Section

Principle:

The Dental Ante-mortem Section procures, analyzes, and consolidates dental information into a single, standardized, comprehensive ante-mortem dental record. A team of no fewer than two trained and qualified individuals will perform all recording and transcription of information.

Procedure:

1. Assist in procurement of dental records at the FAC, via telephone, or visits to dental offices.
2. Transcribe dental information from dental records into standard format using WinID nomenclature.
3. Record ante mortem dental information into WinID.
4. Scan non-digital image information (radiographs and photographs) and enter into WinID graphics file.
5. Enter digital image information into WinID graphics file.

4.8.3 Dental Postmortem Section

Principle:

The Dental Postmortem Section performs the postmortem dental exam including postmortem dental radiography and photography, and records the results in WinID or in a standardized format compatible with WinID. The postmortem section examinations and data entry will be performed by teams of no fewer than two trained and qualified individuals.

Procedure:

Dental Autopsy

Craniofacial Dissection: Any facial or dental dissection required for a complete and accurate dental examination must be approved in advance by the Medical Examiner or his designee. No craniofacial dissection will be performed if adequate information can be obtained without dissection.

Visual Examination and Charting: When practical, all dental autopsy information will be recorded directly into WinID. If computer use in the autopsy area is not practical, information will be recorded onto standard forms and transferred to the appropriate area for data entry.

Radiographic Examination: A complete radiographic survey of the available craniofacial remains should be recorded using digital intraoral sensors. Extraoral radiography may be employed when available and practical if it assists identification.

Dental Models: Impressions for dental models may be made if they will assist in identification of a decedent. Standard dental impression materials should be used following manufacturer instructions.

4.8.4 Dental Comparison Section

Principle:

The Dental Comparison Section compares ante-mortem and postmortem dental information. Comparisons resulting in positive identifications are reported to the Identification Documentation Team and then to the Medical Examiner via the means established for the event.

Procedure:

Dental Comparison team members must be familiar with WinID including advanced search and comparison functions.

Teams will work in pairs, when possible, to facilitate the comparison process and minimize errors.

Positive dental identification recommendations are agreed upon by two qualified individuals and confirmed by the Dental Team Leader before submission to the Identification Committee.

4.9 Pathology

Principle:

The examination and documentation of remains in the Pathology Station can provide detailed information assisting in identification, defining injury patterns and determining cause and possibly manner of death. Forensic Pathologists can and should be called in to assist the local medicolegal authority as needed.

Procedure:

Whenever possible, an autopsy assistant should support each forensic pathologist. A forensic photographer should be available when needed.

At the triage station, the pathologist should:

1. Assess the remains using an event-specific probative index to identify remains (such as dental fragments or orthopedic appliances) that will lead to identification.
2. Document, remove and save non-human and/or non-biological materials for proper disposal.

The forensic pathologist should, for each decedent:

1. Review radiographs.
2. Document general physical characteristics.
3. Document specific scars, tattoos, and other unique identifying features.
4. Document injuries and trauma with special attention to direction given by the Medical Examiner.
5. Document and recover, when appropriate, internally implanted medical devices for identification.
6. Recover evidence as indicated or requested.
7. Take DNA tissue samples as directed by the AFDIL or other accepted standard.
8. Collect appropriate toxicology samples if warranted.

9. Conduct a complete autopsy, if indicated.

The autopsy can be performed by either the Virchow or Rokitanski method, whichever is preferred by the forensic pathologist performing it. Additionally:

1. Representative samples of all organs will be retained in formalin.
2. All tissues and organs will be returned to the body
3. The autopsy report is to be dictated at the end of the autopsy (preferred) but no later than the end of the shift.
4. Document all findings completely in VIP format and on body diagrams.
5. Document salient findings by photography.

4.10 Anthropology

Principle:

The anthropology section should consist of at least two forensic anthropologists (one of whom is designated as team leader) and one assistant to serve as scribe. Staffing and equipment needs may vary according to disaster-specific needs and the functional assignment of the section.

Procedure:

In a mass disaster, the anthropology section assists in two functional areas of the operation: (1) assisting with the initial evaluation, documentation and sorting of human remains in the morgue triage, and (2) providing comprehensive forensic anthropological documentation of human remains in the morgue. The anthropologist may also be asked to provide additional types of analyses and support within the morgue.

In the triage area, the anthropologist will:

- Assess the remains using an event-specific probative index to identify remains such as dental fragments or orthopedic appliances that are more likely to lead to identification.

In the anthropology station, the anthropologist will:

1. Log in and document remains as they are processed at the anthropology station.
2. Complete a standardized VIP forensic anthropology report form.
3. Compile a logbook to document the specimens examined at the station.
4. Evaluate and document the condition of the remains.
5. Separate obviously commingled remains and return the remains to the admitting section for subsequent processing in the morgue.
6. If the remains are fragmented, describe the anatomical structure(s) present.
7. Provide a biological profile of the decedent or remains, including: Sex and Age at death.
8. Ancestry.
9. Forensic stature.
10. Ante-mortem trauma or pathology.
11. Anomalies and idiosyncratic variation including surgical hardware and prosthetic devices.
12. Perimortem trauma.
13. Document, remove and save non-human and/or non-biological materials for proper disposal.

The forensic anthropologist can also be expected to:

1. Obtain DNA samples from bone.
2. Assist in taking radiographs (to ensure proper alignment of the specimen).
3. Interpret trauma in consultation with the pathologist.
4. Obtain and isolate dental evidence in consultation with the odontologists.
5. Interpret and compare ante-mortem and postmortem records and radiographs.
6. Assist the pathologists and odontologists in establishing identity via ante-mortem-postmortem radiographic comparison.
7. Examine identified remains prior to release to confirm that the biological evidence used for identification matches the biological parameters of the remains.

4.11 DNA Specimen Collection

In most mass fatality responses, the Department of Defense DNA Registry (referred to in this document as the Armed Forces DNA Identification Laboratory or AFDIL) will conduct DNA identification efforts. The procedures below are specific to AFDIL.

Principle:

These guidelines provide uniformity for Department of Defense DNA Registry/AFDIL personnel to conduct operations in field environments, sample human remains for specimens, and submit samples to the Armed Forces DNA Identification Laboratory for analysis.

Procedure:

If asked by the Medical Examiner, AFDIL representatives deployed to field sites have responsibility for DNA specimen collection criteria and selection, collection processes, establishing and maintaining the evidence chain of custody, and submission of DNA evidence to the laboratory.

Interagency Coordination:

The deployed AFDIL representative reports to the Armed Forces Medical Examiner and the Medical Examiner.

The AFDIL representative coordinates and controls the DNA specimen collection process. The lead agency or official with authority for the investigation (typically the medical examiner/coroner) maintains control of remains recovery and processing.

The AFDIL representative coordinates pertinent aspects of remains recovery, storage, and processing with the designated authority. In addition, the AFDIL representative informs and educates this authority on DNA identification technology including the capabilities of DNA identification and re-association, the limitations of DNA identification, and to convey the needs of the DNA laboratory to achieve successful results.

The authority and the AFDIL representative must agree to the DNA specimen collection process. Discord in this arrangement must be coordinated through the Director, DoD DNA Registry or his appointed representative.

DNA Specimen Collection Equipment

The deploying AFDIL member(s) hand-carry enough DNA specimen collection supplies and personal protection equipment to sustain a three-person team for four days. Additional supplies are coordinated through and shipped from AFDIL or the appropriate vendor.

The AFDIL representative transports the Laboratory Information Systems Application (LISA) Mobile computer hardware to record evidence, produce printed evidence labels, and the evidence chain of custody documents. Digital photography is used to document the DNA specimen collection effort.

DNA Specimen Selection Criteria

Selection criteria are dictated by completeness and condition of the remains. Biological material sampled for DNA will be photographed prior to sampling. Since DNA sampling of human remains is a destructive process, the AFDIL member insures the sample being collected does not destroy or alter the characteristics of the evidence critical for identification by another scientific means such as dental or fingerprint identification. DNA specimen collection is typically the last step in the identification examination sequence.

DNA Specimen Collection

Collecting DNA samples is the responsibility of the AFDIL member. The sample selection is based upon obtaining the best biological specimen presenting the highest degree of potential success for the laboratory with the least amount of challenge for DNA extraction. In order of general preference sample selection choices are:

- 1st - Whole blood
- 2nd - Tissue
- 3rd - Bone
- 4th - Teeth
- 5th - Hair

Other specimen collection guidelines:

- ❖ Less preferable samples may be selected when the sample is more likely to produce successful laboratory results. For example, bone may be selected over tissue if the tissue exhibits signs of advanced stages of decomposition or contamination.
- ❖ Remains identified by other conventional means of identification should be sampled for DNA identification.
- ❖ DNA samples obtained from intact remains during autopsy are collected by the pathologist performing the autopsy. The pathologist should be encouraged to consult the AFDIL representative to identify the most appropriate material for DNA sampling. The pathologist may assign responsibility for sampling the remains to the AFDIL representative and oversee the process.
- ❖ DNA samples obtained from fragmented and disassociated remains may be collected by AFDIL and other properly trained personnel.
- ❖ Whole blood should be collected in a purple top tube and refrigerated. When possible, the blood should be spotted onto a DNA specimen collection card (preferably untreated filter paper), air-dried, and individually packaged for shipment. The remaining blood from the purple top tube should be left in the custody of the Medical Examiner or discarded.

- ❖ Tissue, bone, teeth, and hair should be collected in a 50ml conical tube. Each item collected must be placed in a separate container and each container must be marked with an evidence label.
- ❖ The DNA sample should not normally be obtained from human remains fragments if the sample will consume the entire remains. Further, an item too small to sample safely should not be sampled for DNA analysis. In circumstances where it is deemed necessary and appropriate to collect the entire sample for DNA analysis, the Medical Examiner must be informed that the entire remains was collected for DNA analysis and the contents will be consumed in analysis. This circumstance may lead to a positive DNA identification with no remains available for return to surviving family members.

When entire fragmented remains are collected for a DNA sample the tracking record for recovered remains must be annotated to reflect the entire sample was collected for DNA analysis.

Family Reference Specimens

Family reference specimen collection is not the responsibility of the responding AFDIL members. The Medical Examiner is responsible to coordinate this effort and may work with local law enforcement or other responder's groups to collect reference samples. The Family Assistance Center may become the focus for sample collection.

The AFDIL representative can inform local authorities about appropriate family references and proper sample collection. The AFDIL representative can make family reference collection kits or DNA bloodstain cards available to the responsible authorities. Family reference specimen collection equipment includes donor consent forms for use by medical authorities for execution by the appropriate family member authorizing AFDIL to perform DNA analysis of the donor samples. Family reference specimens collected by appropriate medical authorities should be released to the on-site AFDIL representative for submission to the laboratory. The donor consent forms should accompany the associated family reference.

Direct Reference Specimens

Typically, during a mass fatality response, family reference samples will be the primary source of DNA for victim identification. If required, direct reference samples (samples containing the DNA of the victim) will be used. Examples of direct reference samples include but are not limited to clothing; toothbrushes; used razors; combs; cigarette butts; biopsy slides; Pap smears; extracted teeth; and hair.

Obtaining these materials normally requires interaction with surviving family members. When provided by surviving family members, the Medical Examiner or the assigned agency should account for the samples. Samples should then be submitted directly to AFDIL or released to AFDIL representatives on site.

Custody of Evidence

As the samples are collected, evidence custody of DNA specimens is established using the LISA Mobile program. Each item of evidence sampled for DNA is entered separately onto the chain of custody. The description of the item should include:

1. Morgue reference number (or similar unique specimen identifier).
2. Other available agency identifying number.

3. Specimen type (i.e. bone, soft tissue, tooth, etc).
4. Specific body part if identifiable (e.g. left femur, psoas muscle, tooth #15).
5. Name or initials of the person collecting the sample.

If more than one sample is collected from the same set of remains (i.e. bone and soft tissue from different locations) the samples should be assigned the same evidence number with alphabetic identifiers A and B rather than distinct and separate evidence numbers.

Each DNA sample collected should be segregated into a separate evidence container, labeled with an evidence label generated from the LISA Mobile program, placed in a clear plastic bag, sealed, and labeled with an evidence label identical to the label on the evidence container. Evidence items should be grouped into large self-sealing bags, sealed, and protected with evidence tape.

Temporary Storage and Transfer of DNA Evidence to AFDIL

A single chain of custody document is usually prepared for each day of specimen collection. The duration of the document may be continued for consecutive days to group samples for submission to the laboratory. The AFDIL member safeguards the collected samples on site until they are released for submission to the laboratory. Temporary, lockable storage containers or facilities may be required.

The evidence chain should begin with the medical authority responsible for identification releasing the DNA samples to the AFDIL representative on site. The AFDIL representative subsequently releases the DNA samples to the person hand-carrying the items to AFDIL or releases the samples to the mail service being used to ship specimens.

Each time an evidence shipment departs the collection site the AFDIL member on site should fax a copy of the completed evidence voucher to the laboratory evidence custodian or other designated point of contact. Details of the method of transport and estimated arrival date and time should be reported.

4.12 VIP/Data Management

Principle:

A central repository, known as the Information Resource Center (IRC), will be created for the collection, recording, and storage of ante-mortem and postmortem information. The Victim Identification Program (VIP) computer system manages this information. The IRC procedures include a record library, ante-mortem records tracking procedures, database management system, and management of mission records.

All records and data are kept secure and confidential. Only authorized personnel are permitted inside the IRC area. At the conclusion of the mission, all records and data collected become the property of the Medical Examiner. No information will be released to any person(s) without proper authorization. If a transportation carrier is involved in the incident, then those representatives are not permitted in this area.

Personnel trained in VIP, WinID3 and Office Suite handle data management. Network support and troubleshooting is the responsibility of the Logistics Section.

Procedure:

Information Resource Center (IRC)

Information Security

- All information received in the IRC is confidential.
- Access will be limited to authorized personnel.
- Authorization from the IRC supervisor is required for information to leave the IRC.
- No information is to be released by telephone.
- No information should be transmitted via e-mail without prior authorization from the IRC Group Supervisor.
- Information is only to be faxed to approved fax numbers.
- Ante-mortem information for each decedent is entered into that decedent's unique VIP record. Individual computer records are required even if multiple members of the same family are decedents.
- No ante-mortem or postmortem computer record may be deleted. If an ante-mortem record needs to be removed from the active system, consult with the IRC Group Supervisor for assistance in exporting records to a backup file.
- All ante-mortem records (X-rays, photographs, etc.) must be labeled with the decedent's name. Do NOT place a permanent label directly on them. Place the records into separate envelopes that are labeled with the decedent's name and place them in the designated file folder.
- Prior to any computer entry, the database is queried by name and/or unique number to prevent creating duplicate records. This procedure should be done regardless of whether a completely new entry is being made or whether additional information is being added to a current record.
- Backups are performed at least twice a day using a basic file copy command. Both ante-mortem and postmortem files are copied on CD or other removable media and stored away from the server.
- Certain ante-mortem records may be scanned for the VIP database. These include dental and medical X-rays, dental charts, photographs, fingerprints, footprints, and palm prints.
- Disaster-specific forms will be created by the IRC Group Supervisor (or his or her designee) in the database as directed.
- After initial data entry, records will be printed and edited for accuracy. When completed, the date and the editing person's initials should be noted.

The IRC Group Supervisor or their designee will initiate the preliminary ante-mortem/post-mortem record comparisons based on a variety of possible match points (e.g., scars, tattoos, surgical procedures, unique clothing or other unique personal effects such as a ring with a specific engraving). The IRC Group Supervisor will review these preliminary comparisons before they are passed on to the Identification Team.

Personnel should inform the IRC Group Supervisor of all computer problems. The IRC Group Supervisor will notify appropriate supervisors immediately if maintenance or support is needed.

4.12.1 Records Library

Principle:

The File Manager will maintain a records library in the IRC. Records are evidence and property of the OME and/or Local Coroner. No records or information be distributed to unauthorized personnel.

Procedure:

Information Security

- All information is confidential.
- No information will leave the File Room unless it is properly checked out by the File Manager to approved personnel
- A hard copy ante-mortem file will be created for each decedent. Individual ante mortem files are required even if multiple members of the same family are decedents.
- All ante-mortem information and records received from the Family Assistance Center will be labeled, filed and logged by the File Manager in two places:
 - The decedent's individual file folder
 - The master log (maintained separately from the file folders in case a folder cannot be located).
- The File Manager will notify the appropriate sections if any relevant ante-mortem information becomes available for a decedent.
- The File Manager will maintain a log for any information that leaves the File Room. This log will note the items taken, decedent name, date and time of removal, the person removing the items, who the items were given to, and the date, time, and person returning the items.
- The File Manager and IRC Group Supervisor (or their designee) will reconcile the hard copy files with computer files. The IRC Group Supervisor receives the incoming data, ensures its entry into the computer by a data entry specialist, and forwards it to the File Manager for logging and storage in the records library.
- All ante-mortem and postmortem information and records are treated as evidence. The chain-of-custody of this evidence is maintained via the logs. The File Manager accounts for all received information/records, whether they are in the direct possession of the File Manager or checked out to an authorized individual.
- For postmortem records, the number assigned to remains as they were collected at the scene is referred to as the Field Number. The Field Number is recorded on the Tracking form and the remains are assigned a Morgue Reference Number (MRN) for use in postmortem processing.

Inventory Tracking Log

- Each DVP contains an inventory-tracking log stapled to the interior front of the file folder.
- The inventory tracking log documents the date, time, and identities of the individuals whenever a specific record was received or transferred to another individual.
- Items listed on the inventory tracking log include:
 - Ante-mortem Interview Forms (Victim Information Profile)
 - Dental Records
 - Dental X-rays
 - Medical Records
 - Medical X-rays
 - Fingerprint/Footprint Records
 - Photographs

The records clerk documents the date and time of the receipt for these items and signs for each item.

Dental Records

- Log dental records into the decedent's inventory tracking log.
- DO NOT place dental records or x-rays in an individual victim file folder.
- Dental record and x-ray information is logged into the file contents record. The records and x-rays are then transferred to the Odontology Section using the transfer log.
- Dental data is maintained by the Odontology Section Leader. When items are returned to the case file, complete the "date returned" area on the transfer log.

Photographs

- Log photographs into the decedent's inventory tracking log.
- If an actual photograph is received, write the decedent's full name on the back and make a photocopy of the photograph.
- Place the photograph in a legal size envelope and write the decedent's name on both sides of the envelope.
- Seal and staple the envelope to the rear interior of the decedent's case file folder. DO NOT staple through the actual photograph.

Medical Records

- Log medical records into the decedent's inventory tracking log.
- Write the decedent's name and case number on the top of each page of the medical records.
- If size permits, store the medical records in the individual case file folder.
- Large records or radiographs are placed in a separate storage unit in the records room and their location documented within the decedent's case file.
- All medical radiographs will be labeled on both sides of the radiograph envelope with the decedent's full name and assigned case number.

Fingerprint Records

- Log fingerprint records into the decedent's inventory tracking log.
- Write the decedent's full name and case number on the top of each fingerprint document.
- Staple the fingerprint document to the rear interior of the case file folder.
- Do not penetrate any portion of the fingerprint with the staple.
- A single copy of a "thumb print" on an identification card is considered a fingerprint document.

Out of File Card/Form

- An "out of file" card is created for indicating that information has been removed from a case file.
- The out of file card is placed in the corresponding file folder to specify that documents previously contained within the file have been removed and transferred to another location.
- The out of file card contains the following information:
 - File/Decedent name
 - Date removed and Date returned
 - Document removed
 - Location of document
- The out of file card is retained in the case file folder, even after the document has been returned to the file.

Shredding

- All confidential documents no longer needed (such as duplicates) **MUST** be shredded.
- Confidential documents comprise any paper containing the name or a portion of a name of a victim or any identifying information.
- No document shall be shredded without first being reviewed and authorized for destruction by the supervisor of the Information Resource Center.

4.12.2 Management of Mission/VIP Deployment Records

Purpose:

Original records produced during the incident will be turned over to the Medical Examiner. In the event of a legal challenge or other requirement, these records should be made accessible to any assisting forensic scientists for a period of time after the deployment.

Procedure:

Ante-mortem information received in the IRC is copied and placed in an archival records storage area. All records will be copied and/or scanned and placed in the archival storage area as soon as practical but always before the end of the mission. At the end of the mission all original records are left with the local authorities.

All records and files should be audited and verified for completeness and correctness before relinquishing to the local medicolegal authority.

Records formats will include paper and/or electronic files. If reasonable, all records will be scanned and digitized to minimize paper archival issues.

5.0 Family Assistance Center (FAC)

Principle:

The Family Assistance Center (here after referred to as FAC) supports the local medicolegal authority and the local or federal law enforcement agency conducting missing persons reporting in the collection of ante-mortem data collection, including the collection of DNA reference samples. Working within the FAC, properly trained assisting team members will conduct interviews of the next-of-kin, collect ante-mortem information, and transfer this information to the Information Resource Center. If requested, the assisting team members may also provide information to the next-of-kin and assist the medicolegal authority with death notifications.

An assisting team supports the FAC by:

1. Establishing a command structure to manage FAC staff.
2. Providing trained interviewers for the Family interview process
3. Establishing ante mortem data acquisition and entry plan
4. Coordinating operation with Records Supervisor
5. Establishing and supervising death notification procedures with medical examiner and psychological, and religious personnel if requested
6. Serving as a member of the death notification team
7. Coordinating FAC transportation and security plans for FAC personnel
8. Working with Federal partners assigned to the FAC and ensuring proper support for them.

Procedures:

Any assisting team will work with the oversight of the Medical Examiner and possibly law enforcement. These procedures are typical for most responses, but may not be required for each response.

FAC Activation Procedures

Upon notification by the OME of the need to activate an FAC for a mass fatality incident, the following procedures transpire:

1. An FAC Branch Director deploys with the assessment team to the incident site.
2. The FAC Branch Director contacts team members and other participating agencies to obtain deployment availability information. Following the initial assessment, the FAC Branch Director determines the team size required for deployment.
3. The OME will provide an accurate listing of the accident victims and missing persons to the FAC Branch Director. Victim's names, addresses and telephone numbers should be obtained from the appropriate agencies (airlines, etc.).
4. FAC members should have supplies and materials for interviewing in case family interviews begin prior to the delivery of supplies.
5. The FAC should be familiar with Utah death certificates to identify additional information that may need to be added to the VIP.

FAC Procedures

Designated team members will schedule an interview time with the family, allowing 2 hours for each interview with a 30 minute period between interviews. Special considerations are:

- Conduct interviews in rooms that are quiet and private.
- Collect ante-mortem data using the DMORT Victim Identification Profile interview form. Once completed, the VIP is given to the IRC and other appropriate agencies.
- Arrange for collection of DNA family reference samples. In the case buccal swabs are used; assist the family members in collecting the samples DNA collection/donation. If blood samples will be taken, arrange for local qualified personnel to collect the specimen.
- Call the dental and medical offices to obtain ante-mortem records.
- Set up an address for receipt of all ante-mortem records as specified by the Medical Examiner
- Dissuade family members from acquiring or carrying the victim's medical or dental records to the FAC.
- Only ORIGINAL dental X-rays and ORIGINAL medical/dental records are requested and acceptable. Copies are not useful and are not evidence per 45 CFR 164.512(g) "HIPAA Exemption for Medical Examiners and Coroners".
- If the family members do not visit the FAC, VIP interviews can be conducted over the telephone. The same procedures apply to these interviews (i.e. scheduled, conducted in a quiet, private area, etc). If necessary, FAC personnel may make telephone contact with the next-of-kin before they arrive at the FAC. If this occurs, FAC personnel, working from a scripted checklist, will request location and contact information only for the following:

Physician
Dentist
Hospital

Fingerprints
Photographs
Military service records
Essential vital statistics

- Maintain a log of all incoming data/samples.
- Maintain a log of all VIP files.
- Direct all data/samples to the morgue for review and analysis.
- Direct all VIP files and records to the IRC.
- Once the VIP form is completed and copied by the FAC, it is delivered to the Information Resource Center.
- Copies of pertinent forms are kept at the FAC for reference. FAC workers will destroy all copies at the end of the mission after receiving approval from the Medical Examiner.
- Attend family briefing and Joint Family Support Operations Center meetings as necessary.

6.0 Identification Procedures

Principle:

Proper positive identification is necessary for notification of the legal next-of-kin, resolving estate issues and criminal/civil litigation, and the issuance of death certificates.

Procedure:

The Medical Examiner is responsible for establishing the identity of the decedent in cases under his jurisdiction using:

- Prints (including fingerprints, handprints, toe prints, and footprints, if indicated).
- Odontology, Radiology, and/or DNA analysis.
- Permanently installed medical devices with recorded serial numbers
- Distinctive physical characteristics (e.g. ears, scars, moles, tattoos) for which there is appropriate ante-mortem photographic documentation may be used in an exclusionary capacity. In very unique circumstances, such evidence may be used for positive identification.

Presumptive identification is a preliminary step toward confirmatory identification using some or all of the procedures listed above.

Regularly scheduled identification meetings will allow the Medical Examiner to review and approve all proposed identifications. Once positive identification is made, the name of the individual identified and the method(s) of identification will be forwarded as soon as possible to the staff at the Family Assistance Center.

6.1 Identification Documentation Team

Principle:

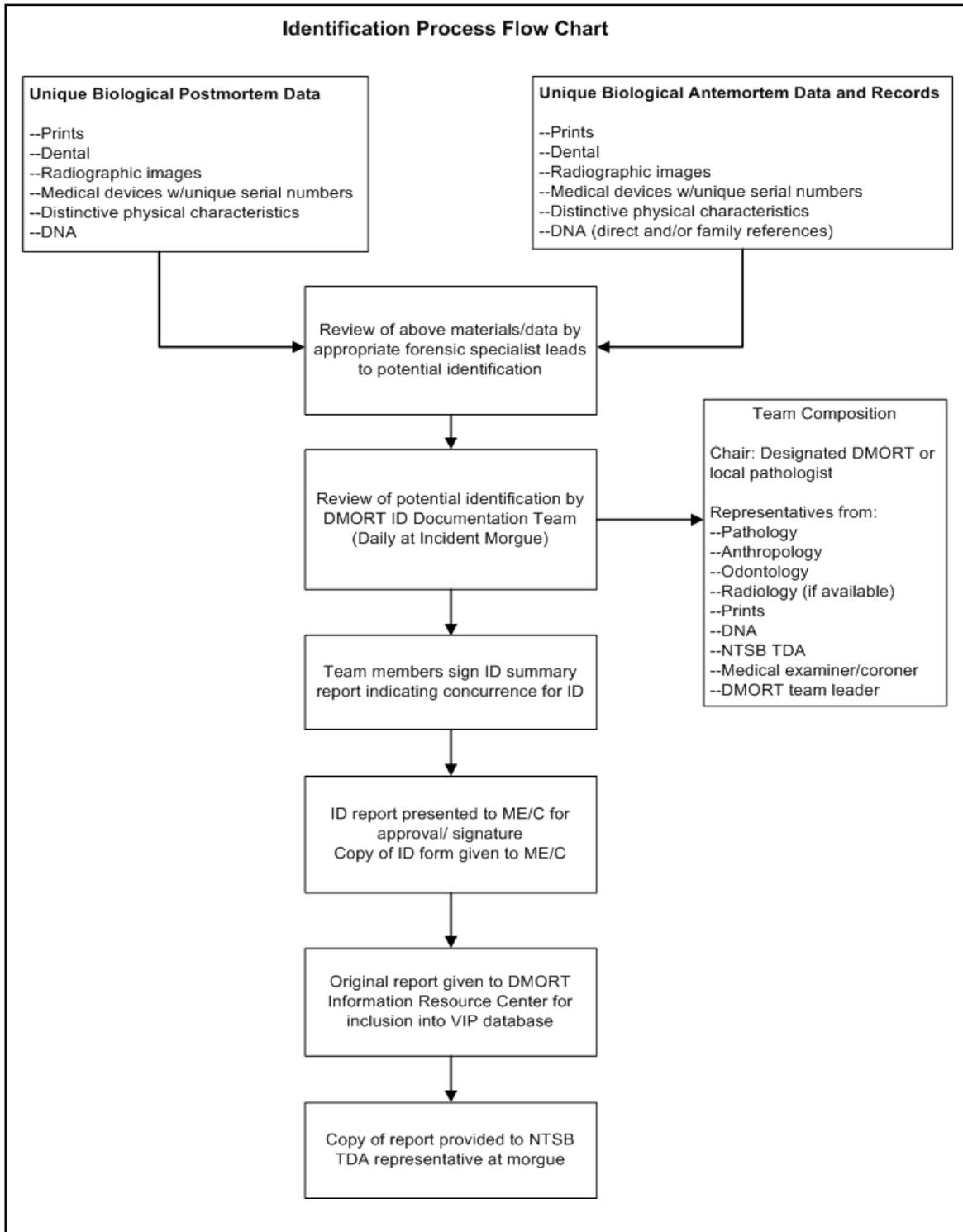
A committee chaired by a pathologist designated by the Medical Examiner will meet daily to review and confirm identifications. The team will consist of representatives from the forensic science disciplines and the Office of the Medical Examiner.

Procedure:

The committee meeting will be called and chaired by the designated pathologist. Attending will be representatives from each of the forensic science disciplines:

Pathology, Odontology, Anthropology, Fingerprints, DNA, and the Office of the Medical Examiner.

The committee reviews the section identification reports and completes an Identification Summary Report (see appendix). All committee members present sign the Identification Summary Report indicating concurrence of identification. Identification Summary Reports are delivered to the Medical Examiner for his/her approval and signature. A copy of the report is given to the Medical Examiner. The original report is given to the Morgue IRC for closing out the pertinent records. A copy of the report is delivered to the Medical Examiner Liaison in the FAC and other jurisdictional agencies as required (such as the NTSB.)



Identification Summary Report

Date: _____

Morgue Reference Number(s) _____

is/are identified as

Name _____

The identification results from scientific analysis and comparison of ante mortem and postmortem data. The specific discipline(s) involved certify the identification by signing below. Supporting identification documents accompany this form.

	Print Name	Signature
Pathology	_____	_____
Odontology	_____	_____
Anthropology	_____	_____
Prints	_____	_____
DNA	_____	_____

Was a DNA analysis requested? Yes No
Has DNA analysis been completed? Yes No
Does DNA result concur with this identification? Yes No

For Medical Examiner only:

To the best of my knowledge and after careful review of all evidence presented, I certify the above identification.

Signed _____ Date _____ Time _____

Print Name: _____

Jurisdiction: _____

**The following narrative details the basis for the identification conclusion:
(continue on separate page)**

7.0 Death Certification and Death Notification

Principle:

The documentation of the identification, the cause and manner of death, and final disposition are required by law and used for vital statistics and the initiation of probate. The death certificate is the legal instrument for this documentation. The Medical Examiner is responsible for legal documentation pertaining to death certification.

Procedure:

The Office of the Medical Examiner is expected to complete its portion of the certificate and transmit the document concurrent with the release of the decedent.

When no human remains are recovered, or scientific efforts for identification prove insufficient, a court-ordered certification of death may be sought.

The nature of the victim identification process demands that the next-of-kin (NOK) be involved in certain decisions regarding the remains of their decedent. Their decision on these matters must be documented and if possible followed.

NOK will be notified by the Medical Examiner when identification is made. This should be accomplished, whenever possible, in the FAC. In the case of complete remains, this notification should be followed as quickly as possible by release to the designated funeral home.

Where appropriate, as in cases of fragmentation or commingling, the Medical Examiner will explain to the families the available options for disposition of any subsequently identified remains and assist them with that process. These options include:

1. Notification each time additional remains are identified.
2. Notification at the end of the identification process.
3. Return the currently identified remains to the family for final disposition.
4. Return of all remains at end of the identification process.
5. Other requirements the family may have will be considered if they do not impact overall identification efforts.
6. What the final disposition of commingled/common tissue will be.

8.0 Final Preparation and Disposition of Remains

Principle:

Remains of decedents must be handled with the utmost respect and care. The Medical Examiner and any assisting team members will ensure that all human remains (identified, unidentified, common tissue, or any other types of remains) are stored with dignity, handled with respect, and transported with professionalism.

8.1 Post-Identification Holding in the Incident Morgue

Principle:

Once remains have been identified, they are securely stored in an environment that retards decomposition and ensures the chain of custody is maintained.

Procedure:

Following identification, remains should be stored in a designated refrigerator trailer or similar container. This container should be designated only for identified remains.

1. Supervisor receives from driver the trailer lock key, if any.
2. Sufficient personnel should be used to carry the litter or move the gurney so that remains are not harmed and so that lifting injuries are reduced.
3. A movement log sheet will indicate the following:
 - Number(s) of the body bag(s) comprising the decedent's remains
 - Date and time in or out of storage
 - Name and signature of tracker
 - Name and signature of storage worker releasing or accepting body bag
4. If more than one refrigerator is used, record which unit the body bag is going in or coming out.

8.2 Reassociation of Remains

Principle:

In situations where remains are fragmented and commingled, identified remains may be reassociated so that remains belonging to individuals are returned together to the next of kin. Often, because DNA analysis is the method used to conduct these identifications, the physical re-association of remains can take place several weeks or months after an incident.

Procedure:

Remains will be:

- Re-associated one decedent at a time.
- Remains related to a particular decedent will be removed from the storage container (refrigerator trailer) and moved into an area designated for re-association.
- The appropriate documentation (Identification Summary Report, DNA laboratory results, VIP forms, postmortem photographs) will be used to select the appropriately numbered remains for that decedent.
- Remains will be examined to ensure that the physical characteristics are identical to those on the associated documentation.
- After review, all remains associated with the decedent will be placed in the appropriate container, such as a casket, transport case, body bag, etc.
- Remains will then be returned back to storage or sent to Embalming if being conducted in the incident morgue.
- If remains are to be released, they should be sent to Final Identification Review before release.

8.3 Final Identification Review

Principle:

The integrity of the identification process and morgue operations demands that remains be reviewed before release from the morgue. This review should include an examination of the identification methods used, a physical examination of the remains, and the proper re-association of remains for that decedent.

Procedure:

When remains are ready to be released, the identification team leader, and the forensic specialists involved in the identification will:

- Conduct a final review of the methods of identification
- Physically examine the remains to ensure that the remains match the biological attributes of the deceased (based on the ante-mortem information)
- Ensure that the numbers associated with each remain are accounted for.
- A form indicating that the remains have been reviewed for final identification will be signed, dated, and placed in the DVP.

8.4 Embalming Section

Principle:

Embalming may or may not be a process that is part of the morgue operation during a mass fatality incident. Embalming may be conducted after the remains have been released. Thorough disinfection, preparation, and minor reconstructive surgical procedures are accomplished on each decedent or part of decedent when authorized by the appropriate next-of-kin or legal authority. Next-of-kin may contract with a funeral home to perform this function. Next-of-kin or legal authority may authorize cremation as the final means of disposition.

Procedure:

The volume of remains, morgue flow and number of shifts will determine the staffing level of embalmers. Embalming procedures shall not be performed on any decedent or remains unless appropriate approval has been granted in writing by the legal next-of-kin or legal authority.

Appropriate embalming case reports shall be completed and inserted into the DVP.

Disaster-specific guidelines for embalming should be established by the embalming station supervisor/unit leader.

The Embalming station supervisor/unit leader shall assign 2 licensed embalmers (with knowledge of postmortem reconstructive surgery) to assess remains according to the potential for viewing by next of kin and any other aspects that may impact embalming.

Embalmers shall use embalming and minor reconstructive surgery techniques that will enhance the possibility of the decedent being “viewable”.

8.5 Casketing

Principle:

Decedents and human remains will be placed in a casket, dressed when appropriate, and relocated to the morgue shipping point.

Procedure:

- ❖ Staffing will depend on volume of remains and morgue flow.
- ❖ Decedents will be dressed with supplied clothing, when appropriate.
- ❖ Decedent may be placed in a plastic pouch, if advisable.
- ❖ Place decedent in casket, and/or other supplied container, as necessary. Use acceptable blocking material to prevent shifting in transit.
- ❖ The outside of the casket and/or container shall bear the name of the decedent and any assigned identifiers.
- ❖ Other containers can include Ziegler type cases, shipping boxes and air trays.

- ❖ Maintain a log reflecting the disposition of the body. The log shall identify the date and time the casket is relocated to the morgue shipping holding area.
- ❖ The Unit Leader shall assure that the person who is supervising the shipping holding area signs the appropriate form, and the form shall be inserted into the DVP.
- ❖ No personal effects, except burial clothing, should be in the casket or container.

8.6 Cremation

Principle:

If chosen by the legal next-of-kin, cremation is an acceptable form of final disposition. Next-of-kin or legal authority may contract with a funeral home/crematory for cremation services.

Procedure:

- ❖ The next-of-kin or legal authority must sign cremation authorization.
- ❖ An authorization to release the decedent or remains to a specific crematory or funeral home must be signed by the next-of-kin or legal authority.
- ❖ Upon request of the next-of-kin, the decedent or remains may be embalmed, and then shipped to the family funeral home or local crematorium for cremation.
- ❖ Any necessary or required authorization will be secured and released with the decedent or remains.

8.7 Funeral Home Contact Information

Principle:

To coordinate the shipping of remains and any NOK considerations, the receiving funeral home must be contacted and information exchanged.

Procedure:

The required information should be gathered at the time the Medical Examiner makes the positive ID notification to the NOK. The information required from the NOK:

- Name of funeral home
- Contact person at funeral home
- Location (city, state, zip code)
- Telephone and fax number
- If the exact address, fax number, email address, and contact person is known, this can be recorded.
- Obtain from the funeral home the best airport or train station to ship the decedent.
- Inform the funeral home of the schedule once the transportation arrangements have been confirmed.

8.8 Transportation of Decedents from Morgue

Principle:

This unit coordinates the transport of released human remains from the Morgue to a designated location, such as an airport for transport to the receiving funeral home.

Procedure:

A minimum of 2 Licensed Funeral Directors should staff this unit. The burial-transit-cremation permit and other documentation required by the receiving funeral home will be secured from the

appropriate authority (normally the vital statistics office of the local community). The burial-transit-cremation permit and other documentation will be placed in the "Head" envelope. The completed "Head" envelope will be securely affixed to the head end of the outside container.

Hearses or other appropriate vehicles normally used to transport decedents will be used.

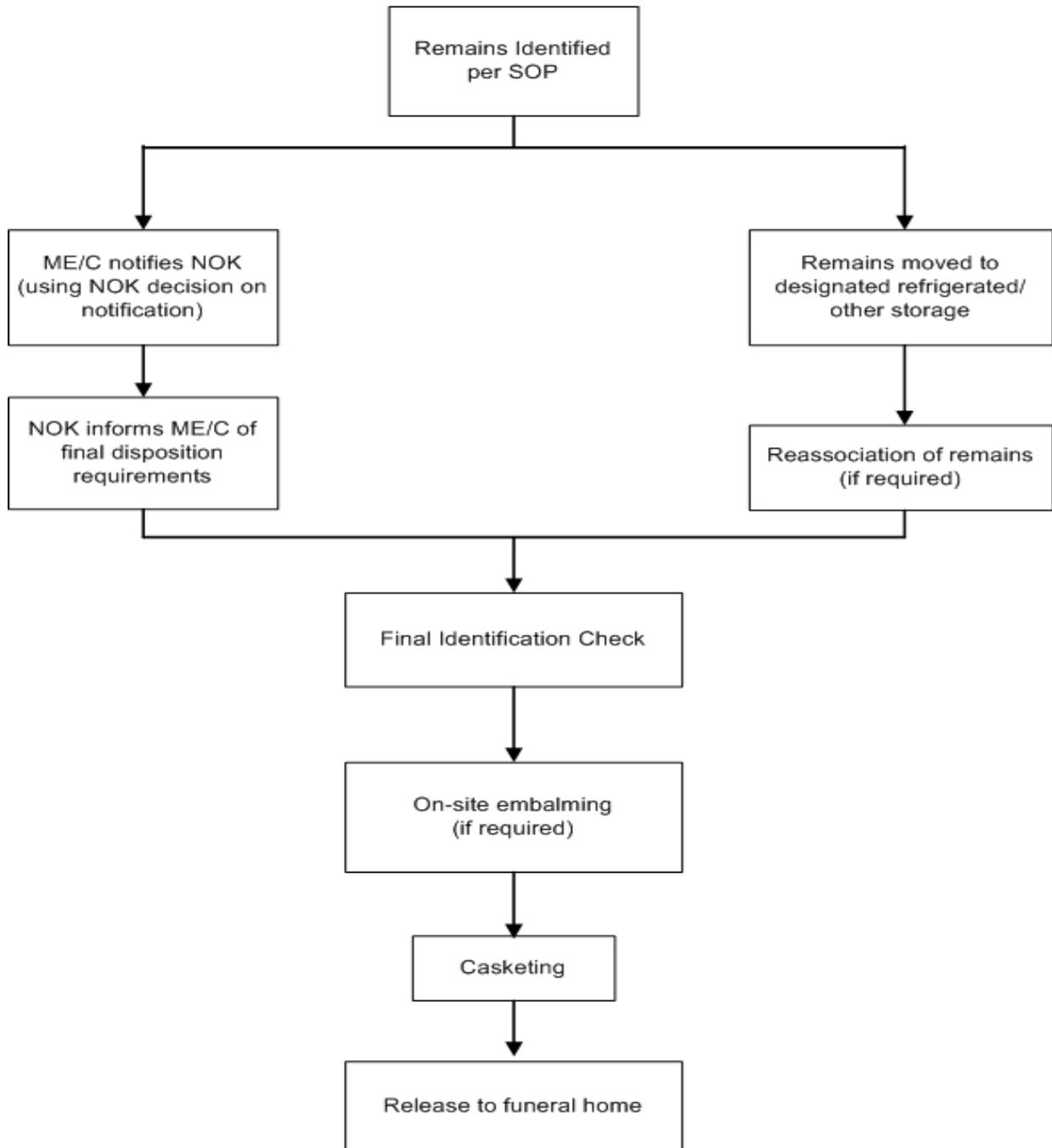
The Unit Leader shall be responsible for assuring that all necessary release and transporter documentation is in order and shall maintain a log reflecting the date, time, transporter vehicle identification, transporter personnel identification, and destination.

Transporting personnel shall wear professional attire during the transport. Movement of the hearses may be coordinated in "procession" style if appropriate. Police escorts may be used when necessary.

An adequate number of casket bearers (team members, volunteer funeral directors, etc.) should be present for loading and off-loading so as to mitigate bearer injury or chances of mishandling the remains.

Drivers should be instructed to travel directly to the destination and directly back to the morgue without any stops except at a designated staging area or to refuel. Security may be requested.

Post Identification Process Flow Chart



9.0 Incident Morgue Demobilization

Principle:

Once incident morgue operations have ceased, all remains have been released, or there is a requirement to close the morgue operation, a standard process will be used to ensure the morgue site is cleaned, the equipment is returned, and that all remains have been accounted for. The incident morgue facility must be turned back to the owner or agent of the owner with no trace of biological contamination. The facility must be restored back to its original condition. Arrangements will be made with the appropriate officials to provide a walk-through with the owner or agent of the owner to ensure that the cleanliness and condition of the facility is satisfactory.

Procedure:

Upon completion of morgue operations and prior to the demobilization of morgue and morgue workers, a general clean up of the morgue will be conducted with proper disposal of any general trash, biohazard waste, both dry and liquid, and worn or discarded PPE.

Each Station Leader should inventory the materials before closing down. Information should be provided to the Morgue Manager of needed supplies that should be considered for future deployments.

Once the morgue is disassembled, a thorough clean up of the area that contained the morgue will commence. (Consideration may be given to the local hire of a cleaning company to accomplish this task, and arrangements will be made through the appropriate process.)

The plastic sheeting covering the floor shall be sprayed with a 5% hypochlorite solution, allowed to dry, and then collected and disposed of according to state and local environmental laws. Cleaning of the area will minimally consist of sweeping entire area, spraying the floor that was covered by the plastic with a 5% hypochlorite solution and inspecting for any area that may require additional cleaning or treatment.

Any area that was used for administrative purposes, such as the Informational Resource Center, shall be cleaned of all trash. All floors will be swept and any carpeted areas vacuumed.

Arrangements will be made by the Office of the Medical Examiner to ensure for the pick-up and disposal of any regular trash, any dry biohazard waste, and any collected liquid that is considered biohazard waste. All biohazard waste will be in approved containers as prescribed by local laws. General trash will not be disposed of in biohazard disposal containers.

Any refrigerated trailers, if empty, shall be decontaminated with a 5% hypochlorite solution and thoroughly washed out.

A final walk-through with the owner or agent of owner in the presence of member of the Office of the Medical Examiner will be conducted to ensure the facility is of satisfactory cleanliness.

Incident Demobilization

Team leaders will ensure that all personnel paperwork has been completed.

All VIP data will be finalized, saved to CD or similar media. A copy of the VIP data will be retained by the Medical Examiner.

Confirmation will be made that all original records pertaining to identification, postmortem documentation, and ante-mortem are in the possession of the Medical Examiner.

The Morgue Leader will ensure that all remains have been removed from the incident morgue location and have been accounted for either physically or via pertinent paperwork.

10.0 After Action Report

Principle:

After action reports (AARs) are critical for documenting the deployment. AAR documentation helps in future planning and response, indicates lessons learned, and may be useful in legal challenges to the identification process.

Procedure:

The team leaders will keep notes during the deployment indicating challenges, changes to SOGs, unique circumstances, or other pertinent information.

Section leaders should also document similar topics.

A final AAR should be compiled using the notes collected and submitted to the Medical Examiner.

AAR should be completed no later than one month after the deployment ends.

Appendix G - Forms

On the following pages are examples of forms that can be helpful in documenting the location as well as chain-of-custody of the remains and personnel effects. Not all of the forms are necessary. Select the use those forms which will be most helpful to your operation, or customize them to fit your needs.

DECEDENT INFORMATION AND TRACKING CARD

This form is used to track one (1) decedent. It includes chain-of-custody for the remains as well as a release for the personal belongings of the decedent.

REMAINS LOCATION LOG

This form can be used to track the location and release of the remains in the morgue (whether it is a room, or a trailer).

TRAILER MAINTENANCE/MORGUE LOG

This form can be used to document and track the maintenance of refrigerator trucks, or other location or facility used to store human remains.

TRAILER/MORGUE MAP

This form is actually a diagram of where the decedent's remains are located in a large morgue or refrigerated trailer (or rather a location where several remains are located.) The example used has three rows down the length of the trailer. The orientation of the map to the trailer is important. Normally, storage managers reference the front of the trailer with the top of the form, and the rear of the trailer (door end of the trailer) is at the bottom of the form.

This example also uses an Alpha/Numerical locator. Morgue managers can utilize any locator system that is simple and easy to implement.

HR (HUMAN REMAINS) RELEASE LOG

This form can be used to document the release of remains to Funeral Homes, the Medical Examiner's Office, or other legal recipient.

FATALITY TRACKING FORM

This form can be used to document several decedents. It is advised that an additional form or column be used for signatures accepting release of the remains.

Facility Name or Logo
 Facility Address
 Telephone and Fax Numbers

First Letter of Decedent's Last Name

DECEDENT INFORMATION AND TRACKING CARD

Incident Name		Operational Period		
Medical Record/Triage #	Date	Time	Hospital Location Prior to Morgue	
First	Middle	Last	Age	Gender
Identification Verified by: <input type="checkbox"/> Drivers License <input type="checkbox"/> Other Photo ID <input type="checkbox"/> Other Method (explain) <input type="checkbox"/> Family Member (name):				
Address (Home address, City, State, Zip)				
Photo attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fingerprint Card attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Death Certificate Signed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Entered in EDEN? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Next of Kin Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Relation	Contact Information	
Status	Location	Date/Time In	Date/Time Out	
Hospital Morgue / Temporary Storage				
Hospital Morgue / Temporary Storage				
Hospital Morgue / Temporary Storage				
Hospital Morgue / Temporary Storage				
Final Disposition	Date/Time	Name of Recipient	Signature of Recipient	
Released to: <input type="checkbox"/> Funeral Home <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Other	Date: Time of Release:	Please Print		
List Personal Belongings:			Storage Location	
			Storage Mgr Name:	
			Signature for Receipt:	
Personal Belongings Released to:				
Name (Print):	Signature:	Relationship:		
Original on File in MFI Unit/EOC	<input type="checkbox"/>			
Copy with Decedent Remains	<input type="checkbox"/>			
Copy to MFI Unit Director	<input type="checkbox"/>			

Facility Name or Logo
Facility Address
Telephone and Fax Numbers

TRAILER/MORGUE MAP



Front of Trailer

Alpha 1	Bravo 1	Charlie 1
Alpha 2	Bravo 2	Charlie 2
Alpha 3	Bravo 3	Charlie 3
Alpha 4	Bravo 4	Charlie 4
Alpha 5	Bravo 5	Charlie 5
Alpha 6	Bravo 6	Charlie 6
Alpha 7	Bravo 7	Charlie 7
Alpha 8	Bravo 8	Charlie 8

Rear of Trailer (Doors)



Personnel completing Map:

1) _____

2) _____

Date/Time: _____

Facility Name or Logo
 Facility Address
 Telephone and Fax Numbers

HR (HUMAN REMAINS) RELEASE LOG

Id #	ID Verified	Decedent Name	Signature of Recipient	Signature of Morgue Mgr	Personal Effects Included
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

Facility Name or Logo
 Facility Address
 Telephone and Fax Numbers

FATALITY TRACKING FORM

Incident Name				Date/Time Prepared			Operational Period Date/Time		
MRN or Triage #	Name	Sex	Date of Birth/ Age	Next of Kin Notified	Entered Into EDEN	<u>Hospital Morgue</u>		Final Disposition/Released to	
						In Date/Time	Out Date/Time	Funeral Home/OME/ Other	Date/Time
Completed by Facility Morgue Mgr			Name:						

Copies to Patient Registration/EOC/Medical Care Branch

APPENDIX - H
Mass Fatality Internet Resources

Department of Health and Human Services

- I. ***Disaster Mortuary Operational Response Team***
www.dmort.org

- II. ***DMORT: Flight 93 Morgue Protocol***
<http://www.dmort.org/DNPages/DMORTDownloads.htm>
Morgue protocol from the DMORT response to the crash of United Flight 93 on September 11, 2001. The criminal nature of this event caused DMORT to alter some of its morgue operations, and this protocol was adopted for this response.

- III. ***Department of Defense: Capstone Document: Mass Fatality Management for Incidents Involving Weapons of Mass Destruction***
http://www.ecbc.army.mil/hld/dl/MFM_Capstone_August_2005.pdf
Guidance for medical examiners, coroner, and emergency managers for responding to a mass fatality situation following a WMD terrorist incident, mainly focusing on chemically and biologically contaminated remains. Includes information on developing incident-specific plans for managing catastrophic events. Prepared by the U.S. Army Research Development and Engineering Command Military Improved Response Program and DOJ Office of Justice Programs, Office for Domestic Preparedness (August 2005).

- IV. ***Medical Examiner/Coroner Guide for Mass Fatality Management of Chemically Contaminated Remains***
http://www.edgewood.army.mil/downloads/reports/coroner_guide.pdf
A condensed version of the above guide, in checklist form (2 pages, 31 KB PDF).

- V. ***Dealing With the Stress of Recovering Human Dead Bodies***
<http://chppm-www.apgea.army.mil/documents/FACT/36-004-0202.pdf>
Two-page overview of expectations for disaster responders in the handling of dead bodies. Produced by the US Army Center for Health Promotion and Preventive Medicine.

- VI. ***Armed Forces DNA Identification Laboratory***
<http://www.afip.org/Departments/oafme/dna/index.html>
The *Armed Forces DNA Identification Laboratory* provides worldwide scientific consultation, research, and education services in the field of forensic DNA analysis to the Department of Defense and other agencies. The DOD DNA Registry provides DNA reference specimen collection, accession, and storage of United States military and other authorized personnel.

Department of Justice

- VII. ***Mass Fatality Incidents: A Guide for Human Identification***
<http://www.ojp.usdoj.gov/nij/pubs-sum/199758.htm>
Produced by the National Center for Forensic Science with the assistance of a group of experienced mass fatality forensic responders, this guide aids the medical examiner or coroner in preparing disaster plans with a focus on victim identification.
- VIII. **Identifying Victims Using DNA: A Guide for Families**
<http://www.ncjrs.org/pdffiles1/nij/209493.pdf>
A 13 page guide written for family members answers questions concerning the DNA identification process, the collection of reference samples, and other issues surrounding DNA identification of human remains.
- IX. ***FBI Disaster Squad***
<http://www.fbi.gov/hq/lab/disaster/disaster.htm>
The *FBI Disaster Squad* is a forty-person team of agents trained in fingerprint identification methods, forensic dentistry, forensic anthropology, and the proper operational procedures to follow after a disaster.
- X. ***FBI Evidence Response Team (ERT)***
<http://www.fbi.gov/hq/lab/ert/ertmain.htm>
The *FBI Evidence Response Team (ERT)* is a group of FBI personnel specializing in organizing and conducting major evidence recovery operations.
- XI. ***Providing Relief to Families After a Mass Fatality: Roles of the Medical Examiner's Office and the Family Assistance Center***
http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf_11_2001/welcome.html
Providing Relief to Families After a Mass Fatality: Roles of the Medical Examiner's Office and the Family Assistance Center (November 2002) is an excellent resource for a variety of mass fatality family assistance and victim identification concerns. Areas addressed include:
1. Primary issues and concerns of the victims' families
 2. Examples of a State/Federal partnerships for victim assistance services in a Medical Examiner's office.
 3. Lessons learned about what is helpful when working with victims' families
 4. Family Assistance Center operations and resources, including a summary of procedural considerations.

National Transportation Safety Board, Office of Transportation Disaster Assistance

- XII. **National Transportation Safety Board**
<http://www.nts.gov/Family/family.htm>
The NTSB Office of Transportation Disaster Assistance provides family/victim support coordination, family assistance centers, forensic services, communication

with foreign governments, and inter-agency coordination to assist communities and commercial carriers in the event of a major transportation disaster. There are also links on this site to the full version of the Aviation Disaster Family Assistance Act of 1996 (Public Law 104-264), the Foreign Air Carrier Family Support Act of 1997, and amendments to both laws.

XIII. ***Federal Family Assistance Plan For Aviation Disasters***

<http://www.nts.gov/publicn/2000/spc0001.htm> (PDF and HTML)

Describes responsibilities for airlines and Federal agencies in response to aviation accidents involving a significant number of passenger fatalities and/or injuries. It is the basic document for organizations that have been given responsibilities under this plan (e.g. American Red Cross, DMORT, airlines) to develop supporting plans and establish procedures (August 1, 2000).

XIV. ***Responding to an Aircraft Accident - How to Support the NTSB (For Police & Public Safety Personnel)***

http://www.nts.gov/Family/LEO_brochure.pdf

Brochure listing the major tasks required of law enforcement and public safety personnel in the first stages of aircraft accident response.

World Health Organization/Pan American Health Organization

XV. ***Management of Dead Bodies After Disasters: A Field Manual for First Responders***

<http://www.paho.org/english/dd/ped/DeadBodiesFieldManual.htm>

This manual presents simple recommendations for non-specialists to manage the recovery, basic identification, storage and disposal of dead bodies following disasters, in addition to suggesting ways to provide support to family members and communicate with the public and the media. The principles outlined in this document are being implemented and promoted by a variety of organizations, including the Pan American Health Organization, the World Health Organization, the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies.

XVI. ***Management of Dead Bodies in Disaster Situations***

<http://www.paho.org/english/dd/ped/ManejoCadaveres.htm>

Comprehensive guide to a variety of mass fatality issues, including preparedness for mass death response, medicolegal work, health considerations in mass fatalities, sociocultural issues, psychological aspects, legal concepts, and several case studies from recent South and Central American disasters.

XVII. ***Infectious Disease Risks from Dead Bodies Following Natural Disasters***

http://publications.paho.org/english/dead_bodies.pdf

Report indicating that dead bodies from disasters do not pose an infection risk

National Association of Medical Examiners (NAME)

XVIII. *NAME Mass Fatality Plan*

<http://www.thename.org>

NAME's Mass Fatality Plan is a template for jurisdictions creating a plan. Many of the forms are similar to those in use by DMORT (1.9 MB PDF).

Publications and Articles

XIX. *World Trade Center Human Identification Project: Experiences with Individual Body Identification Cases*

<http://www.cmj.hr/2003/44/3/12808716.pdf>

Presents individual body identification efforts as part of the World Trade Center (WTC) mass disaster identification project.

XX. *Challenges of DNA profiling in mass disaster investigations*

<http://www.cmj.hr/2005/46/4/16100756.pdf>

This paper examines the different steps of the DNA identification analysis (DNA sampling, DNA analysis and technology, DNA database searching, and concordance and kinship analysis) and reviews the "lessons learned" and the scientific progress made in some mass disaster cases described in the scientific literature.

XXI. *Forensic Dental and Medical Response to the Bali Bombing: A Personal Perspective*

http://www.mja.com.au/public/issues/179_07_061003/lai10499_fm.html

A short article describing, in personal and professional terms, the response to identify victims from the Bali bombing.

XXII. *After Action Report for the Station Nightclub fire, West Warwick, RI (February 2003)*

www.hari.org/EmergencyPreparedness.shtml.

Contains a section on fatality management that focuses on lessons learned and medical examiner office management.

XXIII. *World Trade Center DNA Identifications: The Administrative Review Process*

www.promega.com/geneticidproc/ussymp13proc/contents/hennesseyrev1.pdf

Describes the process of DNA identification at the WTC, the complications encountered and how they were overcome, and a some lessons learned that are applicable in future situations.

XXIV. *Handling of Disaster Victim Human Remains: A Quick Guide for Health Care Workers, Medical Examiners, and Funeral Services*

https://www.femors.org/ssl/docs/FEMORS_Handling_of_Disaster_Victim_Human_Remains.pdf

Produced by the Florida Department of Health under a grant from the US Department of Health and Human Services and distributed by the Florida Emergency Mortuary Operations Response Team (www.femors.org). This 12 page guide covers, in easily understood diagrams and text, many of the technical, legal, and medical aspects of mass fatality remains handling.

XXV. *Los Angeles County Mass Fatality Incident Management: Guidance for Hospitals and Other Healthcare Entities - August 2008*

Developed in collaboration between the following Los Angeles County partners: Department of Coroner Department of Health, Services, Emergency Medical, Services Agency, Department of Public Health, Office of Health Assessment & Epidemiology, Data Collection & Analysis Unit

Appendix - I

6.3.4 Trailer Management Concepts

Principle:

In mass fatalities cases the use of refrigerated trailers is generally required for holding the remains. Emergency plans should include the name and contact number of a company (preferably three companies) that is willing to enter into a contract to provide refrigerated trailers as needed. It would be prudent that the company provides on-going maintenance and refueling while the trailers are deployed as part of the contract.

Procedure:

1. A refrigerated trailer can only hold 20 – 24 remains. **At no time can remains be stacked.** Remains must be handled with the utmost respect at all times.
2. Each trailer should have an easy to identify label, such as 1, 2, 3, or A, B, C, etc. It may be useful to keep unidentified remains in trailers labeled 1, 2, 3, etc. and identified remains in trailers labeled A, B, C. Once remains have been identified and authorized for release to the funeral home, placing them in a separate trailer (labeled “Ready for Release”) would help prevent accidental release of remains not authorized for release.
3. Considerations for refrigerated trucks:
 - A. Refrigerator trailers shall have a metal floor.
 - B. Company names on the side of the trailers cannot be visible.
 - C. After use, trailers must be cleaned and disinfected and cleared by local health before being returned to private sector use (transportation of food.)
 - D. Trailers should be set up so that activities cannot be viewed by the public/media.
 - E. Remains are to be released **ONLY** by the morgue manager and with proper documentation.
 - F. Keep a log showing which remains are in which trailer...update as deemed necessary, whether that's daily, weekly, etc. A record needs to be kept of each time remains are moved within the trailer or when they are moved in or out of the trailer. Know where the remains are at all times!
 - G. The use of a system in which the body pouches are clearly and securely labeled is very important. The numbering system must remain consistent throughout the response. Some tags are prone to tear loose or smear in the refrigerated trucks – use care in the selection of tagging material.
 - H. Regularly check trailers to ensure they are maintaining proper temperature and that the refrigeration units are fueled.
 - I. Keep extra body pouches and personal protective equipment on site.
 - J. The trailers should be parked in a secure fenced area. If that is not available, then security should be posted. Security must be coordinated with local law enforcement. Keep trailers locked at all times unless moving/removing/replacing remains. Area where remains are kept must have 24/7 security. Keep each trailer locked at all times unless moving/removing/replacing remains.

- K. Ramps should be built so that remains can be easily placed in or removed from the trailers.
 - L. Remains must be handled with the utmost respect at all times. NEVER, NEVER stack remains on top of each other.
4. Trailer Management Forms
- The forms listed below are samples of documentation used to track and manage remains in the trailer management section. Forms can be found in Appendix D – Planning Template: Facility Mass Fatality Management Plan and Appendix G – Forms.

Remains Location Log

Logging the remains in numerical order will facilitate locating remains quickly. This form can be maintained on computer or by hand. Back up the Log and print a hard copy after each shift. When remains have been released to a funeral home, record the date the remains were retrieved by the funeral home and require signatures and confirmed ID.

Trailer Maintenance/Morgue Log

The trailers need to be checked on a regular basis to ensure the temperature is between 38 – 40 degrees F, that fuel level is sufficient, and to ensure the trailer doors are securely locked.

Trailer/Morgue Map:

This log helps locate remains within each refrigerated trailer. The labels Alpha 1, Bravo 1, etc. designate the location within the trailer where the remains are located.

The location of the trailer needs to be recorded in cases where trailers are situated in separate locations. This map may appear redundant with the Location Log, but it is not.

As remains are placed into the trailer or as the trailer is double-checked, it is best to have one person reading the I.D. tag and another person serving as scribe. The scribe should repeat the I.D. number to ensure accuracy. This log can be used as remains initially arrive for holding in refrigeration.

HR (Human Remains) Release Log

When remains are picked up by the Funeral Home, the “HR Release Log” form can be filled out using the information from the Remains Location Log. As the remains are removed from the trailer, the Funeral Director/Staff will sign for the decedent, and the morgue manager will also sign showing release of the decedent to the Funeral Home.

Attachment 1

Excerpts from *“Providing Relief to Families After a Mass Fatality: Roles of the Medical Examiner’s Office and the Family Assistance Center”*

Published by the Department of Justice, Office for Victims of Crime

http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf_11_2001/welcome.html

Primary Issues and Concerns of the Victims’ Families

After a mass fatality, the victims’ families will have many questions and concerns as they assimilate and accept information about the deaths of their loved ones. As information and answers are being provided, the families may benefit from an explanation about the organizations and agencies participating in the response effort, their roles, and the resources and efforts they are contributing. Below are some frequently asked questions from victims’ families, arranged in the order they are most typically asked.

How will families be notified if their loved ones are recovered and identified? A notification team will be formed to notify families in accordance with established procedures. Information about the victims should be given to their families as soon as possible. It is extremely important to the families where the notification occurs, which family members are notified, and how they are contacted. The families need to be assured that the spokesperson is releasing accurate information that was officially issued by the medical examiner’s office.

In Oklahoma City, the families were told that notifications would take place at the designated family assistance center, the Compassion Center, or at a location convenient to them. Families were warned that only information and notification provided by the Oklahoma City Medical Examiner’s Office through the Compassion Center were credible and that information received elsewhere, such as from the media, may not be correct. Some organizations, including the military, law enforcement, and federal agencies, had their own death notification systems in place. In these cases, the Compassion Center provided information to the organizations for distribution through their own notification systems. Families were briefed at 9:30 a.m. and 3:30 p.m. for the 16 days the Compassion Center was in operation. The Compassion Center closed when the last body was recovered.

What method is used to identify the families’ loved ones?

Personnel from the medical examiner’s office should inform the families about all identification methods, explaining what they involve and their reliability. In some cases, more than one method may be used to make the identification, including fingerprinting, dental records, DNA testing, and radiology. In particular, DNA testing involves considerations that should be explained to the families. For example, DNA testing may require that family members provide blood samples. After the blood samples are obtained, the DNA testing may require 6–12 months before an identification can be made. Families should be told that during the DNA identification process, no material will be released until DNA testing of all common tissue is completed or at the discretion of the medical examiner in consultation with the families.

When will the victims' personal effects and belongings be returned to the families?

In some cases, only one personal item of a victim is recovered and identified. That item becomes very important to the family. The process for recovering and returning victims' personal effects and belongings must be established as soon as possible after the mass-fatality event and coordinated with other agencies. The procedure needs to be explained to the families so they will understand the process and know how long it may take. In criminal cases, some or all of the personal effects and belongings may be retained as evidence until after the trial.

Responding to the aftermath of the Oklahoma City bombing was an uncommon experience for the forensic pathologists because it was a criminal event rather than a natural disaster. As a criminal event, certain procedures were required. For example, a mandatory evidence collection process was established. The personal effects and belongings on the bodies at the time of recovery were transported with the bodies to the Medical Examiner's Office, which worked closely with the Federal Bureau of Investigation (FBI), the agency in charge of the investigation. The FBI stationed agents with the pathologists to help identify evidence. After evidence was identified, the agents packaged and documented it. The teamwork of the Medical Examiner's Office and the FBI ensured proper identification, collection, handling, and preservation of as much evidence as possible, all within a secure chain of custody.

The process of recovering personal effects and belongings at a mass-fatality site involves several agencies and organizations. As is true throughout the entire response effort, it is important for each agency involved to understand the goals and responsibilities of all the other agencies and organizations to avoid duplication of effort. In Oklahoma City, for instance, local law enforcement had overall supervision of the handling of victims' personal effects and belongings. At the conclusion of their examination, the FBI and the Medical Examiner's Office turned the victims' personal effects and belongings over to the Oklahoma City Police Department, which was responsible for cataloging, warehousing, and arranging all personal effects and belongings for return to the victims' families.

Another example of the need for agencies and organizations to communicate and coordinate occurred in Oklahoma City. Initially, staff of the Medical Examiner's Office were inclined to dispose of the unidentified human remains collected from the disaster site because they believed this would save families additional trauma. It was pointed out, however, that this was a problem because the unidentified human remains may conceal a victim's personal effect or belonging and therefore should not be discarded. It was decided that the unidentified human remains recovered from the site should not be discarded or destroyed without first consulting the families.

May the families go to the disaster site?

Over the years, in different mass-fatality events, victims' families have had a common initial response. When they hear that their loved ones are dead, the families immediately want to go to the event site or to the designated site when the original site is too dangerous or cannot be reached. Feeling compelled, the families converge on the site where their loved ones drew their last breaths. For many family members, being at the site allows them to feel close to their deceased loved ones, imagine their last moments, honor them, and say good-bye. Most important for the families, being at the site allows them to begin the long, difficult journey of psychologically and emotionally processing the event.

Deborah Spungen, a noted author, writes about the grief and trauma suffered by those whose loved ones are killed by homicide. Using the term "co-victim" to refer to those who survive, Spungen (1998: 132) writes about the significance of crime scene visits to surviving friends and family:

The crime scene often plays an important role to the co-victims as they begin to process the event. Some co-victims want to view the location of the death. This request is usually made to law enforcement personnel in the immediate aftermath of the homicide or even days or weeks later.

Spungen notes that opinions about crime scene visits differ from jurisdiction to jurisdiction, and not all law enforcement personnel sanction them. However, Spungen argues that “this is a matter of choice, and co-victims should have the right to make this decision.” In another observation about crime scene visits, Spungen (1998: 132) writes

There has been a growing practice for a crime scene located in a public place to be made into a shrine. Friends, family, neighbors, and community members may stop by to leave a flower, a candle, a card, a stuffed bear, or other mementos. Or they may pray or stand in quiet contemplation of the scene. For most co-victims, this activity can be quite beneficial.

Visits to the mass-fatality event site should always be coordinated with the organization or agency that has jurisdiction of the site. If the event was criminal, the FBI has jurisdiction. If it was a transportation accident, the National Transportation Safety Board (NTSB) has jurisdiction. The office in charge of taking families to visit the site needs to keep a few things in mind. If the visit takes place during the recovery process, recovery work should stop to show respect. Visiting families should not be exposed to bodies, body parts, or personal effects and belongings. Also, it is important for those overseeing the site visit to be aware that families of surviving victims and families of deceased victims will be experiencing very different feelings during a site visit. Although both groups will be mournful, one group will be celebrating the survival of their loved ones while the other group will be grieving the deaths of their loved ones. If both groups are on the same site visit, there may be problems. Families of the deceased may feel that the survivors’ joy and celebration are not appropriate at the site of so much loss and sorrow. Consequently, offices that coordinate site visits should arrange separate visit times for families of survivors and families of the deceased.

In addition, the medical examiner’s office or other offices with a role in coordinating site visits should be aware that visiting families may need to be prepared for what they are about to see. To meet this need, NTSB provides mental health professionals to brief visitors before they visit a site to view the wreckage of a transportation accident. The counselors tell the visiting families what they will see at the site, describing the conditions, the wreckage scene, and the odors. This kind of preparation makes the site visit less difficult for both visitors and coordinators.

After recovery of bodies in Oklahoma City was complete but before the site was released, the victims’ families were bused to the bombing site in a visit arranged in coordination with law enforcement, the Compassion Center, and federal authorities.

What is the condition of the body?

The condition of the body is a major concern for families. Explaining the condition of the body requires compassion, honesty, and tact. In Oklahoma City, the director of operations of the Medical Examiner’s Office reminded families that a huge bomb had destroyed most of a nine-story concrete and steel building and that the condition of the bodies, in some cases, was severe. He explained that the location of a victim in relation to the blast point affected the condition of the body.

After the body of their loved one had been recovered and identified, each family was advised that they could meet privately as a family at the Medical Examiner's Office to discuss the condition of their loved one's body. It was important to reassure each family that the body of their loved one was being treated with the highest degree of respect and dignity regardless of its condition.

When personnel from the medical examiner's office speak to families about the condition of their loved ones, they should use language that is sensitive to the family's needs. Avoid words or phrases such as "damage to the body," "fragmentation," "dismemberment," "pieces," "parts," "destroyed body parts," and "the body is in bad condition." Replace such words with more appropriate choices like "severe," "significant," "trauma to the body," or "condition of the body" rather than "damage to the body." Often, family members may prefer that the personnel from the medical examiner's office refer to the victims as "loved ones" rather than victims. As a general rule, the amount of information families can handle is revealed by the questions they ask and the feedback they give. Medical examiner personnel should take cues from the families and tell them only what they want to know.

Will an autopsy be performed?

The determination of whether to perform autopsies depends on the nature of the event and the decision of the local medical examiner or coroner. Family requests, cultural customs, and religious beliefs that prohibit autopsies for their loved ones should be considered; however, in most areas of the country, the medical examiner or coroner makes the final decision about whether an autopsy is necessary. If an autopsy is recommended, then the families should be told why it is necessary. In Oklahoma City, the chief medical examiner made the decision to perform autopsies only for cases in which the cause and manner of death could not be determined by other means. Of the 168 victims killed in the bombing, 13 were autopsied.

How do families know that the information they receive is accurate?

When a mass fatality occurs, information becomes public knowledge through a number of sources, including print media, television, radio, and the Internet. Families should learn about the injury or death of their loved ones from a credible source in a compassionate way—not through the news media.

Speculation over the cause of the Oklahoma City bombing was widespread. Generally, the investigative agency does not disclose to the public every detail of the investigation and its analysis. Only general information is released. In that situation, families should be reminded that information from any source other than the officially recognized source(s) may be unreliable. In Oklahoma City, the families had been told that the only reliable sources of information were the spokesperson of the lead investigative agency and the representative from the Medical Examiner's Office. These individuals communicated with the families at family meetings held in the Compassion Center.

Family members who live out of town or are physically unable to come to a family assistance center should not have to depend on unreliable news reports. They also should have access to reliable, firsthand information from the investigating agencies. To solve this problem, NTSB sets up a telephone-conference bridge at major accident sites that allows families to remain at home with their natural support system and receive current, accurate information. Using a toll-free number and a pass code, victims' families back home can hear updated information in real time as can families who traveled to the site or to the city nearest the site. This gives families at home and at the site the same information and essentially the same opportunity to ask questions.

The medical examiner's office should provide victims' families who travel to a family assistance center with a written record to help them keep track of the difficult and overwhelming information they will receive. In the aftermath of a mass fatality, families often are in shock and may not accurately recall what was said to them. In such a stressful situation, families can easily misunderstand what they read and hear and get an inaccurate perception of past and present events and future expectations. Not having the correct information can be very distressing to the families not only at the time of the event but also later.

May families obtain copies of the medical examiner's or coroner's report?

Contact persons from the office of the medical examiner or coroner should be sensitive to and understanding of the needs of family members. The families should be provided the names and numbers of the contact persons and encouraged to call if they have questions. Many families will want to go over the case or see photographs of their loved ones. The contact person from the medical examiner's or coroner's office should also be able to explain to the families how and when the reports will become available.

Attachment 2

Lessons Learned About What Is Helpful When Working With Victims' Families

http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf_11_2001/pg3.html

The Crash of ValuJet 592, A Forensic Approach to Severe Body Fragmentation documents the lessons learned in the aftermath of the crash of ValuJet 592 into the Florida Everglades on May 11, 1996, which killed all 110 persons on board. Written by medical examiners who worked on this case, this book describes forensic lessons learned as well as lessons learned about helping victims' families.

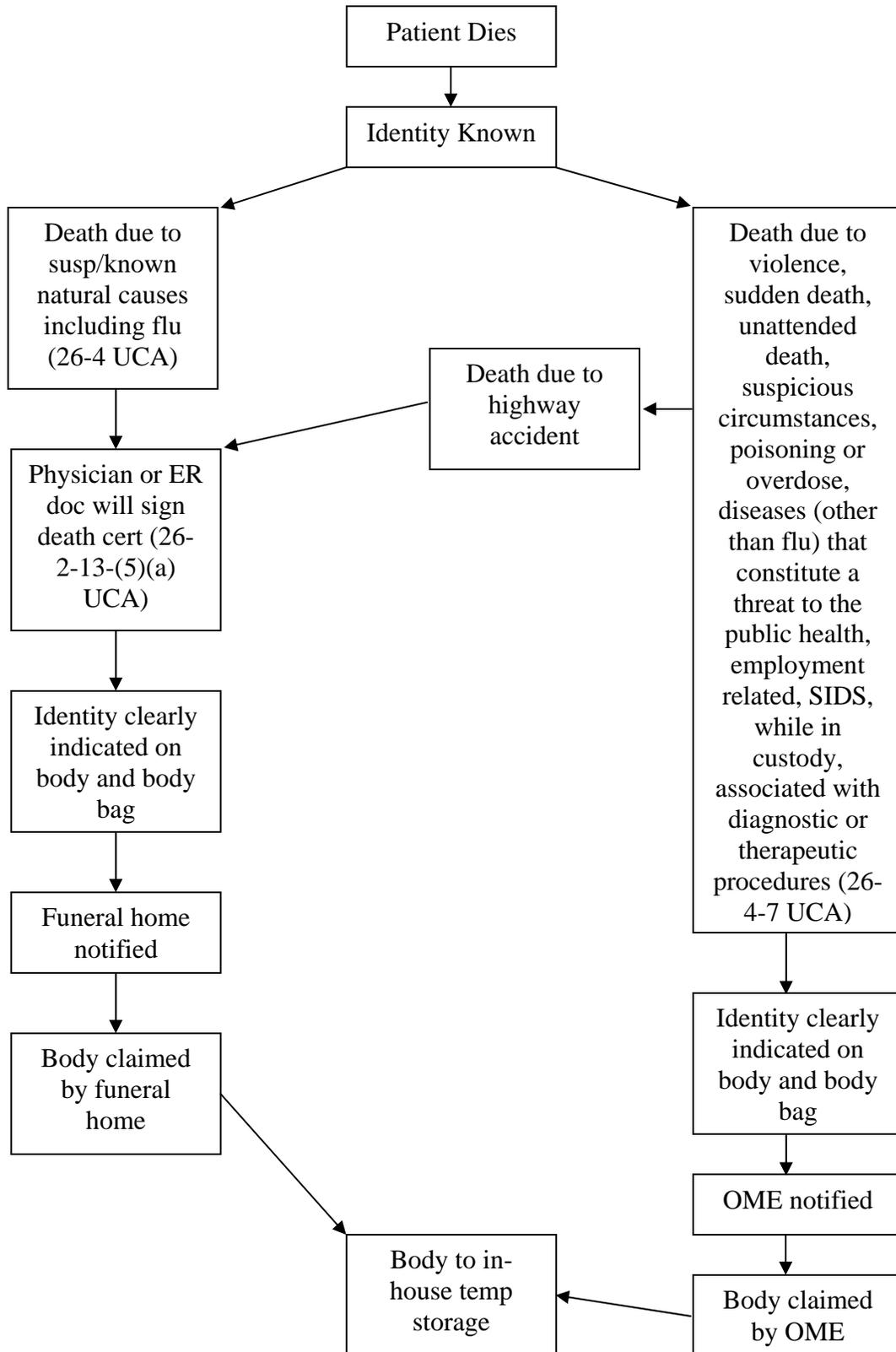
This book reports that after the crash of ValuJet 592, the families immediately wanted information. They expressed concern about not knowing what was going on regarding recovery of the remains, identification, and issuance of death certificates. It became very important to provide the victims' families accurate information, so an informational letter addressing identification and notification procedures, disposition options, issuance of death certificates, and matters related to unidentified remains was sent to all families. A follow up letter with updated information was later sent to the families.

In any mass fatality, it is extremely important to be humane and considerate when notifying next of kin after an identification has been made. Decisions about how to accomplish this may differ in different mass-fatality events. *The Crash of ValuJet 592, A Forensic Approach to Severe Body Fragmentation* describes the notification protocol established during the ValuJet 592 recovery effort. The same protocol was followed for all identifications: all notifications had to be made in person, not by telephone. This protocol was established to show respect to the families and ensure that the families received the proper information and understood it. Every family was visited by a notification team consisting of one law enforcement officer, to show respect, and one mental health professional or member of the clergy, to offer the family help and support.

Like other air disasters, the ValuJet 592 air disaster left in its wake severely fragmented bodies. The following excerpt is taken from *The Crash of ValuJet 592, A Forensic Approach to Severe Body Fragmentation* (2000: 52). The medical examiners in this case learned how important it was to allow the victims' families a choice regarding the disposition of body fragments that had been identified as coming from their loved ones.

When severe fragmentation occurs, it is critical to permit family choice in the disposition of an identified fragment, especially when the identification process may involve multiple fragments from one person recovered over an extended time period. It would cause great consternation for the family to release their loved ones' remains for burial only to inform them later that another fragment has been identified. Choice in the disposition of such remains is best decided as soon as one piece of tissue is identified.

Death in Hospital – Due to Pandemic Flu



Death in Hospital – Due to Pandemic Flu

