

Mass Fatalities Incident Management:  
*A Statewide Plan and Guidance for Local Jurisdictions,  
Hospitals, Healthcare Facilities, and other Entities  
Involved in Fatality Management in the State of Utah*

Developed by UHA, Utah Hospitals and Health Systems Association  
(UHA)

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## **INTRODUCTION**

In 2008, UHA, Utah Hospitals and Health Systems Association (UHA), convened a planning group to address fatality management for the State of Utah. This planning group consisted of health care facility representatives, the Utah Funeral Directors Association, the Utah Emergency Management Association, the State Office of the Medical Examiner, the Utah Department of Health, and local health districts.

The purpose of the planning group was to create a statewide, integrated plan to address fatality management issues that arise from a mass fatalities incident. This plan is a result of those efforts and fulfills the grant objectives outlined in the Hospital Preparedness Program Grant CFDA #93.889 funded by the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR), in partnership with the Utah Department of Health.

Since this is an integrated approach to planning, the concepts outlined herein are more comprehensive and detailed due to the nature of the planning elements, and become more complex due to the specific needs of the key players in an Mass Fatalities Incident. As an integrated approach, the components contained in the plan must address issues for key participants in the response, including, but not limited to:

1. Healthcare Facilities
2. Funeral Homes
3. Utah Department of Health, Office of the Medical Examiner (OME)
4. Local Law Enforcement
5. Local Emergency Management
6. Utah Department of Public Safety, Division of Homeland Security (DHLS)
7. Utah Department of Health (UDOH)

The plan is divided into key sections. As written, each major section of this plan can actually be a STAND ALONE plan for a specific discipline/participant in the overall response.. The casual reader should not be alarmed by apparent redundancy in the major sections because of this stand alone utility inherent within the plan.

While this planning approach may be unique, it is felt that the integration required to respond to and recover from the impact of mass fatalities on the community, is critical, and thus, the plan itself must also be integrated in its approach.

As an all hazard planning approach, this plan also outlines a morgue protocol for the OME. This section, while interesting, is not critical to the implementation of fatality management for local jurisdictions, but is absolutely critical to the OME. If an all hazard plan for fatality management is the goal of the planning effort, then a morgue protocol for the OME also needed to be addressed. It is hoped that all participants in a mass fatality incident will become well versed in the planning concepts outlined herein specific to their discipline, and at least familiar with or aware of those elements relative to their response partners. It is the planning group's intent to facilitate and enhance statewide integration and interoperability with this unique plan.

## **PURPOSE**

A mass fatalities incident (MFI) results in a number of deaths above what is normally managed by medico-legal and emergency response systems. In the event of a major disaster within the State of Utah, it may be several days before the State of Utah Office of the Medical Examiner (OME) or other response organizations, agencies or private mortuaries can respond to process

and recover decedents. This plan, along with response guidelines incorporated herein, have been developed to aid the OME, local response agencies, hospitals and other healthcare entities in their response to an MFI.

The principles outlined can be applied anytime a local jurisdiction, funeral home, hospital or care facility is experiencing a surge of deaths above what is normally managed by the entity. The forms and checklists included in this plan can be personalized by your facility as needed. The principles outlined here include information on preserving and safeguarding decedents, property, and evidence. It will also discuss the processes and issues for decedent identification, next of kin notification, death certificate processing, tracking, storage, and final disposition.

The goal of these guidelines is to enhance the ability of local agencies to support the OME, funeral homes, and local healthcare facilities by creating an interoperable and integrated approach to an MFI for all effected, responding and supporting agencies. This will enable the OME, local jurisdictions and healthcare facilities and partners throughout Utah, to respond to and manage a surge in the number of decedents as a result of any disaster, including an influenza pandemic effectively and efficiently.

The importance of religious, cultural and mental health considerations is recognized and these elements must also be addressed. While much of the plan focuses on decedent processing for medical and legal reasons, those critical elements are also addressed but only peripherally. However, allowances for those operations within the emergency support functions are important to the success of the response and recovery from the incident and must be considered.

This plan was developed in collaboration between the Utah Department of Health, Office of the Medical Examiner, Utah Department of Health, Utah Department of Public Safety, Division of Homeland Security, the Utah Hospitals and Health Systems Association, the Utah Health Care Association, representatives of local emergency management and the Utah Funeral Director's Association. This document is a public document and available to all interested parties.

## **PLANNING ASSUMPTIONS**

This plan is predicated upon the following basic assumptions:

1. The State of Utah Dept. of Health (UDOH) registers approximately 14,000 deaths/year.
2. It is the responsibility of the OME to determine the circumstances, manner and cause of all violent, sudden, unusual or unattended deaths.
3. A mass fatalities incident (MFI) results in a surge of deaths above which is normally managed by a community's usual medico-legal and emergency response system. MFI's are declared when an incident is beyond both the OME's and local jurisdiction's abilities to respond (when resources are overwhelmed) and not based upon a specific number of fatalities.
4. The OME is the lead jurisdictional agency to manage an MFI. However it is not solely responsible for all aspects of response to an MFI.
5. Medico-legal and healthcare systems, as well as all response agencies will continue to experience a "normal" response case load as well as the additional case load from the MFI.
6. The OME, hospitals and other healthcare entities have limited fatality surge space or equipment.
7. Federal Government, Department of Defense, or National Guard assistance in fatality management may not be available to local jurisdictions in widespread incidents such as a pandemic. For planning purposes, it is assumed that these resources will not be available during a pandemic.
8. Final disposition of human remains requires a death certificate. There may be some

circumstances where a death certificate is not complete. Close coordination between regulatory agencies (State Vital Records) during a mass fatalities incident is critical.

9. **Regardless of the incident circumstances, human remains will always be treated with dignity and respect.**
10. It is preferred that a treating or primary care physician sign a death certificate provided the patient dies from natural causes and that the physician has knowledge of the cause and manner of death.
11. When handled appropriately, human remains do not pose additional health risks to the community.
12. Those who physically handle remains may be at risk of blood borne or body fluid exposure requiring universal precautions and proper training for handling the dead.
13. It is more important to ensure accurate and complete death investigations and identification of the dead than it is to quickly end the response.
14. The time required to manage an MFI may exceed six months to a year.
15. The Utah Electronic Death Entry Network (EDEN) will be operational.
16. State and local response agencies, healthcare professionals, mental health professionals, social service organizations and religious leaders will need to integrate and coordinate within the mass fatalities management process at all levels to ensure the response process is understood and can be properly implemented and communicated to responders and to the general population. State emergency management, local emergency management, and health department coordination capabilities will remain intact and will work in tandem to support all levels of fatality management.
17. Communication capabilities will to one extent or the other, remain intact. Necessary communications between agencies will be possible.
18. Declaring a health emergency will trigger local emergency management and health district communication and coordination networks in conjunction with the State Emergency Operations Center (EOC), UDOH Coordination Center and state communication and coordination networks. While a physical EOC site may likely not be opened, the EOC functions will be operational via WebEOC or other technology.
19. Funeral Directors may be forced to call upon volunteers or public safety officials to assist them in their duties of responding to decedents. UDOH, DPS, DHLS and the Dept of Commerce will work with the Governor to review and to possibly relax certain restrictions pertaining to Funeral Directors related to State Code 58-9-305 and pertaining to exemptions from Administrative Rules R156-9-401, 402 and 403, thus allowing unlicensed staff and volunteers to assist Funeral Directors in certain aspects of the process. While State Code currently allows for Staff to assist, restrictions should be reviewed to allow for Funeral Directors to supervise assistance from untrained staff and funeral home volunteers and public officials who may be called upon to assist when and if needed. Strict supervision will be required.
20. During a Pandemic Flu outbreak, there may be many questions that families will have if a loved one succumbs. Local, State emergency management and health departments will utilize informational call centers, hotlines, WebEOC and other public information avenues to disperse information to the general population.
21. State and Local Health Districts will provide guidance and assistance (sampling and clearing for re-use) as possible in the cleaning and disinfecting of refrigerated trailers so that they can be returned to regular private sector use.

## **MULTI-AGENCY COMMUNITY-WIDE COORDINATION**

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 an 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.

The OME is the lead agency on fatality management during a disaster as defined by state statute and the State EOP and as outlined in this Emergency Response Plan. Included in this plan is a Morgue Operational Protocol, which outlines the actions to be taken by the OME, as well as those agencies, jurisdictions, and entities including health care partners with a jurisdictional and/or supporting emergency response function, via NIMS. This would include the local operational area agencies, state and federal law enforcement, fire, hazmat, funeral homes, State and Local department of health agencies, and health care facilities. The Morgue Protocol addresses such topics as operational deployment, equipment, scene assessment, decedent transport, examining, processing, identification, and release and body storage options.

This plan also addresses fatality management for such incidents as pandemic influenza and presents specific considerations for management of such deaths which may or may not fall under OME jurisdiction. A community-wide incident, especially one due to a disease outbreak or other public health emergency will also have jurisdictional implications for UDOH, local health agencies, state and local emergency management agencies, and health care facilities.

It is imperative, given the consequences of mass fatalities resulting from pandemic influenza, that local emergency management agencies assist local health agencies, local law enforcement, area hospitals, area health care facilities, care givers, funeral homes, Red Cross, and all other entities involved in fatality management. This would include those agencies involved in fatality management up to and including those entities involved in the final disposition of the remains (cemeteries, vault manufacturers, casket suppliers, etc.) All entities involved should stay alert for communication, coordination and supplemental information related to the response and recovery efforts.

Local emergency management agencies will be required to continue to interact with and provide and receive informational/incident updates from area hospitals, funeral homes, local health agencies, local law enforcement, public safety, and all other entities involved in the community with the incident. Communication will be via established systems including the phone, public safety radio, HAM radio, UNIS (Utah Notification Information System), WebEOC, and other established systems throughout the state and at local levels.

## **Standard Operating Guidelines for Mass Fatalities During a Pandemic Flu Incident**

### **1.0 Introduction and Overview**

#### **1.1 Pandemic Flu and Mass Fatality Management**

While mass fatalities incidents are usually contained in a specific geographic locale, there are situations which may arise that necessitate a more community wide or rather global approach. One such situation is the pandemic flu scenario.

If Utah is faced with a pandemic flu event, there will be a large impact on the local jurisdiction's ability to respond. This impact will also carry over to the State level and will even effect the Nation's ability to respond and recover from the pandemic. This document will define and clarify the response needed at the local and state levels for a pandemic flu event as it relates to fatality management.

While social distancing and infection control measures may impact or even reduce the response capabilities of a jurisdiction, the pandemic's impact on the work force population alone will greatly reduce the jurisdictional operations and capabilities. Planning estimates suggest that there may be up to a 40% absenteeism rate in the workforce due to illness. This impact will necessitate a complete paradigm shift in the way we accomplish our work.

To this end, this plan will outline those necessary changes and procedures that will be implemented in order to carry out our jurisdictional responsibilities. It will also create an integrated framework to support the jurisdictions and agencies/entities throughout the state as they attempt to respond to the impact of the pandemic upon their infrastructure. (For definitional purposes of this plan, infrastructure is defined as "workforce population".)

At such time as the Governor and/or Utah Department of Health determine that a pandemic is imminent, the Office of the Medical Examiner (OME), Department of Health (UDOH), Division of Homeland Security (DHLS), local Emergency Management agencies, local health departments, State Health Care Association, and local hospitals and care facilities, funeral homes and all other entities involved in fatality management will, or will begin to:

1. Provide and distribute guidance, information and updates on pandemic influenza and mass fatality management protocols to local jurisdictions, hospitals, and funeral homes, based upon state and local plans relative to specific outbreak epidemiology.
2. UDOH and local health will coordinate with the State Medical Examiner, funeral directors, emergency management, Hospice, law enforcement and other relevant staff in the adaptation of state and local plans to the specific outbreak epidemiology. This may include the development of specific procedures and protocols for the specific pandemic Influenza response.
3. DHLS, local emergency management and local health directors will review plans in regards to fatality management and communicate with local health care agencies.
4. Health care systems and local jurisdictions will review use of patient transfer and data tracking and exercise the data tracking within local health care systems.
5. UDOH and local Vital Statistics will train Medical Doctors, Health Department M.D.'s, funeral directors, OME, and other medical staff on use of EDEN.
6. All participants in fatality management will purchase and coordinate the delivery of supplies to aid local jurisdictions in mass fatality management. Stockpiles may include: PPE, body bags, identification tags, Bioseal, backboards and other items as deemed necessary.
7. Public Information Officers from all agencies and entities involved in fatality management will review and train as necessary, individuals in Joint Information Center/System protocols at the State, Tribal, Local and agency levels.
8. OME will review identification procedures and documentation practices, including protocol for unidentified bodies, correctly identifying pan flu victims, and suspicious cases.
9. Local emergency management will assist local agencies in developing and executing Memorandums of Understanding (MOUs) with local providers for storage and transport of bodies.
10. DHLS and local emergency management will establish and test communication pathways between all response entities involved in fatality management.

## 1.2 Pandemic Period

Once a Pandemic has been officially declared, all involved agencies will work together to:

1. Communicate information and share coordinated assistance regarding fatality management to local jurisdictions through the State EOC, UDOH Department Coordination Center, State Joint Information Center, local EOCs, local call centers and/or Joint Information Centers, and other established local informational sharing networks (per local protocols).
2. Utilize local emergency management and law enforcement networks to assist the State OME, funeral directors, medical and health care system, Hospice, and law enforcement to carry out fatality management operations, including necessary documentation practices, transport, storage, release and final disposition actions.
3. All entities should implement Just-In-Time training for staff in Pan flu protocols, Pan flu Call Center, protocol for unattended deaths, correctly identifying flu victims as opposed to suspicious cases at the local level, and other response functions and tasks.
4. Implement decedent tracking system in conjunction with the OME and other entities involved in the response as required.
5. Vital Statistics will ensure ready access to the electronic death entry (EDEN) system.
6. Respond to requests for supplies from the State stockpile and transport them to local jurisdictions. These supplies may include: PPE, body bags, Bioseal, backboards, and other items as needed.
7. Coordinate mutual aid use of crematoriums and/or cemeteries throughout the state as well as supplies and equipment necessary for final disposition.
8. Assist local jurisdictions in activating MOU agreements.
9. Medical facilities, Funeral Homes and Vital Statistics will coordinate records processing.
10. UDOH and DHLS will advise the Governor, and local emergency management and health officials will advise Chief Elected Officials, in necessary emergency actions that may need to be implemented to facilitate final disposition of the deceased.
11. Local emergency management and health department emergency coordinators will establish communication and information sharing between all entities at the local level for situational awareness and resource status.

*As most fatality management will be done at a local level, it will be imperative for emergency management to coordinate and communicate with the UDOH coordinator in the State EOC and to be in close contact with local entities to establish situational awareness and information. Coordination at all levels of State and local government will be crucial to the success of the response.*

## 1.3 Mortality Rates

### **Principle:**

All planning is based upon assumptions relative to specific hazards. This Pandemic Flu plan is based upon possible morbidity rates extrapolated from the Pandemic Flu outbreak of 1918. Based upon that outbreak, it is expected that Utah could experience death rates as high as approximately 15,930 victims (estimate taken from State Pan Flu Plan based on a severe outbreak similar to 1918). It is estimated that this “surge” on the funeral home industry could take place within as short a time frame as 6 weeks. This plan is based upon those projected death rates.

A table showing death rates based upon the 1918 Pandemic Flu outbreak is included. It is listed by county so that each county may identify their resource gaps in order to plan and implement a response to the fatalities that are expected.

Since the normal death rate in Utah is approximately 13,988 deaths per year (2007 year totals), it is reasonable to assume that funeral homes can expect a one (1) year case load within a 6 to 12 week period, in addition to their normal case loads.

**Figure 1.3 Projected Mortality Rates based upon 1918 Pan Flu (Severe Outbreak)**

<b>STATE/COUNTY</b>	<b>POPULATION 2006 Census</b>	<b>NUMBER OF ILL</b>	<b>NUMBER OF HOSPITALIZED</b>	<b>NUMBER OF DEAD</b>
Utah Totals	2,550,063	748,850	83,454	15,930
Beaver	6,294	1,901	209	40
Box Elder	47,197	13,543	1,490	284
Cache	98,662	30,743	3,382	646
Carbon	19,469	5,762	634	121
Daggett	947	290	32	6
Davis	276,259	82,912	9,120	1,741
Duchesne	15,701	4,513	496	95
Emery	10,698	3,148	346	66
Garfield	4,534	1,394	153	29
Grand	8,999	2,607	287	55
Iron	40,544	12,064	1,327	253
Juab	9,420	2,675	294	56
Kane	6,532	1,828	201	38
Millard	12,390	3,992	439	84
Morgan	8,134	2,558	281	54
Piute	1,347	407	45	9
Rich	2,040	626	69	13
Salt Lake	978,701	291,224	32,035	6,116
San Juan	14,365	4,333	477	91
San Pete	24,196	7,634	840	160
Sevier	19,640	5,848	643	123
Summitt	35,469	10,925	1,202	229
Tooele	53,552	15,551	1,711	327
Uintah	27,995	7,895	868	166
Utah	464,760	136,193	14,981	2,860
Wasatch	20,225	6,041	665	127
Washington	126,312	37,503	4,125	788
Wayne	2,544	758	83	16
Weber	213,247	63,812	7,019	1,340

## 2.0 Funeral Homes

### 2.1 Funeral Home Surge Planning

#### **Principle:**

Utah funeral homes can on average expect a death surge of up to 5 times their normal business. At the same time, they may lose 30-40% of their staff due to illness or other circumstances. In some areas of the state, funeral homes may not be able to keep up with the surge of death cases. While hospitals, alternate care facilities and nursing homes would quickly fill to capacity in a surge of sick and afflicted, Funeral Homes would also experience the same type of surge in death cases. This section will address procedures and policies relative to those decedents who have died “in-care” of a medical provider. This section (2.0) does not address those cases under the immediate jurisdiction of the OME.

#### **Procedure:**

In order to facilitate an effective and efficient response within the funeral home industry, it is imperative that industry-wide planning be implemented at this particular point in time. Funeral Homes should plan for a pandemic by:

1. Identifying alternate storage (trailers or facility) for the deceased.
2. Develop contracts with vendors that may be activated during a pandemic for temporary storage containers, refrigerator trucks, embalming supplies, caskets, vaults, alternate storage sites, etc.
3. Identify and train employees for cross training in case of loss of staff.
4. Identify and train volunteers to assist in all areas of the funeral home operation.
5. Stockpiling of key items such as PPE, body bags, gloves etc.
6. Develop processes for increased funeral home case load. Include processing increased numbers of case loads with decreased staffing.
7. Develop processes for increased burials and cremations. Assess with local emergency management, surge capabilities of all local cemeteries. Develop alternative burial resources as possible.
8. Coordinate with local emergency management and health department planners in developing resource lists for alternate storage (refrigerated trailers) in support of the OME for morgue operations (MFI) and in support of funeral homes operations (pan flu).
9. Assess, with local emergency management and burial vault manufacturers, methods to develop a process to increase production of vaults.

### 2.2 Death Certificates

#### **Principle:**

During a Pandemic Flu, the increase in the number of death certificates will greatly impact the final disposition process. Any delay in the registering of death certificates will impact the funeral homes and their ability to provide a timely final disposition. The State Electronic Death Entry Network (EDEN) system will be a critical component of the response. All personnel involved in the electronic death certificate process will be trained and urged to accommodate a quick and speedy resolution to all death certificate requirements.

#### **Procedure:**

UDOH will maintain EDEN and train personnel wherein:

1. The medical community can electronically input death information with electronic signatory certifications.

2. Funeral homes can access this program for final disposition approvals.
3. The OME can also access this program for cause and manner of death, identity information, and release to Next-of-Kin (NOK) for unattended or suspicious deaths.
4. State and Local Vital Statistics personnel will communicate and coordinate with each other in an attempt to encourage and train the medical profession in the use of EDEN and provide technical support during any emergency if so required.

## **2.3 State Codes and Administrative Rules**

### **Principle:**

The Funeral Home industry is regulated by State Codes and Administrative Rules. Utah Codes specifically governing the funeral home industry are found in Utah Code Annotated Title 58 Chapter 9 Utah Funeral Licensing Act. Administrative Rules governing the Funeral Home Industry are found in R156-9 Funeral Service Licensing Act Rules. Rules and codes regulating death certification can be found in Utah Code Title 26-Chapter 2 Utah Vital Statistics Act, and Rules relating to death certificates are found in R436.

Some of these codes and rules may delay the accelerated speed required to provide final disposition during a Pandemic Flu, and/or may impede the necessary processes that will be required to protect the funeral home workers, funeral directors, Deputy Investigators and the OME's office staff. UDOH, in conjunction with the Department of Public Safety (DPS), the Division of Homeland Security (DHLS) and the Department of Commerce will collaboratively seek relaxation of those rules pertaining to funeral services such as, but not limited to; embalming, cremations, final disposition and the making of funeral arrangements with the families, which may hinder the community response. The agencies will also work with other state agencies to implement necessary emergency changes in other state rules which may effect the speed necessary to protect the public and the aforementioned personnel.

### **2.3.1 Time Allowed for Registration and Transmittal of Certificates by Local Registrars to the State Registrar – State Rule R436-10 Birth and Death Certificates**

#### **Principle:**

State Rule R436-10-1 Registration and Transmittal of Certificates by Local Registrars to the State Registrar states in paragraph (6) that: "Original certificates shall be transmitted to the State Registrar within ten days of their receipt by the local registrar." During a Pandemic, the surge of increased numbers of decedents due to the pandemic may overwhelm funeral homes and local and state registrar offices to the extent that transmittal of death certificates may not be accomplished within the ten (10) day requirement.

#### **Procedure:**

The following actions will be undertaken upon the declaration of a health emergency due to a pandemic flu:

1. Local emergency management and health emergency coordinators will monitor (situational status only) the case load of local registrars and forward reports to the UDOH Coordinator in the State EOC.
2. UDOH, DPS, DHLS, and the Dept of Commerce will advise the Governor to relax this code as necessary.

### **2.3.2 State Administrative Rules R436-8-3 in relation to the Preparation of Bodies and Transportation**

#### **Principle:**

State code dictates that bodies must be embalmed or refrigerated within twenty four (24) hours (State Administrative Rules R436-8-3 Preservation of Bodies.) During a Pandemic, the surge on the Funeral Home industry may overwhelm funeral homes to the extent that they are unable to embalm or cremate within the 24 hour requirement. Funeral homes may find the need to temporarily store remains until they can be embalmed or cremated.

#### **Procedure:**

The following actions will be undertaken upon the declaration of a health emergency due to a pandemic flu:

1. The UDOH, DPS, DHLS will request the Governor to immediately relax the 24 hour requirement as part of his emergency powers.
2. Funeral Homes will be required to store the remains at 38 - 40 degrees Fahrenheit.
3. Local emergency management and health coordinators will assist with MOUs to obtain trailers and/or alternate facilities for the Funeral Home industry.
4. The Utah Funeral Directors Association will assist in coordinating mutual aid between funeral homes for embalming and/or storage assistance as necessary.

### **2.3.3 Social Distancing and PPE for Funeral Directors and Deputy Investigators**

#### **Principle:**

Funeral Directors, Deputy Investigators and the OME Office will need to maintain continuity of operations throughout a Pandemic Flu outbreak. Attached in this section are various actions that personnel can take to lessen the likelihood of being affected by the outbreak while attempting to maintain their operations. These actions will not guarantee freedom from sickness.

#### **Procedure:**

##### **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. Encourage coughing persons to isolate themselves from others.
- ❖ Use “Ask for a Mask” campaign materials (or other materials) to demonstrate the sequences for donning and removing personal protective equipment. 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.
- ❖ 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.
- ❖ Maximize the distance between employees and clients. Minimize exposure to others.

Implement social distancing protocols including but not limited to:

- a. Conduct meetings at a distance where possible. Utilize telecommunications capabilities; expand online and self-service options for customers and business partners.
- b. Hold conference calls instead of meetings.
- c. Encourage employees to get the annual flu shot and pneumococcal vaccine.
- d. 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.
- e. Move work stations further apart and stagger shifts.
- f. Determine which outside activities are critical to maintaining operations and develop alternatives.

- ❖ Refer to State Pan flu website for additional information:

<http://www.pandemicflu.utah.gov/index.htm>

## **2.4 Storage of Un-embalmed Bodies**

### **Principle:**

During a pandemic, some funeral homes may be unable to adequately store un-embalmed remains within their facility. Alternate storage must be arranged and properly implemented into the funeral home process.

### **Procedure:**

Funeral homes will essentially have 2 options to expand their ability to store un-embalmed remains.

#### Refrigerator Trailer

Funeral homes should have MOUs with trucking companies, trailer rental companies or other suppliers of refrigerated trailers. When the funeral home is unable to adequately store un-embalmed remains, a refrigerator truck can then be procured (rented or purchased) for the storage of all un-embalmed bodies until the funeral home is able to either bury or cremate the remains.

The funeral home shall provide 24 hour security. Maintenance and refueling for the refrigerator trailer(s) should be made part of any contract with a supplier.

*Local Emergency Management should have resource lists available of trucking companies and trailer rental companies or other suppliers of refrigerated trailers to make them available to local funeral homes. It is not the intent of this plan to make local government responsible for storage of remains. This is still considered a function of the funeral home industry.*

### Alternate Facility

If a refrigerator truck is unavailable, funeral homes may opt to have a designated facility identified within the community to store un-embalmed remains with the ability to control temperature. Use of alternate facilities will be allowed with the express approval of the local jurisdiction (ie., zoning, security, public health issues) . Selection of an alternative facility must be done with care as this building will carry a “stigma” with them from thenceforth.

Alternate facilities will necessitate the installation of a temporary temperature controlled system to control the temperature to 38-40 degrees Fahrenheit if the facility does not already have one. The facility will be run solely by the funeral home and only funeral home personnel are allowed access. The funeral home shall provide 24 hour security for facility.

Examples of suggested facilities would include but not be limited to: warehouses, insulated garages, and the like. Extreme care must be given in the selection process. Dignity of the deceased is not to be compromised.

*Local Emergency Management should also have resource lists available for possible facilities to use in the event funeral homes require assistance in finding them.*

### Transport to and From Alternate Facility and/or Refrigerator Trailer

Funeral Directors should follow the same general principles and concepts as found in “On Scene and Morgue Standard Operating Guidelines for Mass Fatalities Incidents” Section 2.5

Transportation of Remains to Incident Morgue and section 8.8 Transportation of Deceased from Morgue.

#### **2.4.1 Refrigerator Trailers**

##### **Principle:**

Funeral homes should have in their plans the name and contact number of a company (preferred to name three (3) companies in their plans) that is willing to enter into a contract (MOU) to provide the funeral home with a refrigerator trailer as needed. It would be prudent for the funeral home to pre-arrange with a trucking company or trailer rental company that can provide a sufficient number of refrigerator trucks to the funeral home in case of an emergency as well as provide on-going maintenance and refueling while the trailers are deployed as part of the contract. Use of trailers requires specific steps, procedures and actions.

##### **Procedure:**

The following actions will be undertaken upon the declaration of a health emergency due to a pandemic flu:

1. Funeral Homes should be prepared to receive one (1) years worth of cases within a 6-12 week period in addition to their normal case loads.
2. Refrigerator trailers shall have a metal floor.
3. Trailer should be parked in a secure fenced area. If that is not available, then security should be posted or contact local emergency management for assistance.
4. Use trailers with no visible company names.
5. Temperature of trailer is to be kept at 38-40 degrees Fahrenheit with low humidity.
6. Ramps should be built so that remains can be easily placed in or removed from trucks.
7. Refrigerator trucks can only hold up to 20-24 bodies per truck, no stacking allowed. Trailers can be laid out as shown below with an easily implemented mapping system.

Three examples are shown below. No matter the mapping system used, it should be easy to understand and follow.

## 2.4.2 Local Jurisdiction's Assistance in Storage of Un-embalmed Remains

### Principle:

Local Funeral Homes may need assistance in obtaining a secure site for refrigerated trailers.

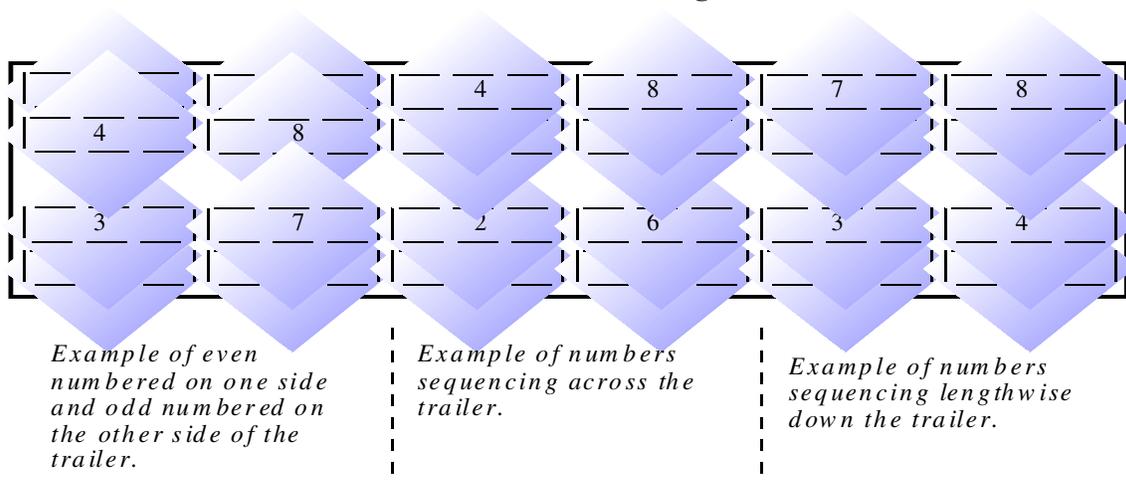
### Procedure:

Funeral Homes can call upon local Emergency Management (County or City) and/or local health districts to assist them in obtaining a secure site for refrigerated trailers, refrigerated trailers, or alternate facilities.

Examples of sites that can be considered for staging trailers are: Sheriff's Offices, Fire Stations, or other government sites that can be secured (minimum standard is fenced and locked gate).

Local jurisdictions may, at their option, determine if assistance in the transportation and storage of the remains from the place of death to the storage site is needed. The decision on whether or not to provide assistance to the funeral homes in this function will remain a local policy decision of the jurisdiction.

### Model shown herein is a 40 foot Refrigerator Trailer (Refer).



## 2.5 Un-embalmed Bodies/Family Viewing

### Principle:

Certain options apply to funeral homes pertaining to un-embalmed bodies and the desire of families to view their loved ones before final disposition.

### Procedure:

If remains are NOT being embalmed, then Funeral Directors will have the following options in viewing un-embalmed remains:

1. Direct Disposition in sealed casket. No viewing allowed after removal from place of death. In accordance with State Code Title 58 Chapter 9, Section 102, Paragraph 12 wherein Direct Disposition is defined as "the disposition of a dead human body: as quickly as law allows; without preparation of the body by embalming; and without an attendant funeral service or graveside service."

2. Immediate cremation. No viewing allowed after removal from place of death.
3. Viewing in casket. Viewing allowed only behind glass. No large crowds.
4. Funeral home may provide pictures and /or video of deceased prior to disposition.  
(With families written permission only)

## **2.6 Pre-Need Funeral Arrangements**

### **Principle:**

As defined in State Rule R156-9-618 “Goods and Services Not Provided – Refund”, any pre-need funeral goods and services arrangements and any unexpended earnings thereupon will be distributed to the pre-need contract buyer or the buyer's representative or in their absence, the buyer's heirs and beneficiaries. During a Pandemic Flu, requests pertaining to funeral ceremonies may be impossible to honor. While the person with the duty of burial shall honor to the extent reasonable and possible, Funeral Homes should not be held accountable for those requests that they are unable to honor.

### **Procedure:**

Local Health Directors, UDOH, and/or the Department of Commerce will respond to requests on a case-by-case basis from Funeral Directors regarding directives for issues arising from pre-need funeral requests that they are unable to honor. If the pre-need requests have been paid for, then the Funeral Home is required to refund that amount to the family.

## **2.7 Suspension of Funeral Services**

### **Principle:**

During a Pandemic Flu, social distancing will be a critical element of the actions that can be taken to contain, slow down, and or stop the spread of the disease. Cancellation of public gatherings will be imposed by city and county executives, local health officers, and UDOH. This action will assist staff at funeral homes who are a critical asset during this kind of health emergency. This will reduce the pandemic flu impact on the funeral home employees, both health wise and staffing wise (potential loss of 40% of personnel.)

Once the pandemic flu public health emergency is declared, city and county executives, local health officials and UDOH will declare that regular funeral services will be discontinued. Only short grave side services will be allowed upon request of the family and based upon local resource capabilities.

### **Procedure:**

Funeral Directors will have various options to protect themselves and their staff while allowing for some services for the families to be conducted.

1. Immediate burial - Casket interred - Families conduct own grave side w/out funeral home staff or cemetery representative present (preferred.)
2. Delayed Burial - Casket placed on Grave - Cemetery representative is present - Funeral Director may leave - Families conduct own grave side w/out funeral home staff present.
3. Delayed Burial - Casket lowered into vault - Cemetery representative is not present - Funeral Director can watch from distance - Families conduct own grave side w/out funeral home staff present.
4. Delayed Burial - Casket placed on Grave - Funeral Director may conduct short grave side if they desire while implementing appropriate social distancing procedures.  
(Refer to social distancing checklist Section 4.0).

## **2.8 Cremation**

### **Principle:**

Under normal operations, a crematory will produce visible smoke for about 10-12 minutes per case. This amount is not necessarily regulated. During a Pandemic Flu, it is anticipated that crematoriums will be used more extensively to help keep up with the surge on the funeral homes. If funeral homes operate their crematoriums on a constant basis, then crematoriums will out of necessity, produce more visible smoke than normal.

### **Procedure:**

UDOH, and DHLS will work with the Governor and the Utah Division of Air Quality to address any complaints or public information regarding the additional release of smoke from crematoriums, and will assist the Funeral Home industry in any issues arising from the increased use of crematoriums.

## **2.9 Relaxation of Funeral Director Requirements**

### **Principle:**

Under State Code, only licensed Funeral Directors or licensed Interns may participate in specific tasks when working with the dead. During a Pandemic Flu outbreak, funeral home staff may be called upon to assist in certain Funeral Director tasks. Funeral Directors may even be forced to call upon volunteers or public safety officials to assist them in their duties of responding to decedents and preparing them for final disposition.

### **Procedure:**

UDOH, DPS, DHLS and the Dept of Commerce will work with the Governor to review and to possibly relax certain restrictions pertaining to Funeral Directors related to State Code 58-9-305 and pertaining to exemptions from Administrative Rules R156-9-401, 402 and 403 , thus allowing unlicensed staff and volunteers to assist Funeral Directors in certain aspects of the process. While State Code currently allows for Staff to assist, restrictions should be reviewed allow for Funeral Directors to supervise assistance from untrained staff and funeral home volunteers and public officials to assist when and if needed. Strict supervision will be required.

## **2.10 Pan flu Call Center Protocols**

### **Principle:**

During a Pandemic Flu outbreak, there may be many questions that families will have if a loved one succumbs. UDOH and local health districts will need to provide exceptional amounts of information and address specific case-by-case questions that the public and responders may have regarding the emergency. A Pandemic Flu outbreak will make a centralized information Center impossible to activate and impractical to operate, to address concerns and questions that the public may have. To this end the State and local entities will create a virtual Call Center(s) to address the information and questions that the public will have.

### **Procedure:**

UDOH will create a virtual phone center by utilizing the Department Hotline Phone Bank system referred to as “Code Red” to provide public information. “Code Red” will be used by staff to inform the public and address case-by-case questions that may arise. The State and local emergency management and health agencies will:

1. Implement WebEOC to give Pan flu Call Center staff up- to-date information. WebEOC will also be used to post procedures and resource information that can be disseminated to the public.

2. Train designated staff in WebEOC, Code Red, and other critical programs that will aid them in answering questions from the public. Staff will also be trained in researching answers and directing the public to the proper agencies for answers.
3. Call Center staff (and all agencies involved in fatality management) will obtain and share information from and between Medical Doctors, Health Departments, funeral directors, OME, other medical staff, and the public.
4. Coordinate information processes with local health districts that have established call centers (JIC/JIS) in partnership with local emergency management.
5. Local health districts will partner with local emergency management in developing local call centers where practicable. This will mirror the “virtual” system by utilizing WebEOC and establishing forwarded call lines to employee homes where possible.

## **2.12 Burial Vault Manufacturing**

### **Principle:**

During a pan flu event, the increase in numbers of burials will overwhelm the burial vault manufacturing suppliers. The status quo within the vault manufacturing process will not maintain enough supply to keep up with demand. The unavailability of burial vaults will greatly impact the ability of the state to maintain a heightened response to fatality management. Vaults are constructed of cement which requires a curing period.

### **Procedure:**

Local emergency management will contact those local vault manufacturers in their area (if any) and establish emergency construction agreements/processes for forms used in the vault manufacturing process as well as a quickened curing timeline for the cement vaults that will not compromise their integrity.

1. Dimensions of vault forms will be used to create additional forms. Vault forms are metal and would be quickly fabricated in numbers sufficient to maintain supply. In some cases, this would only require an additional 3-4 forms.
2. Vault manufacturers usually allow for a one week processing and curing time for each vault. An abbreviated curing time would be implemented. Extra care in handling of the vaults will be required.

## **3.0 Office of the Medical Examiner (OME)**

### **Principle:**

In the State of Utah, the Utah Department of Health, Office of the Medical Examiner (OME) is charged with conducting death investigations according to the Utah Medical Examiner Act. As cited in Utah State Code Annotated Title 26 Chapter 4, the Medical Examiner has authority to: “conduct investigations and pathological examinations; perform autopsies authorized in this title; conduct or authorize necessary examinations on dead bodies; and notwithstanding the provisions of Subsection **26-28-122(3)**, retain tissues and biological samples for scientific purposes and those the medical examiner considers necessary to accurately certify the cause and manner of death. In the case of an unidentified body, the Medical Examiner shall authorize or conduct investigations, tests and processes in order to determine its identity as well as the cause of death” in jurisdictional cases only. The OME conducts investigations into the cause and manner of death and performs autopsies under authority of the Utah Medical Examiner Act.

By law, any suspicious or unattended death shall be reported to the OME. Every death that occurs as a result of violence or accident; suddenly when in apparent good health; in a suspicious

or unusual manner; or patients of the state hospital or inmates of a state, county, or city penal institution are subject to OME jurisdiction.

A local law enforcement officer investigating a death thought to be associated with Pan Flu may contact the OME for assistance in handling the death. The circumstances surrounding the death and law enforcement's involvement with the death will determine if OME involvement is warranted or if the case can be handled without OME involvement.

**It is not the goal of this plan, nor does the situation warrant, that the OME be involved with all deaths associated with Pan Flu.**

### **3.1 OME Protocol for Unattended Deaths**

#### **Principle:**

Historical evidence shows that victims of a Pandemic Flu may succumb suddenly and not have the advantage of a recent visit to a medical practitioner. This circumstance is technically referred to as an "unattended death."

During a public health emergency, Deputy Investigators from the OME will continue to be called upon to investigate deaths that fall within their jurisdiction. This will increase the Deputy Investigator's interaction with the public, and expose them to additional risk of the disease. If anticipated rates of sickness prevail, then the Deputy Investigators throughout Utah, may face a 40 percent reduction in personnel.

**The concern in response is not with those deaths that clearly warrant the OME initiate an investigation. The concern lies in not overloading the OME system with unnecessary cases.**

#### **Process:**

The OME will support, and Deputy Investigators will preplan their response by:

1. Evaluating their daily case load to establish a case load limit before implementing emergency processes. This will give them a point at which the normal day-to-day process is terminated and a non-routine protocol is implemented.
2. Once a non-routine case load limit is established then Deputy Investigators should consider the following procedure to be coordinated with and trained with local law enforcement:
  - A. Initiate a phone conference with on-scene local law enforcement investigator.
  - B. If situation is not suspicious, and if the attending physician is not authorized or refuses to sign a death certificate, then the Deputy Investigator will explore and pursue the most appropriate option ie., a terminated case, an absentia case, or a regular case.
  - C. If Deputy Investigator is unsure of the situation, then initiate a phone conference with OME to relay on-scene situation and circumstances.
  - D. If situation is suspicious and warrants investigation by OME, then coordinate transport to OME morgue for post mortem and autopsy as per normal protocols.

### **3.2 Storage at OME**

#### **Principle:**

The OME will need to establish alternate storage of remains if Pandemic Flu case load overwhelms existing storage capability.

#### **Procedure:**

The OME will follow the same general guidance and processes explained in preceding Sections 2.4 and 2.4.1 of this protocol. State DHLS and UDOH will support the OME in obtaining storage.

### **3.3 Transport to OME Morgue**

#### **Principle:**

Normal transport arrangements to the OME Morgue are presently coordinated by the OME, or local Deputy Investigator who may utilize local Funeral Homes for transport. During an Pandemic Flu, funeral homes that act as transport contractors may be impacted to the point of inoperability.

#### **Procedure:**

During a Pandemic Flu crisis, if any transports of decedents to the OME Morgue are not being met by the present system (funeral homes), then alternate transportation will be coordinated by the State EOC/UDOH Coordination Center. Alternate systems include:

1. Emergency contracting with different funeral homes and/or transportation companies.
2. Emergency contracting/utilization of local Law Enforcement covered pickup trucks.

### **3.4 OME Pan Flu Autopsies**

#### **Principle:**

There will be some cases where local law enforcement is unable to determine if a deceased victim has succumbed due to influenza and the death was unattended.

#### **Procedure:**

In those situations, the OME, at his discretion, may choose one of the following options:

- A. The OME may request local law enforcement to take nasal swabs, then hold the remains at the funeral home for 3-4 days while cultures are made. No transport to Salt Lake will be necessary unless the nasal swab is negative or inconclusive.
- B. A victim may be transported to Salt Lake for examination.
  - 1) A thorough external examination will be conducted.
  - 2) Nasal swabs will be taken for culture.
  - 3) OME will coordinate additional case loads with State Lab.
  - 4) Victim will be retained for 4 days until culture from nasal swabs can confirm Pan Flu as the cause of death.

### **3.5 State Code Title 26 Chapter 4 Section 16. Release of body for funeral preparations.**

#### **Principle:**

Under State Code 26-4-16, the Medical Examiner must release autopsied remains for funeral preparations no later than 24 hours after the arrival at the office of the Medical Examiner unless an extension is ordered by a District Court.

**Procedure:**

UDOH, and DHLS will work with District courts and the Attorney General's Office to address legal needs of the OME if the situation does not allow remains to be released within the 24 hour requirement.

## 6.0 Hospital/Medical Care Facility Plan

**Principle:**

During a Pandemic Flu, there will be a great demand placed upon both medical facilities and funeral homes for care of the deceased. The situation may arise that the demands placed upon these systems due to the surge of decedents will require short-term storage of those remains at medical facilities until arrangements can be coordinated for the release of the remains. Additionally, while short-term storage of remains may become a requirement of the surge, medical facilities may also find themselves in a situation where the normal post-mortem care for the decedents given by the medical facility may not be possible (i.e. washing, preparing for release, etc.).

### 6.1 Temporary Care of Decedents - Planning

**Principle:**

It is assumed, that the situation may arise wherein local Funeral Homes may be unable or unavailable to provide immediate pick up of remains from the Medical Facility. It is assumed, that Medical Facilities will be required to hold remains for short periods of time while arrangements for body removal can be accommodated. Medical Facilities must be prepared for contingencies related to additional demands placed upon them due to temporary storage of large numbers of decedents. Medical facilities may also need to request assistance from local emergency management, local health or state health agencies in this process. **This principle relates only to those victims dying at the facility. It is not intended that local medical facilities become temporary morgue sites for the entire community.**

**Process:**

Medical Facilities should include in their planning efforts, alternate, yet temporary (short-term), storage capabilities for the remains of those patients who have succumbed to Pan Flu while under their care at the facility. This should include planning for and training in the Electronic Death Entry Network (EDEN), mortality tracking/documentation, decreasing of the facility's post-mortem care of the remains, temporary storage of the remains, security for the storage area, staff assigned to fatality management, family support, release of the remains, and mental health support for the workforce. This process will be managed by the Hospital's emergency response team as outlined in their emergency operations plan.

#### 6.1.1 Declaration and Documentation

**Principle:**

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

**Procedure:**

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

1. Certify the death via the State electronic death certificate program.
2. Utilize mortality tracking/documentation system for those remains not immediately removed from the facility.
3. Notify Family in appropriate manner while protecting staff
4. Release remains only to a licensed Funeral Director or other authorized official

5. Maintain documentation of decedent's temporary/staging location and obtain signatory of release to Funeral Director/Authority.

## 6.2 Body Preparation

### Principle:

During normal operations, many, if not all Medical Facilities in the State of Utah, provide 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 UDOH, Medical Facilities should 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 bath the decedent.
4. Wrap the remains in the existing bedding (sheets) upon which they are lying, 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. The following information should be included on the outside of the pouch:
  - ❖ Time of Death \_\_\_\_\_ A.M \_\_\_\_\_ P.M.
  - ❖ Patient's Name \_\_\_\_\_
  - ❖ Patient's Home Address \_\_\_\_\_
  - ❖ Relative Responsible \_\_\_\_\_
  - ❖ Relative's Address or contact info \_\_\_\_\_
8. Caregivers should be dressed in PPE.
9. Remains are then to be wheeled on a gurney to an appropriate location in the facility to await arrival of the Funeral Home Director.
10. 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.
11. 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. Mis-identification of any decedent is not acceptable. Please refer to the "On-Scene and Morgue Standard Operating Guidelines for Mass Fatalities Incidents," Section 8.3 Final Identification Review for additional reference material which can be adapted to this aspect of the emergency response.

12. Personal effects of the decedent should be logged and given to family members. If family members are not present or available, then personal effects should be logged and placed with the remains and given to the funeral directors when they arrive.

### **6.2.1 Activation of Fatality Management Protocol**

#### **Principle:**

Medical Facilities must have a process in place to assess the impact of the situation on the transfer of remains to Funeral Directors, and activate facility resources when the surge has become unmanageable under normal protocols.

#### **Process:**

Alternate Storage protocols will be implemented when the facility is informed that Funeral Directors will be unable to respond to the facility for more than 6 hours or some other critical benchmark specific to that facility. The Facility's Crisis Management Team (CMT) will notify local health coordinators, and/or local emergency management of the activation of their fatality management protocols. Close coordination will be maintained throughout the incident between local emergency management officials and the facility. The facility will also notify local officials upon termination of the protocol.

### **6.3 Temporary Care of Decedents - Storage**

#### **Principle:**

Due to the demand placed upon the funeral home system, Medical Facilities may be required to store remains of patients who have died at their facility. **This is only for temporary (short-term) storage only.** Storage of the remains must be documented, secured, organized and orderly. There is a high degree of probability that deceased remains, once they are pouched, will not be viewed again by any family members. It must be stressed that transfer of the decedent's remains to the care of a Funeral Home should be accomplished as quickly as possible.

In addition to the logistical nature of this element, State code dictates that bodies must be embalmed or refrigerated within twenty four (24) hours (State Administrative Rules R436-8-3 Preservation of Bodies.) During a Pandemic, the surge on the Funeral Home industry may overwhelm funeral homes to the extent that they are unable to embalm or cremate within the 24 hour requirement. Funeral homes may not be able to respond to a health care facility to remove the decedents. Thus there may be a need to temporarily store the remains until they can be embalmed or cremated. This Code may hinder the facility's operations.

#### **Process:**

Medical Facilities should identify a location in their facility to temporarily "hold" remains until Funeral Homes can accommodate removal of the remains. Appropriate locations will vary from facility to facility but should all retain dignity and respect for the individual. Sites to consider include, but are not limited to:

1. Secure room that can be cooled separately by HVAC or open window in winter.
2. Secure Basement (cool)
3. Warehouse area / loading dock area attached to main facility which can be secured
4. Refrigerated Trailer placed in secure parking area at rear of facility or directly parked at loading dock area. *Note: The Medical Facility would be responsible for any costs associated with this option. There will be nothing to preclude the facility from recovering these costs from the family or from an agreement with local Funeral Homes.*
5. Any other appropriate location at the facility which can be secured.
6. Temporary storage should not be longer than 24-48 hours.
7. Staff must be assigned to manage and secure the temporary storage of remains.

8. Documentation must be maintained, and must be absolutely accurate as to the decedent's identity and their location in the temporary storage area. Please refer to forms in Appendix D - Planning Template: Facility Mass Fatality Management Plan
9. Funeral Homes will make it a top priority to retrieve remains from hospitals as quickly as possible.
10. UDOH, UDHLS will work with the Governor to relax R436-8-3 thus allowing medical facilities flexibility in temporary storage, while awaiting Funeral Home arrival.
11. Local emergency management and health coordinators will assist with MOUs to obtain trailers and/or additional necessary resources.
12. Remains must not be stacked. This demonstrates a lack of respect for the individuals, can distort the faces of the victims, makes the remains difficult to manage, makes individual tags and markings on the pouches difficult to read, and increases the risk of contamination of body fluids as pouch zippers will leak.
13. Do not freeze the remains. This will impact the tissue (dehydrate and change coloring) which can have a negative impact on interpretation of any injuries and hinder any visual recognition by the family members.
14. Rapid freezing can cause post-mortem injury including cranial fracture.
15. Handling frozen bodies can also cause fracturing.
16. Process of freezing and thawing accelerates decomposition of the remains.
17. Ice rinks are not an option for storage:
  - ❖ Bodies laid on ice will partially freeze and eventually stick to the ice sheet.
  - ❖ Ice rinks are dangerous for workers to walk on and this poses an unacceptable safety risk.
  - ❖ Clean up of body fluids will be difficult and mental impact on the general population will stigmatize the facility.
18. Do not use ice to cool the remains:
  - ❖ Remains will be difficult to manage due to ice weight and transport issues.
  - ❖ Very large amounts are required to preserve a body for even a short time.
  - ❖ Ice is difficult to obtain in an emergency and has a priority use for medical units.
  - ❖ Ice creates large areas of contaminated run off water.
19. Do not pack the remains with chemicals.
20. Do not use dry ice to cool the remains. While this procedure is acceptable in some areas, there are serious issues created by its use:
  - ❖ It is expensive and difficult to obtain. This procedure requires 22 pounds of dry ice per remain, per day.
  - ❖ Requires special handling to avoid "cold burns."
  - ❖ When dry ice "melts" it creates carbon dioxide gas which can be toxic.
21. Refrigeration will not stop decomposition, it only delays it.
22. Factors that affect decomposition:
  - ❖ Temperature
  - ❖ Humidity
  - ❖ Surface where the body lies
  - ❖ Water
  - ❖ Fire
  - ❖ Condition of the person prior to death
  - ❖ Wrapping/coverings
23. Floor can be used to place remains on. Whenever possible, use beds, gurneys, cots, or racking systems.

24. Staff safety must be paramount. Standard precautions are essential for those handling dead bodies.
25. In hazmat or WMD events, the appropriate level of PPE is required depending on the agent.

### 6.3.1 Refrigerator Trailers

#### Principle:

Medical Facilities should have in their plans the name and contact number of a company (preferred to name three (3) companies in their plans) that is willing to enter into a contract (MOU) to provide the facility with a refrigerator trailer as needed. It would be prudent for the facility to pre-arrange with a trucking company or trailer rental company that can provide a sufficient number of refrigerator trucks in case of an emergency as well as provide on-going maintenance and refueling while the trailers are deployed as part of the contract. Use of trailers requires specific steps, procedures and actions.

#### Procedure:

The following actions will be undertaken upon the declaration of a health emergency due to a pandemic flu:

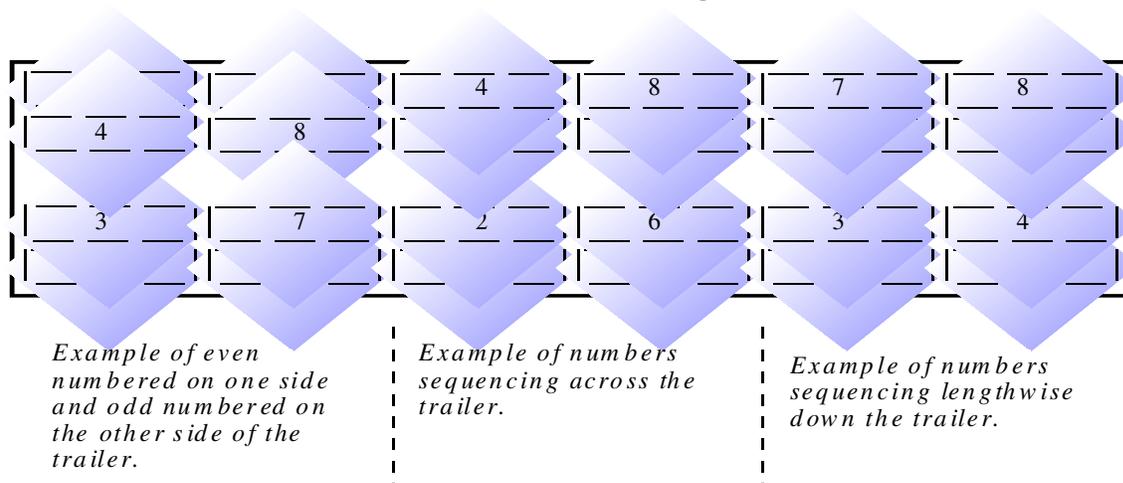
1. Refrigerator trailers shall have a metal floor.
2. Trailer should be parked in a secure fenced area. If that is not available, then security should be posted or contact local emergency management for assistance.
3. Use trailers with no visible company names.
4. Temperature of trailer is to be kept at 38-40 degrees Fahrenheit with low humidity.
5. Build ramps so that remains can be easily placed in or removed from trucks if a loading dock is not available.
6. Refrigerator trailers (40') can only hold up to 20-24 bodies per truck, **no stacking allowed**. Trailers can be laid out as shown below with an easily implemented mapping system. Three examples are shown below. No matter the mapping system used, it should be easy to understand and follow.
7. If shelving is desired, then care should be given to build one level of shelves on the outside row (along the wall of the trailer) of bodies. Enough room must remain below the shelf for easy access to the remains of the floor of the trailer. Shelves will make it difficult to access remains along the wall of the trailer. Shelves should not be lower than 4 feet. **Caution:** Inside rows of remains on floor may need to be removed to access remains on outside rows of floor which will increase chance of confusion. Staff must be careful when lifting remains on or off of the shelves.

### 6.3.2 Local Jurisdiction's Assistance in Storage of Un-embalmed Remains

#### Principle:

Local medical facilities and funeral homes may need assistance in obtaining a secure site for refrigerated trailers.

**Model shown herein is a 40 foot Refrigerator Trailer (Refer).**



#### Procedure:

Funeral Homes can call upon local Emergency Management (County or City) and/or local health districts to assist them in obtaining a secure site for refrigerated trailers, refrigerated trailers, or alternate facilities.

Examples of sites that can be considered for staging trailers are: Sheriff's Offices, Fire Stations, or other government sites that can be secured (minimum standard is fenced and locked gate).

Local jurisdictions may, at their option, determine if assistance in the transportation and storage of the remains from the place of death to the storage site is needed. The decision on whether or not to provide assistance to the funeral homes in this function will remain a local policy decision of the jurisdiction.

Local medical facilities can call upon local Emergency Management (County or City) and/or local health districts to assist them in obtaining security for their refrigerated trailers. While the nature of the fatality management process does not preclude a medical facility from obtaining an alternate location for a trailer, selecting a site away from the facility does not seem practical. Hospitals should consider security staff if they choose to utilize a trailer for storage of human remains.

### 6.3.3 Assistance in Storage of Remains

#### Principle:

Medical Facilities may be unable to secure a location in their facility for the temporary (short-term) storage of remains.

**Procedure:**

- 1) Medical Facilities can arrange for off-site surge capacity if necessary. Memorandums of Understanding, and/or contractual agreements would need to be implemented.
- 2) Medical Facilities can call upon local Emergency Management (County or City) and/or local health districts to assist them in obtaining a refrigerated trailer for use at their facility. UDOH will also be available to local health and emergency management if local resources are unavailable.
- 3) Please refer to the “On-Scene and Morgue Standard Operating Guidelines for Mass Fatalities Incidents,” Section 8.1 Post Identification Holding in the Incident Morgue, for additional storage information and guidelines.
- 4) Again, it must be stressed that transfer of the decedent’s remains to the care of a Funeral Home should be accomplished as quickly as possible. Body retrieval will be a top priority of Funeral Homes.

**6.3.5 Assistance in Transportation of Remains****Principle:**

If Medical Facilities are unable to secure a location at their facility for the temporary (short-term) storage of remains, other resources in the community may be called upon to assist in the transportation of remains to the Funeral Home. Medical Facilities may also, if capable, elect to transport the remains to the Funeral Home if the Funeral Home is unable to transport.

**Procedure:**

Medical Facilities can call upon local Emergency Management (County or City) and/or local health districts to assist them in coordinating the transportation of remains to a storage site at a Funeral Home. UDOH can also be contacted if local resources are unreachable or unavailable by local health or local emergency management.

It must be noted that local jurisdictions will make the final determination if assistance in the transportation and storage of the remains from the place of death to the storage site is necessary, appropriate, or supportable by local government. This will remain a local policy decision of the jurisdiction. Pre-disaster coordination with local law enforcement, Funeral Homes, and Emergency Management agencies is required. Transportation of remains to the Funeral Homes must be a high priority of this response in order to protect the medical infrastructure.

**6.3.5.1 Transfer of Remains to Funeral Home****Principle:**

Verification of the decedent’s remains must be documented by the Funeral Home. Care should be given to not relax security protocols or release of remains protocols due to the emergency.

**Procedure:**

Upon arrival of the Funeral Home, appropriate hospital personnel will identify the location of the decedent in the temporary storage area, if one has been created, and escort the Funeral Home Director to the room where the remains are being kept. Personnel will be properly dressed in PPE and will verify with the Funeral Home Director, the identity of the decedent using the hospital wristband, and any other documentation present. The Funeral Director will verify receipt of the remains. Logs will be signed verifying receipt of the decedent. Refer to HR Release Log form.

### 6.3.6 Unclaimed Remains

**Principle:**

Given the dynamics of the community, there may be situations where remains are unclaimed, either from lack of identification, or inability to contact family (Next of Kin-NoK), or refusal of the NoK to claim the remains. Hospitals should understand the framework available to assist them in the removal of these remains from their facilities.

**Procedure:**

Facilities have two options to pursue, depending on whether or not the decedent's remains are identified or not.

1. If the decedent is not identified, refer case to the OME. The OME will attempt to establish identity, only. Counties are responsible for final disposition as outlined in State Code 26-4-25. Burial of Unclaimed Body, for unclaimed remains.
2. If the decedent is identified, refer case to local officials via local city/county EOC.

In either case, the remains will be removed, and referred to a Funeral Home for final disposition.

### 6.4 Medical Facility Planning

**Principle:**

Once a public health emergency has been declared, it is advised that all medical facilities implement an action plan which will enable the facility to provide a continuation of services to the community, while protecting its most valuable resource, the workforce. An operational template for Pan Flu Continuity of Operations and Response is necessary for each medical facility. Local medical facilities must implement a Pan Flu emergency response and can use this template or modify it for use within their facilities, as applicable.

**Procedure:**

A basic template for planning assistance regarding a medical facility's response actions is included in Appendix –D-. Medical facilities can adopt the following plan, in part or in its entirety as part of their facility plan for fatality management or refer to the simpler version in Appendix –D-.

#### 6.4.1 Sample Plan Outline

**Principle:**

During the planning process, facilities can be assisted in their planning efforts through use of a simple plan outline.

**Procedure:**

Facilities can use this outline as the basis for their fatality management plan and include any of the concepts as outlined in any section of this plan, in full or in part, or adapt the concepts herein, in any manner necessary to accommodate their specific planning situation.

1. Purpose, Scope and Planning Assumptions
2. Authorities - Promulgation
3. Plan Activation, Triggering Point, Procedures
  - a. Who Activates
  - b. Notifications
  - c. Events (internal and/or external) that activate the plan
  - d. Who does what to activate this plan

4. Fatality Management
  - a. Fatality Management Team – Who is assigned
  - b. Staffing Needs (sliding scale based on numbers of deceased)
  - c. Location of Morgue (Where to store bodies) 3 options
  - d. Equipment and or supplies needed
  - e. Procedures for Temporary Care of Decedent
  - f. Procedures for Decedent Identification and Tracking
  - g. Procedures for Electronic Death Entry Network (EDEN)
  - h. Procedures for Personal Property and Evidentiary Chain of Custody
  - i. Forms
  - j. PPE, Staff Infection Control (if applicable or referenced to other plan)
5. Coordination/Liaison
  - a. Local Emergency Management and Health Coordinators
  - b. Local Funeral Homes, Contact numbers
  - c. Call Centers (State and Local)
6. Psychosocial Considerations
7. Plan Evaluation
  - a. Revision Process
  - b. Training and Exercise
8. Call out Lists, Resource lists, References, Related Documents

Many of the concepts, principles and procedures in this plan can be used by any facility in whole or in part.

Medical facilities should carefully examine and consider elements found in other sections of this plan and incorporate those applicable concepts into their own plan. At the very least, medical facilities should be familiar with other sections in this plan so that they understand the relationships and procedures used by all members of the community's fatality management team.

## **6.5 Notification/Activation**

### **Principle:**

Once the medical facility has 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 agency by the local public health district or local emergency management. The point of contact will likely be the Hospital Emergency Coordinator (as outlined in existing emergency operations plans).

### **Procedure:**

Once notified, the medical facility should activate some level of an emergency response team as outlined in their Emergency Operations Plan (EOP) which will be the official source of health information to employees and the command and control of the facility throughout the duration of the emergency. Any new directives regarding operational assignments, or calls for service will be reviewed, and where appropriate responded to as directed by the facility's emergency response team.

The staff managing the incident for the facility will meet as appropriate or as outlined in existing emergency operations plans. (preferably twice daily). 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 center through Web-EOC or other similar programs, or even the use of e-mail, may be implemented.

Facilities should refer to existing emergency operations plans for direction on plan activation.

## **6.6 Liaison with Public Health Agencies**

### **Principle:**

Close coordination, communication and information sharing between local medical facilities and local health and emergency management agencies is critical to support the community's response to the Pandemic.

### **Procedure:**

If possible, communications/liaison with the local EOC (City/County/Local Public Health) should be established. The Liaison shall participate in the EOC (or rather "virtual EOC") to provide the agency with the best possible health information coming from the area. The facility would provide this liaison officer with daily updates of health related issues at the medical facility. 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 EOC. If providing a Liaison is not possible, close communications between the agency and the EOC will be maintained throughout the incident.

## **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 Law Enforcement 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.