

# Mass Fatality Plan

## EOP Functional Annex 7



**State of Tennessee Department of Health**

**2013**

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## I. Authorities

- A. Tennessee Department of Health Mass Fatality Plan
- B. Tennessee Code Annotated (TCA) Title 38 Prevention and Detection of Crime, Chapter 7, Post-Mortem Examinations, Part 1, Post-Mortem Examination Act, TCA 38-7-101 (2012), Short Title, This part shall be known and may be cited as the "Post-Mortem Examination Act."

### 38-7-102. Post-mortem examination division.

The department of health is authorized and empowered to create and maintain a post-mortem examination division or service. The division or service shall have as its functions the investigation of certain deaths as defined in this part, and the keeping of full and complete records of all reports on investigations and examinations made pursuant to the provisions of this part. The commissioner of health, acting for the state and with the approval of the governor and considering the recommendation made by the Tennessee medical examiner advisory council, shall appoint a chief medical examiner to direct the division or service, and such other personnel as the commissioner may find appropriate to the enforcement of the duties and powers of this part. The commissioner is authorized and empowered to spend such funds as may be appropriated for the enforcement of this part, and to promulgate rules through the department of health to establish fees for autopsies, guidelines for death investigations and forensic autopsies, and other costs and services associated with this part.

HISTORY: Acts 1961, ch. 174, § 2; 1980, ch. 810, § 2; T.C.A., § 38-702; Acts 2008, ch. 969, § 1.

### 38-7-103. Chief medical examiner -- Deputies and assistants -- Duties and authority.

(a) The chief medical examiner shall be a physician with an unlimited license to practice medicine and surgery in the state of Tennessee, or who is qualified and eligible for such license, and shall be required to obtain a license within the six-month period after employment. The chief medical examiner shall be a pathologist who is certified by the American Board of Pathology and who holds a certificate of competency in forensic pathology. In addition to the chief medical examiner's other administrative duties, the chief medical examiner's educational duties shall include developing and providing initial training and regular continuing education to all county medical examiners and medical investigators. The chief medical examiner shall be appointed to a five-year term, and may serve unlimited consecutive terms.

(b) The Tennessee medical examiner advisory council shall recommend to the chief medical examiner three (3) deputy state medical examiners, one (1) from each grand division of the state. The chief medical examiner, in consultation with the advisory council and with the approval of the commissioner of health, shall appoint the three (3) deputy state medical examiners and any assistant state medical examiners needed for regional administrative, professional and technical duties. The deputy medical examiners shall be based in one (1) of the state forensic centers. These state medical examiners shall have the same qualifications as the chief medical examiner. In addition to their other administrative, professional and technical duties, the deputy and assistant state medical examiners may lecture to medical and law school classes and conduct such special classes for county medical examiners, law enforcement officers and other

investigators.

(c) The chief medical examiner shall have investigative authority for certain types of death that are in the interests of the state, including mass fatality incidents, for the identification, examination and disposition of victims' remains, and instances that represent a threat to the public health or safety, or both.

**HISTORY:** Acts 1961, ch. 174, § 3; T.C.A., § 38-703; Acts 1994, ch. 775, §§ 1, 2; 2008, ch. 969, §§ 2-4.

38-7-104.County medical examiner.

(a) A county medical examiner shall be appointed by the county mayor, subject to confirmation by the county legislative body, based on a recommendation from a convention of physicians resident in the county. A county medical examiner shall be a physician who is either a graduate of an accredited medical school authorized to confer upon graduates the degree of doctor of medicine (M.D.) and who is duly licensed in Tennessee, or is a graduate of a recognized osteopathic college authorized to confer the degree of doctor of osteopathy (D.O.) and who is licensed to practice osteopathic medicine in Tennessee, and shall be elected from a list of a maximum of two (2) doctors of medicine or osteopathy nominated by convention of the physicians, medical or osteopathic, resident in the county, the convention to be called for this purpose by the county mayor.

(b) If it is not possible to obtain an acceptance as a county medical examiner from a physician in a county, authority is given for the election of a county medical examiner from an adjacent or another county. A county medical examiner, when temporarily unable to perform the duties of the office, shall have the authority to deputize any other physician in the area to act as county medical examiner during the absence. If the county legislative body fails to certify a county medical examiner for a county or if the county medical examiner resigns or is unable to fulfill the duties of the office during the interim between county legislative body sessions and a deputy has not been appointed by the county medical examiner, the chief medical examiner shall have the authority to appoint a county medical examiner to serve until the next session of the county legislative body.

(c) A county medical examiner shall serve a five-year term, and shall be eligible for reappointment by the county mayor with confirmation by the county legislative body.

(d) Whenever any county medical examiner shall be called as a witness in any proceedings before the grand jury or in any criminal case, the county medical examiner shall receive from the county as compensation for services as witness a fee as shall be determined by the court before which the proceedings are conducted, unless the fees are paid under provisions of § 38-7-111 [repealed].

(e) The county medical examiner may be suspended by the county mayor for good cause, which shall include, but not be limited to, malfeasance in the performance of the duties of a county medical examiner, criminal conduct, or behavior that is unethical in nature or that is in violation of a relevant code of professional medical responsibility. The suspension shall be for a period of ninety (90) days. At the end of the ninety (90) day period, the suspension shall terminate, unless the county mayor has recommended to

the county legislative body in writing that they remove the county medical examiner from office. If the county mayor recommends removal of the county medical examiner, then the county legislative body shall vote on whether to remove the county medical examiner from office within ninety (90) days of the date of the written recommendation. A majority vote shall be required in order to remove the county medical examiner from office. If a majority of the county legislative body does not vote for removal of the county medical examiner from office, then the suspension of the county medical examiner shall terminate immediately.

(f) (1) A medical investigator shall be a licensed emergency medical technician (EMT), paramedic, registered nurse, physician's assistant or a person registered by or a diplomat of the American Board of Medicolegal Death Investigators and approved by the county medical examiner as qualified to serve as medical investigator.

(2) If the county has an elected coroner, the coroner shall serve as the medical investigator for the county; provided, that such coroner meets the qualifications for a medical investigator set out in subdivision (f)(1). If the coroner is not qualified to serve as medical investigator, then the county legislative body shall, by resolution, either authorize the county medical examiner to appoint a medical investigator subject to confirmation by the county legislative body, or provide for this function through a contract for service approved by the county medical examiner and the county legislative body; provided, however, that, if the county has an elected coroner who has served in that capacity for ten (10) years or more, such coroner shall serve as the medical investigator for the county, regardless of whether the coroner meets the qualifications set out in subdivision (f)(1).

(3) The county medical investigator may conduct investigations when a death is reported, as provided in § 38-7-108, under the supervision of the county medical examiner. The county medical investigator may make pronouncements of death and may recommend to the county medical examiner that an autopsy be ordered. However, the county medical investigator shall not be empowered to sign a death certificate. The county medical examiner may delegate to the county medical investigator the authority to order an autopsy.

(g) County medical examiners and medical investigators shall be required to receive initial training and regular continuing education through the chief medical examiner and to operate according to the death investigation guidelines adopted by the department of health.

HISTORY: Acts 1961, ch. 174, § 4; 1967, ch. 399, § 1; 1969, ch. 21, § 1; 1971, ch. 246, § 1; 1977, ch. 141, § 1; impl. am. Acts 1978, ch. 934, §§ 7, 36; T.C.A., § 38-704; Acts 1983, ch. 12, § 1; 1994, ch. 775, § 3; 2003, ch. 90, § 2; 2004, ch. 651, §§ 1, 2; 2005, ch. 472, § 1; 2008, ch. 969, §§ 5-10.

38-7-105. Facility for performance of autopsies.

All autopsies must be performed at a facility accredited by the National Association of Medical Examiners (NAME). A facility must receive accreditation from NAME within one (1) year of July 1, 2011, maintain that accreditation, and operate pursuant to NAME guidelines.

HISTORY: Acts 1961, ch. 174, § 5; 1967, ch. 399, § 2; 1968, ch. 626, § 1; impl. am. Acts 1978, ch. 934, §§ 7, 16, 36; T.C.A., § 38-705; Acts 1994, ch. 775, § 4; 1995, ch. 258, § 1; 2008, ch. 969, § 11; 2009, ch. 392, § 1.

38-7-201. Tennessee medical examiner advisory council -- Creation -- Members.

(a) There is created the Tennessee medical examiner advisory council. The council shall consist of nine (9) members, each of whom shall be a resident of this state. The director of the Tennessee bureau of investigation shall be a permanent member of the council. The governor shall appoint one (1) district attorney general, one (1) district public defender, three (3) county medical examiners, one (1) from each grand division of Tennessee, one (1) licensed funeral director, and one (1) public citizen to the council. The commissioner of health or the commissioner's designee shall serve as an ex-officio, nonvoting member of the council. All regular appointments to the council shall be for terms of three (3) years each, with a maximum of two (2) consecutive terms. Each member shall serve until a successor is appointed. Vacancies shall be filled by appointment of the governor for the remainder of the unexpired term.

(b) Each member of the council shall receive reimbursement for travel expenses in accordance with the comprehensive travel regulations promulgated by the department of finance and administration and approved by the attorney general and reporter.

(c) The council shall organize annually and select a chair and other officers as needed. Meetings shall be held at least annually with additional meetings as frequently as may be required.

(d) The council shall have the power and duty to:

(1) Review candidates and make a recommendation to the commissioner of health on the appointment of the chief medical examiner and deputy state medical examiners;

(2) Assist the chief medical examiner in the development and updating of guidelines for death investigations and forensic autopsies in this state, to be promulgated as rules through the department of health; and

(3) Issue an annual report on death investigations in this state.

HISTORY: Acts 2008, ch. 969, § 23.

C. Tennessee Code Annotated (TCA) Title 68 Health, Safety and Environmental Protection, Health, Chapter 4 Disposition of Dead Bodies, Tenn. Code Ann. § 68-4-103 (2012)

68-4-103. Persons dying in publicly-supported institutions or to be buried at public expense -- Notice to relatives -- Notice to chief medical examiner -- Removal of body -- Embalming -- Infectious or contagious cases.

(a) Whenever a person dies in any hospital, infirmary, mental health institute, poorhouse, penitentiary, house of correction, workhouse, jail, or other charitable or penal institution that is supported in whole or in part at public expense, or whenever a body is delivered to a public official for the purpose of burial at public expense, it is the duty of the public official or of the custodian, superintendent or active head of such institution to

immediately notify the nearest or other relative of the person, if any relative be known, of the person's death.

(b) (1) After the notification pursuant to subsection (a), the custodian, superintendent or active head of the institution or public official shall then hold the body of the deceased person not less than ninety-six (96) hours, and if at the end of that time no relative claims the dead body and no provision has been made for its interment other than at public expense, then the custodian, superintendent or active head or public official shall notify the chief medical examiner or the chief medical examiner's representative that the custodian, superintendent or active head or public official has the body, and, upon demand by the chief medical examiner or the chief medical examiner's representative, shall deliver or surrender the body to the chief medical examiner or the chief medical examiner's representative or to either of their order.

(2) Notification shall be made in any manner that the chief medical examiner shall direct and all the expense of notification and delivery or surrender of the body shall be at the expense of and shall be borne by the institution obtaining the dead body.

(c) If the chief medical examiner or the chief medical examiner's representative, upon receipt of the notification, does not, within twenty-four (24) hours, make a demand for the body, then it shall be buried as provided by law.

(d) No custodian, superintendent or head of a charitable or penal institution or public official shall charge, receive or accept money or other consideration for any body.

(e) The chief medical examiner may, by proper instructions, have the body embalmed by such person as the chief medical examiner may direct, and, to the person performing this work under the chief medical examiner's instructions the institution receiving the body shall pay a reasonable compensation.

(f) No person who has died of any contagious or infectious disease shall be held to be within §§ 68-4-102 -- 68-4-109, unless proper precautions, as prescribed by the chief medical examiner, are taken to prevent the spread of contagions or infections.

**HISTORY:** Acts 1947, ch. 163, § 2; C. Supp. 1950, § 2569.9 (Williams, § 5379.2); Acts 1955, ch. 34, § 2; T.C.A. (orig. ed.), § 53-505; Acts 1984, ch. 525, § 4; 1990, ch. 598, § 4; 1996, ch. 744, § 2.

C. Public Law 93-28, Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended

D. Title 44 (Emergency Management and Assistance), Code of Federal Regulations

## **II. Purpose**

The purpose of this plan is to outline the concept of operations and identify specific roles and responsibilities of State of Tennessee departments and private organizations in responding to mass fatality incidents within Tennessee.

### III. Acronyms and Explanation of Terms

#### A. Acronyms

AC	Area Command
CDC	Centers for Disease Control and Prevention
CME	Chief Medical Examiner
DHHS	United States Department of Health and Human Services
DME	Deputy Medical Examiner
DMORT	Disaster Mortuary Operational Response Team
DoD	United States Department of Defense
DVA	United States Department of Veteran Affairs
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EMS	Emergency Medical System
EPI	Emergency Public Information
ESC	Emergency Services Coordinator
FAC	Family Assistance Center
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
FI	Forensic Investigator
IC	Incident Command(er)
ICP	Incident Command Post
ICS	Incident Command System
JFSOC	Joint Family Support Operations Center
JIC	Joint Information Center
MACP	Mortuary Affairs Collection Point
MAS	Mortuary Affairs System
ME	Medical Examiner
MFMG	Mass Fatality Management Group
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NTSB	National Transportation Safety Board
OCME	Office of the Chief Medical Examiner
PIO	Public Information Officer
SEOC	State Emergency Operations Center

TCA	Tennessee Code Annotated
TDH	Tennessee Department of Health
TEMA	Tennessee Emergency Management Agency
TEMP	Tennessee Emergency Management Plan
UC	Unified Command

## **B. Definitions**

1. The post-mortem examination division or service per TCA is under the direction of the department of health. The division or service shall have as its functions the investigation of certain deaths as defined in this part, and the keeping of full and complete records of all reports on investigations and examinations made pursuant to the provisions of this part. The commissioner of health, acting for the state and with the approval of the governor and considering the recommendation made by the Tennessee medical examiner advisory council, shall appoint a chief medical examiner to direct the division or service, and such other personnel as the commissioner may find appropriate to the enforcement of the duties and powers of this part. The commissioner is authorized and empowered to spend such funds as may be appropriated for the enforcement of this part, and to promulgate rules through the department of health to establish fees for autopsies, guidelines for death investigations and forensic autopsies, and other costs and services associated with this part.
2. Area Command (AC): An organization established (1) to oversee the management of multiple incidents that are each being managed by an ICS organization or (2) to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned. Area Command sets overall strategy and priorities, allocates critical resources according to priorities, ensures that incidents are properly managed, and ensures that objectives are met and strategies followed. Area Command becomes Unified Area Command when incidents are multi-jurisdictional.
3. Chief Medical Examiner: The governing forensic pathologist for the Tennessee Department of Health, Office of the Chief Medical Examiner authorized to carry out the provisions of the Tennessee Code Annotated (TCA) Code 38-7-101 through 38-7-105, 38-70201 and 68-4-103.
4. Disaster Mortuary Operations Response Team (DMORT): A DMORT is a team of experts in the fields of victim identification and mortuary services. DMORTs are activated in response to large scale disasters in the United States to assist in the identification of deceased individuals and storage of the bodies pending the bodies being claimed. DMORTS are federal resources and can be requested by a local government through the state Emergency Operations Center or state health department.
5. Family Assistance Center (FAC): The purpose of a FAC is to serve as a location for exchange of information between families of victims and appropriate governmental agencies for the purposes of identifying victims and reunifying families. It is a physical facility, staffed by trained professionals who have the expertise to gather

identifying information that will assist in the identification of deceased victims and the reunification of missing victims with their families. Examples of actual locations might include community centers, office buildings, hotels, or unused military facilities.

6. Health Officer: Health officer means the Commissioner of Health or the duly designated representative of the health officer of each of the 95 counties and the duly designated representative of the health officer, or both.
7. Incident Command System (ICS): A model for disaster response that uses common terminology, modular organization, integrated communications, unified command structure, action planning, manageable span-of-control, pre-designated facilities, and comprehensive resource management. In ICS there are five functional elements: Command, Operations, Logistics, Planning, and Finance/Administration.
8. Joint Family Support Operations Center (JFSOC): The JFSOC is a central location where participating organizations are brought together by the responsible airline to monitor, plan, coordinate, and execute a response operation maximizing the utilization of all available resources following an aviation accident or incident.
9. Joint Information Center (JIC): The JIC is a facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating agencies should co-locate at the JIC.
10. Mass Fatality Incident: An event that results in more fatalities than the local mortuary affairs system can handle utilizing the usual standard of care and processes.
11. Medical Examiner (ME): A Chief Medical Examiner, Deputy Chief Medical Examiner, or Assistant Medical Examiner who is a forensic pathologist authorized to carry out the provisions of Tennessee Annotated Code 38-7-101 through 38-7-105, 38-70201 and 68-4-103.
12. Medical Investigators (MI): A person appointed by the Office of the Chief Medical Examiner who has privileges to enter a crime scene and investigate the circumstances surrounding deaths meeting Office of the Chief Medical Examiner reporting criteria TN 38-7-104g.
13. Mortuary Affairs Collection Point (MACP): MACPs are locations throughout the community where non-contaminated remains are collected, stored, and preserved before being transported to the incident morgue or released to the funeral home chosen by the next of kin.
14. Mortuary Affairs System (MAS): The MAS is a collection of agencies (public and private) all working within a common system that cares for the dead. The MAS addresses the entire spectrum of operations which includes search, investigation of scene and interviewing of witnesses, recovery, presumptive (tentative) and positive identification services, releasing of remains, and final disposition by the next of kin's requested preference regarding funeral services.
15. National Disaster Medical System (NDMS): A nation-wide mutual aid network consisting of federal agencies, businesses, and other organizations that coordinates

disaster medical response, patient evacuation, and definitive medical care. At the federal level, it is a partnership among the Department of Health and Human Services (DHHS), the Department of Defense (DoD), the Department of Veterans Affairs (DVA), and the Federal Emergency Management Agency (FEMA). Non-federal participants include major pharmaceutical companies and hospital suppliers, the National Foundation for Mortuary Care, and certain international disaster response and health organizations.

16. National Incident Management System (NIMS): A system mandated by Homeland Security Presidential Directive (HSPD) 5 that provides a consistent nationwide approach for federal, state, local and tribal governments; the private-sector and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size or complexity.
17. Temporary Autopsy Facility: A temporary autopsy facility is a facility established to store bodies prior to transport, serve as a facility for visual identification, or serve as a substitute location for the routine processing and related activities at the Office of the Chief Medical Examiner's facility or other Regional Forensic Autopsy facility.
18. Temporary Burial (interment): Temporary burial is a process of burying remains to preserve the remains. When or if utilized, the remains are positively identified, properly tagged, placed into a protective container, and placed into the ground. The exact coordinates for the remains is documented by GPS readings. Temporary interment also involves the disinterment of the individual remains to return to the legal next of kin for final disposition.
19. Unified Command (UC): An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC to establish their designated Incident Commanders at a single Incident Command Post (ICP) and to establish a common set of objectives and strategies and a single Incident Action Plan (IAP).

## **IV. Situation and Assumptions**

### **A. Situation**

1. A large number of fatalities may result from a variety of causes including natural disasters, hazardous material incidents, terrorist attacks, transportation accidents, or as the result of a naturally occurring disease outbreak.
2. For purposes of this plan, a mass fatality incident is defined as any situation that results in more fatalities than the local mortuary affairs system can handle utilizing the usual standard of care and processes.
3. The authority for handling decedents is fully vested in the Tennessee Code Annotated.

4. Any physician, undertaker, law enforcement officer, or other person having knowledge of the death of any person from violence or trauma of any type, suddenly when in apparent health, sudden unexpected death of infants and children, deaths of prisoners or persons in state custody, deaths on the job or related to employment, deaths believed to represent a threat to public health, deaths where neglect or abuse of extended care residents are suspected or confirmed, deaths where the identity of the person is unknown or unclear, deaths in any suspicious/unusual/unnatural manner, found dead, or where the body is to be cremated, shall immediately notify the county medical examiner or the district attorney general, the local police or the county sheriff, who in turn shall notify the county medical examiner. The notification shall be directed to the county medical examiner in the county in which the death occurred.
5. Jurisdiction over the body(ies) is determined by the place of death and not the location of the incident. For example, a person injured at a federal installation who is transported to a civilian hospital in Tennessee and subsequently dies would fall under the jurisdiction of CME.
6. Each death requires an investigation by competent and trained personnel, (such as law enforcement and medical investigators) to ensure the cause of death is a result of a natural disease such as influenza versus death by other mechanisms (e.g. fall, homicide, abuse, etc.)
7. Under normal conditions, 88-90% of the fatalities in the region are not Medical Examiner cases because these deaths are due to natural diseases occurring under natural circumstances. Non-Medical Examiner deaths are managed by the local law enforcement agency (if death occurred out of medical treatment facilities), Emergency Medical Services (EMS), treating physicians, hospitals, funeral directors, cemetery or cremation owners and the individual families.
8. For incidents that do not fall under the jurisdiction of the CME such as an outbreak of a naturally occurring communicable disease, the State of Tennessee will establish a Unified Command to coordinate the management of fatalities exceeding the capacity of the local forensic centers. The UC may consist of the health department, emergency management, fire and rescue, and law enforcement.
9. Regardless of the scenario, many Tennessee government divisions and private organizations may have a significant role in mass fatality incidents.
10. Health Emergency Support Function 8 is coordinated by the Tennessee Department of Health – Emergency Services Coordinator (ESC). However, no single agency can handle the full responsibility for mass fatalities, whether those fatalities are naturally occurring or as the result of human actions. In either situation there will be multiple disciplines involved in the management of the mass fatalities.
11. During a mass fatality event all jurisdictions will continue to experience cases where people die from accidents, suicides, homicides, and sudden unexplained deaths which are NOT related to the event. Investigation into each death by law enforcement and county medical examiners necessary to differentiate between

deaths from the naturally occurring disease versus other activity (violence, other disease related, suicide, etc.)

12. In the absence of assigned local authority the CME and Tennessee Department of Health ESC coordinates with the regional forensic centers, local funeral directors and cemeteries to form public/private partnerships to address surge capacity issues.
13. The processing of individual human remains cannot be “rushed” and must maintain specific industry health and safety standards. Therefore it can be expected that delays will occur in a mass fatality operation.
14. Additional obstacles that will challenge the response include the availability of supplies and equipment, personnel/staffing, transportation, funeral home processing and time necessary to conduct funeral services.
15. The National Transportation Safety Board (NTSB) is the lead investigative agency in determining the cause of an accident involving an aircraft, rail or pipeline that results in loss of life, serious injury or major damage. The Aviation Disaster Assistance Act of 1996 requires NTSB to coordinate the disaster response resources of federal, state, local and volunteer agencies. Since the attacks of September 11, 2001, the NTSB has partnered with the Federal Bureau of Investigation (FBI) and has developed a mutual aid agreement that brings in the FBI early in a NTSB investigation. In the event the incident is determined to be a terrorist act, the FBI assumes investigative jurisdiction. In aviation incidents airlines are responsible for the establishment of a Joint Family Support Operations Center (JFSOC) -- a Family Assistance Center (FAC) -- which also incorporates federal, state and local resources. Tennessee Department of Health, as part of a unified command, will provide a liaison to coordinate information and resources requested to support the JFSOC operations.
16. The FBI is the lead agency for the criminal investigation of acts of terrorism or suspected terrorism however appropriate agencies in Tennessee will be expected to provide law enforcement support and coordination in this effort. The CME will have jurisdiction for managing the fatalities except in very rare circumstances when jurisdictional authority lies with U.S. Code Title 10 Sec. 1471 (e.g. involves the President of the United States, etc.). The FBI has a Victim Assistance Team they will deploy to a terrorist incident who can assist in establishing a FAC.
17. Tennessee does not have a Disaster Mortuary Operational Response Team (DMORT), and the Federal DMORT teams may not be available during an infectious outbreak because the members, who are all intermittent Federal employees performing similar functions in their own communities will be needed at home. Mutual aid may not be available for the same reasons. The capacity of existing morgues and/or the autopsy facilities in the state will be exceeded quickly during an infectious outbreak.
18. Death pronouncement of cases that fall under the jurisdiction of the medical examiner may be made by the county medical examiner or county medical investigator (TCA 38-7-104 g). Death determination is the time death is determined or the time the body is found. Any person may determine death. Death determination

is assumed when first responders such as fire/EMS and law enforcement do not initiate resuscitation or obtain orders to stop resuscitation after a physician consult. During a mass fatality event persons who are clearly dead should not be transported to a hospital for death pronouncement, unless an unusual circumstance is involved, since doing so may overwhelm the system that is already stressed. An unusual circumstance would need to be investigated by the usual authorities.

## **B. Assumptions**

1. Operations under this plan will be conducted in accordance with the National Incident Management System (NIMS).
2. Public and private health and mortuary affairs services resources located in Tennessee will be available for use during emergency situations. However, these resources may be adversely impacted by the emergency or quickly overwhelmed by the number of fatalities. There may be shortages of resources such as caskets, litters and transportation vehicles or storage facilities for human remains. The availability of personnel to perform processing, funeral services and transportation services will also impact mortuary services.
3. Large numbers of deaths may backlog the entire mortuary affairs system in the state including law enforcement, forensic investigators, hospital morgues, funeral homes, cemeteries, crematories, the CME and the Office of Vital Statistics. The entire process of managing the fatalities may take months to years to completely resolve.
4. The conventional methods for managing fatalities and the deceased will continue as long as possible until circumstances dictate a change in operation policy and procedures.
5. Management of the deceased will be conducted with reasonable care in a respectful, dignified manner. To the greatest extent possible, respect will be paid to faith based or cultural beliefs related to the disposition and handling of remains.
6. Terrorist incidents or other mass fatality events may occur with little or no warning. However, it may be a period of days or weeks before recognition or confirmation that a bio-terrorism attack has occurred.
7. Incidents that involve biological, chemical, or radiological agents or materials may require special handling of the remains.
8. During a mass fatality incident, media representatives will quickly attempt to establish a strong on-scene presence.
9. As resources become depleted, neighboring counties, the state, and/or federal authorities may be asked to provide additional resources. In a localized, acute event, mutual aid may be available; however, for an incident with regional or national impacts and a high number of fatalities, the mutual aid available to Tennessee may be extremely limited or not available.

10. The incident may have a significant impact on Tennessee employees and resources rendering them unavailable and as such it may be necessary to depend heavily on mutual aid resources.
11. Tennessee divisions and organizations will provide support as outlined in the "Assignment of Responsibilities" section of this plan and as assigned by the Tennessee Emergency Management Plant (TEMP) and functional annexes.
12. Tennessee and private organizations will develop supporting plans and procedures necessary to accomplish their assigned roles and responsibilities under this plan.
13. A mass fatality incident that is the result of a transportation accident or involves the transportation system will be managed by the county ME in cooperation with the NTSB and coordinated with Tennessee authorities.
14. Funeral homes with just-in-time inventory plus reduced industrial capacity due to illness and death will result in shortages of all products and capabilities.
15. When mass fatalities are the result of an infectious disease event:
  - a. Usual funeral/memorial practices may need to be modified in order to reduce disease transmission.
  - b. Social distancing factors should be considered (e.g., use of internet-based services, limiting number of attendees).
  - c. Family members living in the same household as the deceased may be in isolation and/or quarantine.
16. Deaths not related to the mass fatality incident will be ongoing and the mortuary affairs system will have to continue to respond to these needs.
17. Local funeral home and cemetery resources may be overwhelmed and families may not have the ability to choose the funeral home that handles the final disposition of their loved one.
18. Customary funeral/memorial practices may need to be adapted. Religious and cultural leaders should work with funeral service personnel to create strategies to manage the surge of deaths such as abbreviated or group funerals, rapid burial/cremation with postponed memorial services, etc.
19. Family members and loved ones will report to the incident location, local hospitals, or other medical facilities in the region seeking information even if there are no known survivors.
20. The incident may dictate the need for actions such as temporary interment, disinterment, and alternate death certificate processes for which authority is not clearly defined in state or local law.
21. Agencies with roles and responsibilities in mass fatality operations will develop internal policies and procedures that provide further detail on the execution of those responsibilities.

## **V. Concept of Operations**

### **A. General Information, Activation, and Trigger Points**

1. Activation of this plan is authorized by State executive leadership and the Commissioner of Health and will include the Director of TEMA, and may include appropriate State executive leadership. Appropriate declarations and Executive Orders empowering the Commissioner of Health (State Health Officer) will be executed to activate the Mass Fatalities Plan.
2. The Mass Fatalities Plan will be executed when there is Recognition of a mass casualty/fatality event that results in more deaths than the local mortuary affairs system capacity can handle on a daily basis. The triggers may include:
  - a. Recognition that a naturally occurring disease is resulting in increasing numbers of deaths that may exceed local mortuary affairs system capability.
  - b. Notification to the health department from local hospital(s) and/or funeral homes that their capacity to transport, process, store, and funeralize bodies has been exceeded.
  - c. Recognition of any mass fatality event as defined by the CME: Any incident with fatalities which exceed or overwhelm usual local resources.
3. Upon activation of this plan, the organizations identified herein will function to address the entire spectrum of operations that provides for the care of the decedent. This includes (as applicable to an incident):
  - a. Recovery and tracking of the decedents
  - b. Examination of the deceased
  - c. Determination of the nature and extent of injuries
  - d. Recovery of forensic, medical, and physical evidence
  - e. Establishing personal identification of the decedent(s)
  - f. Law enforcement investigation of criminal acts and suspicious deaths
  - g. Certification of the cause and manner of death
  - h. Decontamination of decedent bodies and personal effects
  - i. Processing of decedent's personal effects
  - j. Transportation of the deceased
  - k. Temporary storage of decedent bodies
  - l. Notification of the next of kin
  - m. Release of remains and personal effects to families
  - n. Funeral and/or burial services
  - o. Temporary or permanent interment
  - p. Behavioral health support
  - q. Provision of other information assistance to families of the deceased
  - r. Processing of the death certificate records
4. In addition to the activation of the TEMP, the health department may establish a public health command post to coordinate public health response operations. Other

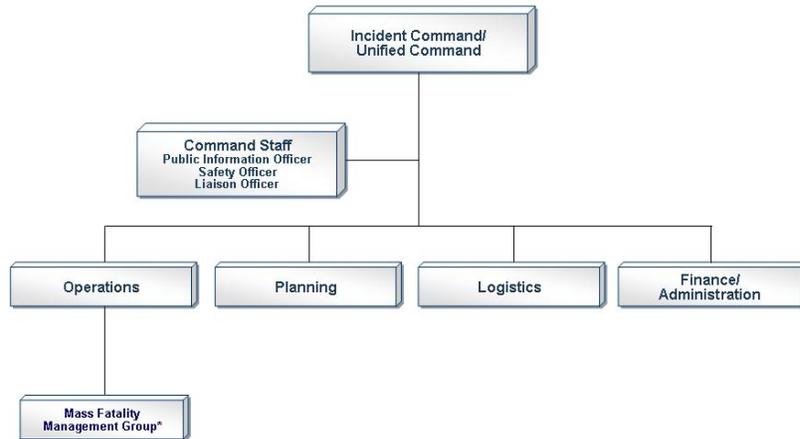
entities may establish their own operations centers/command posts to support the overall mass fatality operation.

5. The Director of the TEMA, in consultation with the Commissioner of Health or designee, and the City/County Mayor(s), will determine if a local emergency declaration is necessary and will initiate the request.
6. In the event that state and/or federal assistance is needed, the Governor of the State of Tennessee will initiate requests for state and federal declarations.
7. Standard universal precautions will be recommended for personnel responsible for the management of the deceased (retrieval, transport, storage and final disposition) unless more advanced personal protective equipment is otherwise recommended or required.
8. This plan acknowledges the fact that there are mass fatality events that will fall under the jurisdiction of the CME and those that will not. Therefore the determination and establishment of jurisdictional authority is a critical decision that should be addressed early in the event to allow for notification of all pertinent agencies and reduce response time and set up.
9. The Commissioner of Health in consultation with the CME and other appropriate state executives, such as in the case of naturally occurring communicable diseases, will coordinate the management and storage of remains exceeding the capacity of the local mortuary affairs system. The TDH will be the lead agency for coordinating the public health and medical response to naturally occurring infectious diseases and will establish appropriate incident or unified command. Other Tennessee government and private organizations may be requested to provide support in accordance with their assigned functional roles and responsibilities in the TEMP and supporting annexes.

## **B. Incidents Under CME Jurisdiction**

1. The CME has jurisdiction over the death of any person from violence or trauma of any type, suddenly when in apparent health, sudden unexpected death of infants and children, deaths of prisoners or persons in state custody, deaths on the job or related to employment, deaths believed to represent a threat to public health, deaths where neglect or abuse of extended care residents are suspected or confirmed, deaths where the identity of the person is unknown or unclear, deaths in any suspicious/unusual/unnatural manner, found dead, or where the body is to be cremated, shall immediately notify the county medical examiner or the district attorney general, the local police or the county sheriff, who in turn shall notify the county medical examiner. The notification shall be directed to the county medical examiner in the county in which the death occurred.
2. CME notification in most mass fatality incidents will be initiated through the local incident command – law enforcement and/or fire and rescue in accordance with established protocols and procedures. In biological incidents, the CME may be the agency that identifies the initial suspected cases and informs the health department of an emerging incident.

3. The CME will be the lead agency for managing the recovery, processing and disposition of decedent bodies and will conduct operations in accordance with the TDH Mass Fatality Plan. CME staff will integrate within the established incident or unified command structure in order to oversee the recovery, processing and disposition of remains. A Mass Fatality Management Group (MFMG), headed by the CME, may be established, likely under the Operations Section, as depicted below to manage the handling and processing of fatalities.



\* Mass Fatality Management Group established at incident scene or EOC as needed

4. As applicable, the CME may also be represented at the EOC or public health command post. The TDH and TEMA will provide support to the CME as necessary to include but not limited to:
  - a. Providing security of the scene.
  - b. Procuring refrigerated trucks/units and other resources such as body bags.
  - c. Procuring space for temporary collection points or a temporary autopsy facility.
  - d. Handling personal effects, photography, and fingerprinting.
  - e. Conducting investigations to confirm identification of the deceased.
  - f. Assist in conducting an assessment of the scene to develop an understanding of the response and recovery needs.
  - g. Notification of Next of Kin.
5. The CME will request assistance through the IC/UC. As necessary the IC/UC will convey requests for resources as outlined in TEMP.
6. The CME will coordinate with the appropriate executive management for the State of Tennessee, requests for federal resources such as DMORT or other federal assets available through the NDMS.
7. The site and/or decedent bodies as defined by the CME and other agencies deemed appropriate by the CME, may constitute a crime scene, making all remains and

- personal effects associated with the event forensic evidence. When the incident is the result of a chemical, biological, radiological or nuclear event the FBI will be the lead investigative agency. Law enforcement and the CME will work concurrently with the FBI and other appropriate agencies to ensure proper fatality management operations.
8. Depending upon the nature and number of fatalities involved, a decision may be made by the CME to establish a temporary autopsy facility. This facility may be used to store bodies prior to transport, serve as a facility for visual identification or serve as a substitute location for the routine processing, autopsy and related activities which normally would occur at the ME facilities. A temporary autopsy facility may serve all or a combination of these functions. Establishing a temporary autopsy facility and what functions it will serve is a decision of the CME. The location of this facility will be incident dependent on the incident and availability of facilities.
  9. In the event a temporary autopsy facility is established, the CME will request assistance via TEMA to provide management and staff and may request law enforcement to provide security.
  10. The Unified Command in coordination with the CME will determine the need to establish a Family Assistance Center (FAC). If activated, the FAC will be established and managed by an appropriate jurisdiction authority. The purpose of the FAC will be to obtain information from families used to identify victims, to provide information to families affected by the incident and to assist with the re-unification of families with the decedent. Family assistance center operations will be coordinated with TEMA and the CME.
  11. In the event of a transportation incident, the NTSB will be the lead agency for investigating the cause of the incident and facilitating support to the victims' families. In an aviation incident, the airline is primarily responsible for family notification of the incident (they may give death notification if it is known all have died but airlines will not notify the families of positive identification – this is the responsibility of law enforcement) and all aspects of victim and family logistical support. The airline will establish a Joint Family Support Operations Center (JFSOC)—(Family Assistance Center) -- to coordinate providing support to the families. The CME with the NTSB will collect ante mortem data and provide the families updates on morgue operations and decedent identification. TEMA and/or TDH will provide a liaison to the JFSOC to facilitate information sharing, coordination of requested resources to support the operation and coordination with the EOC and the on-scene command. In some instances, TDH may be requested to/or it may become necessary for the TDH to provide services/support within the JFSOC.
  12. The FBI will investigate all commercial plane crashes to determine if the incident was terrorist related. If so, the FBI will be the lead criminal investigative agency with support from local law enforcement, and the scene and remains will be designated a crime scene. In coordination with the FBI, the State CME will be the lead for managing the collection, processing, and disposition of the fatalities.

### **C. Incidents Not Under CME Jurisdiction**

1. The CME may be asked to consult and/or assist in mass fatality management as described below. If the jurisdiction does not fall under the CME, such as in the case of naturally occurring communicable disease outbreak, the local EMA may coordinate the management and storage of the fatalities exceeding the capacity of the local mortuary affairs system.
2. TDH is the lead agency for coordinating the public health and medical response to communicable diseases. An event involving a communicable disease will not normally have an “incident site” at which on-scene command would be established. For these events, the health department will activate their public health command post and establish IC/UC as appropriate.
3. The appropriate local law enforcement agency will be the lead local agency for coordinating on-scene incident response and will establish the on-scene command structure if applicable. It is likely that a unified command will be established that includes law enforcement, fire and rescue, CME, emergency management, and other entities, such as the health department, TBI, and FBI.
4. In these incidents, an initial assessment will be conducted by on-scene law enforcement in coordination with fire and rescue to determine the scope of the incident and the need for additional resources.
5. The TDH (including local health departments) provides active disease surveillance in coordination with neighboring state health departments, and the healthcare community. Upon recognition of an emerging event caused by a naturally occurring communicable disease, an initial and ongoing assessment of the case fatality rate will be done by the health department to determine the need for temporary storage sites to store decedent bodies and to predict the available local mortuary affairs system capacity.
6. The CME may have some initial responsibility and jurisdiction in the identification and confirmation of the communicable disease and will continue to be responsible for certain categories of cases that fit criteria established by law (e.g. deaths for which there is no attending physician, unidentified decedents). The investigating law enforcement agency is responsible for determining the identity of unidentified decedents.
7. TEMA may be activated to serve as the direction and control facility depending upon the scope and magnitude of the incident. The TEMA will coordinate the overall response and provide support to the IC/UC.
8. The following are the general actions that will be taken or considered:
  - a. Ensure that the TDH and TEMA have been notified.
  - b. Ensure that the funeral home directors, cemeteries, local health care providers, and local hospitals are notified of potential increase in fatalities and to notify them of any new procedures, identify current capacity and capability and establish information management criteria.

- c. Coordinate with primary partners on the operational and logistical needs required to manage decedents.
  - d. Ensure that the state vital statistics administration has been notified of the pending surge in death certificate processing.
  - e. Identify and track decedents via a joint effort between CME, TDH, and law enforcement.
  - f. Select and procure mortuary affairs collection point(s).
  - g. Identify and procure sources for refrigerated truck or cold storage facilities.
  - h. Identify transportation assets that may be used for the recovery of decedents.
  - i. The CME and the executive staff of TDH shall develop and distribute safety criteria for managing the decedents. Information specific to the incident for first responders will be established and disseminated by the incident safety officer. Safety related information for the general public will be established by the JIC and disseminated through appropriate PIOs.
  - j. As applicable, TDH will provide prophylactic medication or vaccine to those responders who have not yet received it.
  - k. Establish a FAC and/or a call center.
  - l. The agency in charge of the incident will establish a public information plan.
9. During day-to-day operations and during smaller, more contained emergencies, the transportation of the deceased is accomplished by a funeral home or livery service. However it is possible during a mass fatality incident that transportation resources may be scarce or overwhelmed and alternative resources will need to be identified and used to support transportation of decedent bodies. Transportation needs will be coordinated by the local EMA, if possible, or through TEMA, if necessary. As needed, local EMA and/or TEMA will provide support by contracting with or otherwise acquiring from private sources.
10. When the mortuary affairs system processing capacity or local funeral home capacity is exceeded the health department will request assistance, through the CME or the TEMA, from the State Funeral Directors' Association. Note that this assistance may be limited or unavailable if the event is widespread with regional impacts. Potential assistance from the State Funeral Directors' Association may include:
- a. Assist with transportation and storage of decedent bodies.
  - b. Provide experienced staff in a variety of areas (such as medical, legal, and financial expertise)
  - c. Assume responsibility for communication with immediate survivors.
  - d. Coordinate details for post-death activities culminating in final disposition.
  - e. Recognize the need for personal resolution of stress after participation in disaster relief.
11. Based upon the number of fatalities within the jurisdiction and the availability of mortuary affairs services in neighboring jurisdictions, one or more Mortuary Affairs Collection Points (MACPs) may need to be established by the jurisdiction. MACPs are locations where non-contaminated remains are collected, stored and preserved before being transported or released to the funeral home chosen by the family as capacity permits. Staffing for the MACPs will be provided by the jurisdiction employees with technical assistance and support from local funeral homes and the CME if applicable. The local EMA will be the lead agency with support provided from

other government divisions in accordance with their assigned responsibilities under the EOP and functional annexes as necessary.

12. Considerations for a MACP include the following:
  - a. The facility will be available for the timeframe necessary. For a flu pandemic this may be as long as six months.
  - b. The capability to retrofit the facility and the associated costs.
  - c. Non-porous or disposable flooring.
  - d. Room for office space.
  - e. The site/facility should be accessible to tractor-trailers.
  - f. Shower facilities should be available.
  - g. Hot and cold running water.
  - h. Heating or air conditioning dependent upon the season.
  - i. Electricity available (110 volt, 300 amps as a minimum).
  - j. Floor drainage for decontamination.
  - k. Restrooms.
  - l. Space for support staff and rest areas.
  - m. Parking space for staff and trucks.
  - n. Communications capabilities including multiple telephone and fax lines.
  - o. Secure entrances into the general area and into the entrance of the facility with uniformed guards.
  - p. Security for the entire site.
  - q. Removed from public view.
  
13. Decedent bodies will be tracked from the point of recovery through final disposition of the remains. It is imperative that tracking is maintained and validated throughout the process.
  - a. Fire and rescue and/or law enforcement responders will affix the triage tag and associated bar code stickers to the deceased and/or remains and to their known personal effects recovered at the scene.
  - b. Fire and rescue responders affix triage tag to casualties prior to transport for medical evaluation and services.
  - c. EMA may enter the triage tag number into their electronic database or paper record when casualties are received.
  - d. Funeral Directors will be asked to record the triage tag number in their records.
  - e. Law enforcement will be asked to record the triage tag number in their records.
  - f. Family Assistance Center operations will incorporate the triage tag information in their records.

#### **D. Body Recovery/Extrication and Collection**

1. Recovery (extrication) and collection are two distinct processes generally supported by separate agencies. Recovery generally involves the extraction or extrication of a person from the disaster debris and is associated with a search and rescue operation and/or fire and rescue department operations. Collection generally refers to the movement of a body from the location of death to a temporary storage site or funeral home generally conducted by a funeral home or contracted livery service.
  
2. Body recovery is the first step in managing fatalities. The process of body recovery is a critical step in the investigatory phase and the identification process and therefore

must be coordinated effectively. If the incident falls under CME jurisdiction, the fire and rescue department, in consultation with law enforcement, and the CME will coordinate body recovery. None of the decedent bodies shall be moved or touched by workers until direction and approval has been given by the on-scene CME representative. In non-CME jurisdiction cases, decedent bodies shall not be moved or touched until direction and approval have been given by the responsible county ME representative.

3. During an infectious disease outbreak, the county medical examiner and medical death investigators will determine the need for the CME. If it is determined the death is not an CME case, the local first responders may assist the family in making proper transportation arrangements for the decedent body.
4. All information required for the investigation must be collected prior to the movement and collection of the body.
5. Recovery of bodies should not interrupt other interventions aimed at helping survivors.
6. Body recovery may last a few hours, a few days, a few weeks, or may be prolonged dependent on the circumstances of the incident.
7. Rapid recovery is a priority because it aids identification and reduces the psychological burden on survivors.
8. The collection of body parts and personal belongings is the responsibility of the CME and/or the investigating police authority. Body parts should be treated as individual bodies. Recovery teams should not attempt to match the body parts at the scene. Personal belongings, jewelry, and documents should not be separated from the corresponding decedent bodies during recovery.
9. Proper protective equipment should be worn during recovery and retrieval.
10. Medical treatment should be available in case of injury to recovery workers.
11. Conditions and circumstances sometimes preclude the recovery of remains in spite of exhaustive efforts and resources expended by those involved. Once the determination has been made that one or more decedent bodies are unrecoverable, non-denominational memorial services may be arranged. If more than one, all efforts should be made to notify and include the surviving family members of this service. Assistance in post-death activities should be extended to the surviving family members. The family should be given the opportunity to select the location of the non-denominational service if so desired.

## **E. Storage**

1. As previously indicated, the CME may determine that a temporary autopsy site is necessary when the number of decedents exceeds the resources of the medical examiner's office. In non-CME cases, the county ME may establish MACPs when the number of decedents exceeds the daily capabilities of the local mortuary affairs system.

2. A temporary autopsy facility may be used for the temporary storage of the bodies, identification, sanitation, preservation (as authorized), and autopsy, as well as the distribution point for release of the decedent body to their next of kin or their agent.
3. Where the numbers of decedent remains are in excess of the capacity to maintain bodies under refrigeration, alternate means of cold storage such as refrigerated trucks may be necessary. Without cold storage decomposition advances rapidly. Cold storage slows the rate of decomposition and preserves the body for identification.
4. Embalming may be considered as a means of preservation of human remains in instances where extended storage time is deemed necessary.
5. The county ME through local EMA will notify TEMA who will notify the TDH ESC, and CME if refrigeration for decedent remains is unavailable.
6. Temporary burial will only be used when the numbers of decedent bodies exceed the cold storage and embalming capacities or in cases where the bodies may pose a public health risk due to contamination by a chemical, biological or radiological substance. Allowance for disinterment of contaminated bodies will be determined by subject matter experts in public health and hazardous materials. Temporary burial sites should be constructed in such a manner to help ensure future location and disinterment of bodies.
7. Consideration should be given to long-term storage needs and/or disposal if there are unidentified bodies. Burial is the most practical method as it preserves evidence for future forensic investigation if required.
8. Using local businesses facilities or vehicles for the storage of decedent bodies is not recommended and should only be considered as a last resort. The implications of storing bodies at these sites can be very serious, and may result in negative impacts on business with ensuing liabilities.
9. The established tracking system will be utilized to verify, validate, and maintain the identity of the decedent throughout the storage process.
10. There should be no media, families, friends or other onlookers permitted in the temporary storage areas. The exception to this will be if/when there is a need to have families view the decedent for identification purposes. If this is necessary a private and dignified area should be identified and dedicated to this process.

## **F. Tracking and Identification**

### Tracking

1. Tracking is a shared responsibility among the responding law enforcement agencies, fire and rescue services, hospitals, CME, and funeral homes.

2. When managing remains each decedent body must be tracked from the retrieval, transportation, processing through storage and identification processes, and transfer to the funeral homes for final disposition. Currently Tennessee does not have a standardized process for tracking fatalities from the scene of death to final disposition. Agencies have different methods and systems. Fire and rescue will implement the triage tag procedure on-scene and the associated triage tag number will be incorporated in other agency records (hospital(s), CME, funeral homes, etc., when possible for consistency in tracking. It is critical that the decedent tracking is verified, validated, and maintained throughout the entire process.

### Identification

1. In order for a death certificate to be completed and remains returned to the appropriate next of kin proper identification of the decedent must be made.
2. The authority ordering the autopsy (CME, District Attorney General, or county ME) is responsible for identification and notification of the next of kin. Localities or agencies who have custody of the body are responsible for the identification of the dead and the notification of the death to the next of kin (TCA-38-7-103). The hospital performs this function if the death occurs in the facility.
3. During naturally occurring disease outbreaks when a death occurs in a residence reporting by the public will be through the local first responder agency (law, EMS, etc.). All deaths occurring in residential homes and public places will be attended by a law enforcement officer unless hospice has been involved. The attending officer will follow established investigatory operating procedures.
4. In traumatic mass fatality incidents, identification may be done by matching the deceased (physical features, clothes, etc.) with similar information about individuals who are missing or presumed dead. In some cases, it will be impossible to utilize the conventional means to identify the dead because of the lack of identification on the body or reliable witnesses, decomposition, or mitigating purposes. If identification is unsuccessful, identification support from the CME may be requested by the county ME.
5. Ante mortem data collection is a coordinated effort between law enforcement, the CME, the county ME and medical death investigators and supporting organizations such as DMORT or the Tennessee State Funeral Directors Association or other organization approved by the CME. Ante mortem data collection may be conducted in a Family Assistance Center using a standard protocol approved by the CME.
6. Identification of foreign, undocumented nationals and homeless individuals may require much greater effort. Coordination with the State Department or other government entities may be required. It may be necessary for those not easily identified to be placed in temporary storage or temporarily interred while waiting for identification at a later date.
7. It may not be possible to identify all of the remains. Disposition of unidentified remains and/or tissue is the responsibility of and determined by the CME (TCA 68-4-102). When planning for the disposition of unidentified remains the following should be considered:

- a. Under no circumstances should unidentified or unassociated remains or tissue be commingled with identified remains.
  - b. Political pressures should not be allowed to influence the disposition decisions.
8. If an identified body remains unclaimed for 96 hours (TCA 68-4-103b) the CME must be notified and may take custody of the unclaimed body (per TCA 68-4-103b1 and b2) within 24 hours of notification.

## **G. Public Information**

1. In cases where the CME has jurisdiction, TDH will be the lead agency for disseminating public information. TDH will coordinate with the involved counties and may determine the need to establish a Joint Information Center (JIC). All public information officers at all levels of the incident will use the CME as the only source of information for fatality specific information.
2. In non-CME jurisdiction events, the county ME request the establishment of a JIC based upon the scope and magnitude of the event, to coordinate the development and release of public information.
3. Effective communication with the public and the families of the decedents will be critical during mass fatality incidents. Good public communication contributes to a successful victim recovery and identification process. Accurate, clear, timely, and updated information can reduce the stress experienced by those affected, defuse rumors, and clarify incorrect information.
4. Fatality information is very sensitive and requires knowledgeable and well-versed communications. TDH in coordination with the CME in events where the CME has jurisdiction and will provide the necessary incident related information to the media in a manner that respects the privacy of the families involved and does not compromise the investigation of the event.
5. The information sharing process for providing families of the missing and the decedent's current information should be established as soon as possible. This may be done through the Family Assistance Center if established or through an information center for families. The information provided should include the process of the recovery, identification, storage, death certification and other incident specific information. When possible, families should be provided access to this information prior to its release to the media and general public.

## **H. Disposition**

1. The authority and directions of any next of kin shall govern the disposal of the body (TCA § 62-4). However, the State Health Commissioner, in consultation with the Governor, shall have the authority to determine if human remains are hazardous to the public health. If the officials determine that such remains are hazardous, the jurisdiction, with direction from the local health department, shall be charged with the safe handling, identification, and disposition of the remains, and shall erect a

memorial, as appropriate, at any disposition site. "Hazardous human remains" means those remains so contaminated with or other dangerous agent that they may not be safely handled. It is not anticipated that a natural disease outbreak such as influenza will meet the criteria of "hazardous" because there has never been an influenza virus strain which has in the past been demonstrated to be hazardous. However, since the etiology of the natural disease outbreak may not be known, universal standard precautions should always be followed.

2. Generally, funeral and interment or cremation expenses of a decedent are obligations of the decedent's estate or next of kin however, in Tennessee indigent cases are paid by the counties and the funeral homes perform these on a rotation schedule (TCA 68-4-102, and 103).
3. Each funeral home has different processing capabilities and the number of decedents each can handle will vary at the time of the mass fatality incident.
4. In general, funeral homes do not "stockpile" supplies, rather they practice just in time ordering of supplies and equipment necessary to maintain their services. During a mass fatality event additional supplies and equipment will be obtained through existing ordering processes as well as through "mutual aid/shared resources" with other less impacted funeral homes in the region.
5. Crematory services are not available at all funeral homes. Many funeral homes contract these services with independent crematories in the region.
6. Cremation services are limited by standard practices that limit the number of cremations allowed during a specific time frame and then the equipment requires a cool down period as well as a standard daily shut down process. During a mass fatality event cremation services may be a delay point in the disposition process depending on the demand for these services.
7. Each cemetery has different processing capabilities and the number of decedents that can be buried will vary at the time of the mass fatality incident. The ability of a cemetery to accept a burial will impact the storage capacity of the decedent if there is a delay in the burial process.
8. The import into Tennessee or the export from Tennessee of human remains is prohibited except in the following instances:
  - a. Import or export by hospitals, medical schools, colleges or universities for education or research purposes;
  - b. Import for burial or reburial in Tennessee or export for burial or reburial in another state or country; or
  - c. Import or export for preparation for burial or reburial; or
  - d. Import or export for use as evidence in any judicial proceeding.

A violation of this subsection is a Class E felony. Any remains so imported or exported shall be confiscated and subject to disposition as provided in §§ 11-6-104 and 11-6-119. [Acts 1990, ch. 852, § 11; 2006, ch. 896, Part 2]

9. In order to proceed with burial, the mortician must secure completion of the medical certification prior to taking possession of the body and prior to final burial or removal

from the State.. Without this authorization, the manager of a cemetery “may not permit final disposition.” When the manager of the cemetery is presented with the burial-transit permit, the manager must write upon it the date of final disposition, sign the permit, and return it to Vital Records within 5 days

## **I. Disinterment**

In Tennessee, disinterment is outside of the scope of the CME. Per TCA 38-7-107, all the CME has authority to do is recommend a disinterment. The CME doesn't have the authority to order one. Re-interment practices are also outside of the scope of the CME.

1. Regulations for the disinterment and reinterment of human remains and are set out in TCA 68-3-508 which allows that the disinterment and reinterment will be allowed in limited instances:
  - a. to ascertain the cause of death of the person whose remains are to be removed;
  - b. to determine whether the human remains were interred erroneously;
  - c. to move an entire cemetery
  - d. to move part of a cemetery
  - e. to reunite families

Disinterment can also be indicated to perform an autopsy when a person's death occurred under circumstances that fall under the circumstances outlined in TCA 38 and the person was interred before an autopsy could be performed (38-7-107).

2. When human remains are to be removed from a cemetery or other final resting place and transferred to another cemetery or location, a disinterment and reinterment permit shall be obtained from Vital Records.
3. When it is required to disinter human remains for an autopsy purpose, even though the human remains are to be reinterred in the same cemetery, an application for a disinterment and reinterment permit shall be made to Vital Records, or by the State's Attorney any county when acting in the State's Attorney's official capacity in investigating the death.
4. The application for a disinterment and reinterment permit shall be made on a form prescribed by Vital Records.
5. The disinterment and reinterment permit shall be endorsed by the cemetery authority from which the human remains are disinterred, and also by the cemetery authority in which the human remains are reinterred.

## **J. Logistics**

### Transportation

1. Transportation resource requests will be coordinated as described in the Tennessee Mass Fatality Plan and/or TEMP.

2. In general, the following guidelines are recommended when providing transportation services:
  - a. Transfer of decedent remains to other locations should be handled discreetly, with respect and sensitive care of the remains.
  - b. Transport vehicles should be “closed” (i.e. no pick-up trucks) wherever possible and all names or identifying information on transport vehicles should be covered or removed whenever possible.
  - c. Vehicles should travel the same route from the incident site to the CME facility, MACP, or funeral home. These routes should be established in coordination with law enforcement.
  - d. Vehicles should travel at a moderate speed, in convoy style, maintaining order and dignity. At no time should a vehicle make unnecessary stops while transporting.
  - e. Loading and unloading of the vehicle shall be accomplished discretely. Tarps or other ways of blocking the view may be used. The top should also be covered to prevent observance from the air.

### Supply Management

1. Requests for resources will be coordinated as described in the TEMP.
2. In a pandemic situation, it is recommended that funeral directors not order excessive amounts of supplies such as embalming fluids, human remains pouches, etc., but have enough on hand in a rotating inventory to handle the first wave of the pandemic (that is enough for six months of normal operation). Fluids can be stored for years, but human remains pouches and other supplies may have a limited shelf life. Cremations generally require fewer supplies since embalming is not required.
3. Families experiencing multiple deaths are unlikely to be able to afford multiple higher-end products or arrangements. Funeral homes could quickly exhaust lower-cost items (e.g. inexpensive caskets) and should be prepared to provide alternatives.

### **K. Vital Records**

1. Under the Tennessee Vital Records Act of 1977 (TCA 68-3-101) established the Office of Vital Records charged with the responsibility for administering the requirements of vital records throughout the state.
2. Under current law, the authorization county medical examiner is responsible for signing the death certificate in ME cases.

TDH rule 1200-07-.05 and TCA 38 State that medical certification of death be provided by the person responsible for such certification. Since the county ME is the center of the medical examiner system, then the county me is the person responsible for death certification of autopsied cases. In practice, there are some county ME who have agreements with forensic pathologists to sign the dc on autopsied cases, but this is inconsistent throughout the state.

The medical certification shall be completed within 24 hours after receipt of the death certificate by the physician of last attendance in charge of the patient's care for the illness or condition which resulted in death, except when inquiry is required by the medical examiner. In the event that there are numerous deaths from natural causes and they occur outside the health facilities and / or there are decedents without private attending physicians, the hospital will designate hospital physicians, and others as permitted by law at the time, to sign the death certificate.

3. The original death certificate is first filed with the local health department who may issue copies of the certificate up until 30 days after the date of death. The original copy must be filed with TDH Vital Statistics Administration within 7 days.
4. The efficient and proper completion of the required documentation for death certification is an essential step in the processing of fatalities. It is important that those authorized to complete death certificates (CME, and physicians) are educated on this process and available to complete them in a timely manner.
5. During a mass fatality event, the TDH Division of Vital Statistics Administration may determine that it is necessary or more practical to provide an alternative death certificate that can be pre-populated with known information to minimize processing time
6. The State regulates that human remains may not be transported within or out of Tennessee without a valid burial-transit permit (form PH-3774), and the permit must remain with the human remains until it reaches its final destination. Approval of receiving state(s) may be needed. Transportation across international lines (Canada and Mexico) may require State Department approval and the receiving nation's approval.

## **L. Demobilization**

1. The need for continued storage and processing of the deceased may extend beyond the life of the initial incident. This is because of difficulty in body identification, locating the next of kin, and the backlog in achieving a final disposition for each decedent.
2. The regional forensic centers, county ME, and county law enforcement should be prepared to provide ongoing support to mass fatality management in partnership with the CME, if the CME has been involved, to work toward a respectful resolution with decedent bodies. The following are actions to be considered in the aftermath of a mass fatality incident:
  - a. If established, move remains from the temporary interment location to the final resting place.
  - b. Closing, cleanup and restoration of temporary morgue and/or MACP sites.
  - c. Plan for a return to normal operating procedures.
  - d. Provide critical incident stress counseling for the staff who worked the mass fatality functions.
  - e. Redeploy staff and other resources as needed.
  - f. Provide for the disposition of personal effects.
  - g. Complete and process all records kept during the course of the incident.

- h. Evaluate and revise the mass fatality plan and associated policies and procedures based on lessons learned.
3. Demobilization plans will generally be prepared by the Planning Sections of the IC/UC and the EOC as applicable.
4. Local EMA will facilitate an after-action review to identify issues related to the mass fatality operations and to initiate appropriate corrective actions.

## **VI. Organization and Assignment of Responsibilities**

### **A. Organization**

1. All operations in response to a mass fatality event will be handled within the management structure defined in the Mass Fatalities Plan of the TEMP using incident management principles.
2. The impacted jurisdiction will establish an IC/UC to coordinate the response operations. Depending upon the nature of the incident, IC/UC will be established on-scene, at the EOC, or at the public health command post.
3. The EOC may be activated to coordinate support to the IC/UC and to coordinate requests for state and federal assistance.

### **B. Assignment of Responsibilities**

1. Emergency Management:
  - a. Activate and manage the EOC and coordinate support to the IC/UC.
  - b. In consultation with the IC/UC determine the need to activate a JIC.
  - c. Determine the need for a local emergency declaration in coordination with the City/County Mayor(s), and county ME.
  - d. Notify and coordinate with the TEMA to request state and federal assistance as applicable.
  - e. Facilitate an after-action review as soon as possible after the end of operations.
  - f. Determine the need to establish and operate FAC.
2. Health Department:
  - a. Develop and maintain the Mass Fatality Plan and supporting plans and procedures in coordination with the supporting organizations.
  - b. Serve as the lead organization for coordination with the state health department.
  - c. Ensure that appropriate vaccines and/or medication are provided to responding agency personnel supporting victim recovery and identification.

- d. In coordination with emergency management determine the need to establish/support a FAC.
  - e. Coordinate with funeral home directors and cemetery managers to assist them in dealing with the surge of fatalities.
  - f. Provide initial notification of an infection disease outbreak to the CME as appropriate.
  - g. Provide information and guidance to the Safety Officer on the appropriate and necessary personal protective equipment.
  - h. Enter death certificates provided by funeral directors into the State Vital Records system.
3. Law enforcement:
- a. Serve as the lead local agency for investigation of suspected criminal incidents occurring within their jurisdiction.
  - b. Develop and maintain internal plans and procedures for mass fatality incidents.
  - c. Provide access control and protection at various locations as necessary.
  - d. Provide initial notification to CME as appropriate.
  - e. Coordinate the investigation of the incident.
  - f. Provide for traffic management and control.
  - g. Provide security as requested for temporary facilities such as autopsy facilities or FAC and/or MACP.
  - h. Locate, collect, protect, and document non-human evidence.
  - i. Provide support to CME in processing of bodies (fingerprinting, collecting personal effects and documentation of injuries).
  - j. Provide security to the CME operation.
  - k. Perform decedent identification.
  - l. Conduct investigations.
  - m. Conduct next of kin notifications.
  - n. Attend autopsy for collection of evidence if appropriate.
  - o. As appropriate conduct event reconstruction.

4. Fire and Rescue Services:

- a. Coordinate rescue and recovery operations for location of decedents.
  - b. Recommend protective measures for responders, including the CME, to protect against exposure to hazardous materials and blood borne pathogens.
  - c. Provide emergency medical services.
  - d. Conduct decontamination of responders, the deceased, and remains.
5. District Attorney:
- a. Prepare documents to initiate, extend, modify, or end local declarations.
  - b. Advise government officials concerning legal responsibilities, powers, and liabilities regarding emergency operations related to mass fatality incidents.
  - c. Assist with the preparation of applications, legal interpretations, or opinions, and briefing packages regarding emergency operations.
6. Other departments and organizations:
- a. Provide support for the procurement of resources.
  - b. Coordinate the lease of facilities as necessary to support operations.
  - c. Develop and maintain support for the Family Assistance Center Plan.
  - d. Establish and operate a Family Assistance Center if activated.
  - e. Acquire, store and distribute resources in support of operations.
  - f. Coordinate logistical support as requested for establishing and operating facilities.
  - g. Provide support as outlined in the Emergency Operations Plan including but not limited to:
    - 1. Debris removal (in the cold zone)
    - 2. Provide equipment and personnel support
    - 3. Assist with traffic control
    - 4. Coordinate contracts and provide management for additional public works services such as heavy construction equipment
7. State agencies will provide resources to supplement support operations when requested through established protocols.
- a. The Office of the Chief Medical Examiner will:
    - 1. Coordinate with the lead investigating authority and regional forensic centers to document, collect and recover the deceased.

2. Investigate and determine the cause of sudden, unexpected, violent, suspicious, and non-natural deaths.
  3. Determine the nature and extent of injuries.
  4. Assist in technical decontamination of the deceased as required.
  5. Provide technical assistance to the County ME in requesting Federal DMORTs.
  6. Prepare death certificates in cases where the CME has investigative jurisdiction.
  7. Order or conduct autopsies if necessary.
  8. Authorize removal of bodies from incident sites to a temporary storage facility, autopsy facility or morgue.
  9. Determine the need for and establish a temporary storage and/or autopsy facility for incidents where CME has jurisdiction.
  10. Coordinate requests for federal resources as necessary through TEMA
  11. Provide technical assistance to the County ME.
  12. Assist the local law enforcement agency with identification when requested.
  13. Through the PIO in coordination with the event PIO provide information to the news media for the dissemination of public advisories, as needed.
- b. TDH Office of Vital Records:
1. Register all deaths occurring in the state.
  2. Issue copies of death certificates.
  3. Compile and analyze vital statistics data.
- c. Local funeral homes:
1. Provide support, such as facility/storage space to the CME as requested.
  2. Provide support, such as facility/storage space for bodies not under the jurisdiction of CME.
- d. TEMA:
1. Serve as the coordination point for requests for state and federal resources.
  2. Prepare for the Governors' signature an official request for an emergency or major disaster declaration if local and state resources are overwhelmed.
  3. Work with CME to establish staff and maintain a family assistance center when requested.

- e. Tennessee Bureau of Investigation (TBI):
  - 1. Provide the crime lab facility and investigation teams to assist the CME if requested.
  - 2. Maintain on-call list for and dispatch Forensic Investigators when requested.
- 8. Funeral Directors Association:
  - a. Respond as requested by the CME, and/or TEMA.
  - b. Coordinate with the CME and the local jurisdiction authorities to establish the means and methods for the sensitive, respectful care and handling of deceased human remains in multi-death disaster, including but not limited to; post-incident identification, embalming (as authorized), counseling and facilitating the release of identified remains to the next of kin or their representatives as so authorized.
  - c. Identify and request as necessary local, regional, and state-wide funeral home resources such as, transportation, personnel, equipment and supplies, to assist with the mass fatality and family assistance operations.
  - d. At the request of CME, provide representatives to the family assistance center operations for the collection of victim ante mortem data and provision of information to victims' families.
- 9. American Red Cross (ARC):
  - a. Support family assistance operations.
  - b. Provide support to the NTSB in transportation incidents in accordance with the established Statement of Understanding. This may include support services such as mass care feeding and crisis and grief counseling.
- 10. Other agencies that may be listed with roles and responsibilities include:
  - a. Volunteer Centers
  - b. Hospitals

## **VII. Direction and Control**

- A. The direction and control function for a mass fatality incident will be performed by the IC/UC with support provided through the EOC if activated.
- B. Effective exchange of critical information between the EOC and the Incident Command Post (ICP) is essential for overall response efforts to succeed.
  - 1. In incidents in which there is an incident site, the IC/UC will concentrate on the immediate response at the incident site—isolating the area, implementing traffic control in the immediate area, employing resources to conduct appropriate response operations and formulating and implementing protective actions for

emergency responders and the public near the incident site. The IC/UC will direct the activities of deployed emergency response elements.

2. The EOC will handle incident support activities and other tasks, which cannot be easily accomplished by the ICP. Such tasks may include notifications to state and federal agencies and utilities, requests for external resources, activation of shelters (if determined necessary), coordinating wide area traffic control, emergency public information, and similar activities. The Emergency Management Director or designee shall direct operations of the EOC.
  3. In incidents in which there is no discernible incident site, such as in a naturally occurring communicable disease, and area command may be established with support provided through the EOC.
- C. The County/City Mayor, in coordination with the Emergency Management Director, shall provide general guidance for and oversee the operation of the local response.

## **VIII. Readiness Levels**

### **A. TEMA SEOC Level 5—Normal Conditions**

#### Actions

1. Develop supporting plans and procedures.
2. Conduct training and exercises.
3. Address corrective action issues.

### **B. TEMA SEOC Level 4 and 3— Elevated/Declaration of State of Emergency**

#### Actions

1. Monitor the situation.
2. Alert key staff, divisions and agencies, municipalities and non-profit and volunteer organizations of the current situation.
3. Provide appropriate information to the public.
4. Activate or prepare to activate, as applicable, the public health command post and the EOC.

### **C. TEMA SEOC Level 2—Major Disaster**

#### Actions

1. Notify CME/SEOC of the situation.
2. Alert key staff, divisions and agencies, municipalities and non-profit and volunteer organizations of the current situation.

3. As appropriate to the situation, activate the public health command post and/or the EOC.
4. Alert personnel for possible emergency duty.
5. Issue public warnings and provide public information, if necessary.

D. TEMA SEOC Level 1—Catastrophic Disaster

Actions

1. Provide situation updates to and notify the CME/SEOC as applicable.
2. Alert key staff, divisions and agencies, municipalities and non-profit and volunteer organizations of the current situation.
3. Review status of the EOC and activate as applicable.
4. Issue public warnings and providing public information, if necessary.

## **IX. Administration and Support**

### **A. Reports**

1. Initial emergency and situation reports will be written and submitted to appropriate staff.
2. The impacted jurisdiction will continue to establish a system for the identification and tracking of decedents for mass fatality incidents not under the jurisdiction of the CME (e.g. naturally occurring communicable diseases).
3. The CME may require additional reports based upon the nature of the incident. The responsible entity, i.e. law enforcement, health department, will compile and submit the reports as required through the EOC.
4. The local/regional health department has primary responsibility for gathering information concerning injuries and fatalities resulting from emergencies and disasters.

### **B. Records**

Each division or agency will keep detailed records on incident related expenses, including:

1. Labor
  - a. Dollars paid (regular and overtime)
  - b. Volunteer
2. Equipment Used
  - a. Dollar value, description, and operational costs of owned equipment

- b. Dollar value, description, and operational costs of rented/leased equipment
  - c. Equivalent dollar value, description, and operational costs of volunteered/donated equipment
  - d. Dollars and description of equipment in 2.a-c above that has been damaged and/or destroyed during the disaster and/or recovery efforts.
3. Materials
- a. Purchased
  - b. Taken from inventory
  - c. Donated to/from others
4. Contracts (see below)
- a. Services
  - b. Repairs

**C. Contracts**

1. The local EMA or TEMA will monitor all contracts relating to the recovery process. Contracts that will be paid from Federal funds must meet the following criteria:
  - a. Meet or exceed Federal and State Procurement Standards and must follow local procurement standards if they exceed the Federal and state criteria.
  - b. Be reasonable.
  - c. Contain right to audit and retention of records clauses.
  - d. Contain standards of performance and monitoring provisions.
  - e. Fall within the scope of work of each FEMA project.
  - f. Use line items to identify each FEMA project for multiple project contracts.
2. The following contract-related documents must be kept:
  - a. Copy of contract
  - b. Copies of requests for bids
  - c. Bid documents
  - d. Bid advertisement
  - e. List of bidders

- f. Contract let out
- g. Invoices, cancelled checks, and inspection records

#### **D. Training**

1. Under TCA 38-7-104-h, county ME's and medical investigators are required to receive initial training and regular continuing education and operate according to death investigation guidelines.
2. The local EMA may schedule and conduct training for employees and representatives from other organizations who may participate in EOC operations. The local EMA will notify the county ME and the regional forensic center of upcoming mass fatality exercises.
3. Drills, tabletop exercises, functional exercises, or full-scale exercises dealing with mass fatality incidents will be included in the exercise schedule. This plan should be reviewed and revised, if required, based on the results of exercise critiques.

### **X. Plan and Development and Maintenance**

#### **A. Development**

The health department is responsible for developing and maintaining this Mass Fatality Plan.

#### **B. Maintenance**

This plan will be reviewed annually and updated as lessons learned from actual incidents, exercises, or new best practices are identified.

#### **C. Procedures**

Jurisdictions with assigned responsibilities under this plan will develop the necessary operational plans and procedures to carry out those responsibilities.

### **XI. References**

1. Mass Fatality Plan of the Chief Medical Examiner of Tennessee.
2. Tennessee Emergency Operations Plan 2011
3. State Funeral Directors Association Plan
4. National Transportation Safety Board Federal Family Assistance Plan for Aviation Disasters (December 2008).
5. State of Tennessee Postmortem Examiner's Law and Regulations Governing Medical Examiner Cases, Postmortem Act TCA chapter 38.

6. Pan American health Organization, Management of Dead Bodies after Disasters: a Field Manual for first Responders (2006)
7. Santa Clara County Public Health Department Managing Mass Fatalities: A Toolkit for Planning.

## **Attachment 1 - Funeral Homes**

## **Attachment 2 - Religious and Cultural Practices**

*\*Adapted from the Santa Clara County Public Health Department Managing Mass Fatalities: A Toolkit for Planning*

All societies have funeral rituals that have developed over many generations to help people cope with death and loss. Family members and loved ones will have a strong psychological need to identify lost loved ones and to grieve for them in customary ways. Religious and cultural beliefs and practices surrounding death will be important to survivors. There will likely be specific concerns regarding:

- Autopsies.
- Timeframe and handling of the body, including ceremonial washing of the deceased.
- Religious ceremonies and/or items to be left with the dead.

During a disaster, the Chief Medical Examiner will need to determine to what extent he/she is able to accommodate various religious beliefs and practices.

### **Approaches to Being Aware of Survivors' Religious and Cultural Attitudes Surrounding Death**

Mass fatality's victims may be local residents, a combination of local residents and residents of other communities and/or countries, or predominantly residents of other communities and/or countries. There is no way to predict this beforehand. Strategies for getting information on religious and cultural beliefs and death practices of victims' families will be important to demonstrating cultural competence and sensitivity in a mass fatality event—even when it is impossible to meet family requests. Your jurisdiction's population may be very diverse and the CME may be culturally competent and sensitive.

- Begin by exploring the CME approach to handling family member requests related to family religious and cultural beliefs and practices.
- Identify approaches and sources the CME uses to access this kind of information. Examples may include experience of CME personnel, specific resources or Web sites, contact with leaders of faith communities in the jurisdiction, and/or meetings with representatives of immigrant communities.

Additional strategies for ensuring cultural sensitivity in a mass fatality are:

- To note information when families are interviewed to collect ante mortem data at the family assistance center about the family's religious or cultural beliefs, including practices and rituals, daily prayer times, important dates, beliefs about autopsy, and other information that may be relevant to the rescue, recovery and disposition of their loved ones.
- To consult with leaders of the appropriate religious or ethnic communities for guidance on practices and beliefs concerning death as mass fatality victims are identified and cultural/religious backgrounds becomes known.

### **When Requests Cannot Be Met**

A mass fatality is, by nature, a traumatic large-scale event for a jurisdiction that will place extraordinary demands on the OCME. If the mass fatality is the result of a crime or terrorism,

that will further complicate and expand CME responsibilities. As a result, religious and cultural beliefs and practices will most likely lead to requests irreconcilable with the demands on the CME. Whether the CME is unable to meet requests at all or can only meet some requests partially, it is critical to convey this information with compassion and sensitivity.

- Communicate with families. Explain why requests cannot be met and assure them of the CME commitment to treating their loved ones with dignity and respect.
- Consider having representatives of impacted faith communities bless the incident site and morgue daily.
- Inform appropriate faith and ethnic community leaders about the role of the CME in a mass fatality:
  - Commitment to treating the dead with dignity and respect.
  - Determination of the deceased's identification.
  - Determination of the cause of death.
  - Death notification.
- Explain the reasons why requests cannot be met or can be only partially met with compassion and sensitivity. Affirm the CME's professionalism and commitment to treating the dead with dignity and respect.
- Seek the support and leadership of appropriate faith/cultural/ethnic communities during this difficult time in providing information to families/communities that are impacted.
- Keep the Joint Information Center informed of these concerns so that public communications are culturally competent and respectful.

## **Resources**

*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. This publication is available at:

[http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf\\_11\\_2001/welcome.html](http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf_11_2001/welcome.html)

King County's Chief Medical Examiner Speaks on Issues of Cultures, Communities and the Medical Examiner's Office is available at:

[http://ethnomed.org/ethnomed/clin\\_topics/death/me\\_interview.html](http://ethnomed.org/ethnomed/clin_topics/death/me_interview.html)

EthnoMed is a joint project of University of Washington Health Sciences Library and the Harborview Medical Center's Community House Calls Program. It is a website containing medical and cultural information on immigrant and refugee groups. While it contains information specific to groups in the Seattle area, but much of the cultural and health information is of interest and applicable in other geographic areas.

**Attachment 3 - *Death Management Process***

Steps	Requirements	Limiting Factors	Possible Solutions & Expediting Steps	Local Issues
Death Reporting / Missing Persons	<input type="checkbox"/> If death occurs in the home/business/community then a call in system needs to be established <input type="checkbox"/> Citizens call local 911 and report. Often called a check on the welfare call <input type="checkbox"/> 911 or other system needs to be identified as the lead to perform this task	<input type="checkbox"/> Availability of people able to do this task normally 911 operators <input type="checkbox"/> Availability of communications equipment to receive and manage large volumes of calls/inquires <input type="checkbox"/> Availability of trained “investigators” to check into the circumstances of each report and to verify death is natural or other	<input type="checkbox"/> Provide public education about the call centers, what information to have available when they call, and what to expect from authorities when a death or missing persons report is made <input type="checkbox"/> Consider planning an on call system 24/7 specifically for this task to free up operators for 911 calls on the living	
Search for Remains	<input type="checkbox"/> If death occurs in the home/business then law enforcement will need to be contacted <input type="checkbox"/> Person legally authorized to perform this task	<input type="checkbox"/> Law enforcement officers’ availability	<input type="checkbox"/> Consider deputization and training (through the investigations units of law enforcement) of people whose sole responsibility is to search for the dead and report their findings <input type="checkbox"/> Consider having community attorneys involved in the legal issues training for the groups identified <input type="checkbox"/> Attorney General must answer question of who can enter private property to search or whether this can be done at all. <input type="checkbox"/> All search and recovery/rescue groups must come to a standard search assessment marking system for buildings searched in the community. (Ref: Urban Search and Rescue Response System in Federal Disaster Operations, Operations Manual of January 2000. ) <input type="checkbox"/>	
Recovering Remains	<input type="checkbox"/> Personnel trained in recovery operations and the documentation required to be collected at the “scene” <input type="checkbox"/> Personal protection equipment such as coveralls, gloves and surgical masks <input type="checkbox"/> Equipment such as stretchers and human remains pouches	<input type="checkbox"/> Availability of trained people to perform this task <input type="checkbox"/> Availability of transportation assets <input type="checkbox"/> Availability of interim storage facility	<input type="checkbox"/> Consider training volunteers ahead of time <input type="checkbox"/> Consider refrigerated warehouses or other cold storage as an interim facility until remains can be transferred to the family’s funeral service provider for final disposition	<input checked="" type="checkbox"/> Availability of PPE <input type="checkbox"/> Availability of medicolegal death investigators

Steps	Requirements	Limiting Factors	Possible Solutions & Expediting Steps	Local Issues
Death Certified	<input type="checkbox"/> Person legally authorized to perform this task <input type="checkbox"/> If a death due to a natural disease and decedent has a physician, physician notified of death <input type="checkbox"/> If trauma, poisoning, homicide, suicide, etc., Medical Examiner case.	<input type="checkbox"/> The lack of availability or willingness of primary treating physicians to certify deaths for their patients <input type="checkbox"/> Physicians assessing and requiring a fee for service for signing a death certificate <input checked="" type="checkbox"/> People will have trouble getting an appointment <input type="checkbox"/> balancing county medical examiner's primary practice duties with medical examiner duties	<input type="checkbox"/> When possible, arrange for "batch" processing of death certificates for medical facilities and treating physicians. <input type="checkbox"/> Reduce fines equal to the Local Medical Examiner's fees for those treating physicians who refuse to sign for their patients or charge a family (funeral home) for such services. <input type="checkbox"/> Prohibition on requiring a fee for death certificates.	<input checked="" type="checkbox"/> Fewer doctors to certify more death
Decedent Transportation to the morgues	<input type="checkbox"/> In hospital: trained staff and stretcher <input type="checkbox"/> Outside hospital: informed person(s), stretcher and vehicle suitable for this purpose	<input type="checkbox"/> Availability of human and physical resources <input type="checkbox"/> Existing workload of local funeral directors and transport staff	<input type="checkbox"/> In hospital: consider training additional staff working within the facility <input type="checkbox"/> Consider keeping old stretchers in storage instead of discarding <input type="checkbox"/> Look for alternate suppliers of equipment that could be used as stretchers in an emergency e.g., trolley manufacturer <input type="checkbox"/> Outside hospital: provide public education or specific instructions through a toll-free phone service on where to take remains and other mortuary affairs (MA) information	<input checked="" type="checkbox"/> Likely shortage of Litters and Transportation vehicles and staff
Transportation	<input type="checkbox"/> To cold storage, remains holding location and/ or burial site <input type="checkbox"/> From hospitals to morgues, funeral homes or other locations <input type="checkbox"/> Suitable covered refrigerated vehicle and driver	<input type="checkbox"/> Availability of human and physical resources <input type="checkbox"/> Existing workload of local funeral directors and transport staff	<input type="checkbox"/> Identify alternative vehicles that could be used for this purpose <input type="checkbox"/> Identify ways to remove or completely cover (with a cover that won't come off) company markings of vehicles used for Mortuary Affairs operations <input type="checkbox"/> Consider use of volunteer drivers. <input type="checkbox"/> Consider setting up a pickup and delivery service for all the hospitals with set times, operating 24/7 <input type="checkbox"/> Consider finding resources to assist funeral homes in transporting remains so they can concentrate on remains preparations for the families	<input checked="" type="checkbox"/> Likely shortage of Litters and Transportation vehicles and staff
Cold storage	<input type="checkbox"/> Suitable facility that can be maintained at 34 to 37 degrees F	<input type="checkbox"/> Availability of facilities and demand for like resources from multiple localities <input type="checkbox"/> Capacity of such facilities <input type="checkbox"/> Inability to utilize food storage or preparation facilities after the event	<input type="checkbox"/> Develop a regional planning group and identify possible temporary cold storage sites and/or equipment	<input checked="" type="checkbox"/> cold storage resources limited

Steps	Requirements	Limiting Factors	Possible Solutions & Expediting Steps	Local Issues
Autopsy if required or requested	<input type="checkbox"/> Forensic pathologist in a NAME accredited facility	<input type="checkbox"/> Availability of human and physical resources <input type="checkbox"/> May be required in some Circumstances Forensic centers need to accommodate regular case work in addition to event casework <input type="checkbox"/> Availability of case management software for identification and tracking	<input type="checkbox"/> Ensure that physicians and families are aware that an autopsy is not required for confirmation of influenza as cause of death when the outbreak is identified	
Funeral service	<input type="checkbox"/> Appropriate location(s), casket (if not cremated) <input type="checkbox"/> Funeral director availability <input type="checkbox"/> Clergy availability <input type="checkbox"/> Cultural leaders availability.	<input type="checkbox"/> Identify the local resources of funeral service resources <input type="checkbox"/> Availability of caskets <input type="checkbox"/> Availability of location for service and visitation	<input type="checkbox"/> Contact suppliers to determine lead time for casket manufacturing and discuss possibilities for rotating 6 month inventory <input type="checkbox"/> Consult with the Tennessee funeral Directors Association to determine surge capacity and possibly the need for additional sites (use of religious facilities, cultural centers etc.)	<input checked="" type="checkbox"/> Likely shortage of Caskets, embalming supplies and associated hardware <input checked="" type="checkbox"/> Reduced staff and increase work load
Body Preparation	<input type="checkbox"/> Person(s) trained and licensed to perform this task	<input type="checkbox"/> Supply of human and material resources <input type="checkbox"/> Supply of human remains pouches <input type="checkbox"/> If death occurs in the home: the availability of these requirements	<input type="checkbox"/> Consider developing a rotating 6 month inventory of human remains pouches and other supplies, given their shelf life <input type="checkbox"/> Consider training or expanding the role of current staff to include this task <input type="checkbox"/> Provide public education on the funeral service choices during a pandemic	<input checked="" type="checkbox"/> Shortage of Human Remain Pouches <input checked="" type="checkbox"/> Reduced staff and increase work load
Cremation	<input type="checkbox"/> Suitable vehicle of transportation from morgue to crematorium. <input type="checkbox"/> Availability of cremation service	<input type="checkbox"/> Capacity of Crematorium and speed of process <input type="checkbox"/> Availability of county medical examiner to sign cremation permit	<input type="checkbox"/> Identify alternate vehicles to be used for mass transport <input type="checkbox"/> Examine capacity of crematoriums within the jurisdiction <input type="checkbox"/> Discuss and plan for appropriate storage options if the crematoriums are backlogged <input type="checkbox"/> Discuss and plan expedited cremation certificate completion processes	<input checked="" type="checkbox"/> shortage of vaults <input checked="" type="checkbox"/> Cremation is a slow process and a backlog of remains awaiting cremation will likely require temporary storage until they can be cremated <input checked="" type="checkbox"/> Urns
Embalming	<input type="checkbox"/> Suitable vehicle for transportation from morgue <input type="checkbox"/> Trained person to perform <input type="checkbox"/> Embalming equipment and supplies	<input type="checkbox"/> Availability of human and physical resources <input type="checkbox"/> Capacity of facility and speed of process <input type="checkbox"/> Determination if embalming is required for interstate transport	<input type="checkbox"/> Consult with service provided regarding the availability of supplies and potential need to stockpile or develop a rotating 6 month inventory of essential equipment/supplies <input type="checkbox"/> Discuss capacity and potential	<input checked="" type="checkbox"/> Likely shortage of Embalming supplies and equipment <input checked="" type="checkbox"/> Reduced staff and increase work load

Steps	Requirements	Limiting Factors	Possible Solutions & Expediting Steps	Local Issues
	<input type="checkbox"/> Suitable location		alternate sources of human resources to perform this task such as retired workers or students in training programs <input type="checkbox"/> Consider “recruiting” workers that would be willing to provide this service in an emergency	
Temporary storage	<input type="checkbox"/> Access to and space in a temporary vault <input type="checkbox"/> Use of refrigerated warehouses, or other cold storage facilities	<input type="checkbox"/> Temporary vault capacity and accessibility	<input type="checkbox"/> Expand capacity by increasing temporary vault sites	✓ Regional coordination needed for scarce resources for refrigerated storage.
Final Disposition	<input type="checkbox"/> Grave digger and equipment <input type="checkbox"/> Space at cemetery	<input type="checkbox"/> Availability of grave diggers and cemetery space	<input type="checkbox"/> Identify alternate sites for cemeteries or ways to expand cemeteries <input type="checkbox"/> Identify sources of supplementary workers <input type="checkbox"/> Identify sources of equipment such as backhoes and coffin lowering machinery	✓ Cemetery space is limited
Temporary Interment	<input type="checkbox"/> Person to authorize temporary interment <input type="checkbox"/> Location for temporary interment <input type="checkbox"/> Grave diggers and equipment	<input type="checkbox"/> Availability of grave diggers and temporary interment space <input type="checkbox"/> Availability of funeral directors, clergy, and cultural leaders for guidance and community acceptance <input type="checkbox"/> Specific criteria as to when authorization may occur and procedures to follow prior to the interment. <input type="checkbox"/> A complete and reliable tracking system for individual remains <input type="checkbox"/> Availability of resources after the event to dis-inter and to place remains into family plots	<input type="checkbox"/> Identify locations that will be suitable for temporary interment space <input type="checkbox"/> Consider using the global positioning system for individual remains location <input type="checkbox"/> Body containers for individual burials with metal tags or other non-degrading identification tags.	
Behavioral Health	<input type="checkbox"/> Prepare public and responders for mass fatality possibilities prior to pandemic <input type="checkbox"/> Assist responders and other MA workers during pandemic and in post pandemic periods	<input type="checkbox"/> The pandemic will virtually affect the entire nation. A shortage of mental health people will complicate the ability to assist people <input type="checkbox"/> Many people will be doing MA tasks that they are mentally unprepared for and will require assistance	<input type="checkbox"/> Train first responders and some Citizen Corps people in crisis intervention techniques to assist MA teams during the pandemic <input type="checkbox"/> Set up clinics to assist the public separate from the MA workers and first responders	
Event and Community Recovery	<input type="checkbox"/> Persons to authorize reinterment <input type="checkbox"/> Grave digger and equipment <input type="checkbox"/> Clergy and cultural leaders	<input type="checkbox"/> Availability of funeral directors, clergy, and cultural leaders for guidance <input type="checkbox"/> Existing code requirements to have a court order for the dis-interment of human remains	<input type="checkbox"/> Consider that the public may want to erect a monument at the temporary interment site(s) after the pandemic is over.	

Steps	Requirements	Limiting Factors	Possible Solutions & Expediting Steps	Local Issues
			<input type="checkbox"/> Consider establishing a memorial day for the event.	

## **Attachment 4 - Equipment and Supply Considerations**

The following information is a list of the equipment and supplies that will be necessary to effectively respond to a mass fatality incident. It is intended as a planning tool only and may not be an exhaustive list of necessary resources.

- Human remains pouches
- Plastic zip-lock bags
- Waterproof marking pens
- Cloth evidence bags with wire tags
- Stakes, at least four feet in length
- Transfer cases or litters
- White bed sheets
- Workman's cowhide leather gloves
- Personal effects bags
- Rubber gloves
- Surgical masks
- Photographic equipment
- Tags (paper with strings)
- Hammer
- Spray paint
- Face masks or respirators
- Rakes (garden type)
- Shovels

### **Administrative Supplies:**

- Telephone equipment (hard line and cellular)
- Facsimile machine
- Photocopy machine
- Forms
- Files
- Desks, tables and chairs
- Pens, pencils, paper, etc.
- File folders
- Masking tape
- Plastic tape with dispenser
- Computers (Desk and lap top)

## Attachment 5 - Temporary Autopsy Facility and Equipment Requirements

\*Partially adapted from New York State Guidance County Mass Fatality Annex, January 2009

### Guidelines for Temporary Morgue Sites<sup>1</sup>

One or more temporary morgues may need to be established when human remains exceed existing storage and processing capacity and to manage remains from unattended deaths, unidentified remains, and remains requiring autopsies.

The following guidelines may help determine the best alternative(s) available for temporary morgue sites.

#### **Any temporary facility must meet certain requirements for size, layout, and support infrastructure.**

- Airplane hangars and abandoned warehouses have served well as incident morgues. Do NOT use school gymnasiums, public auditoriums, or similar facilities used by the general public. Facility should NOT have adjacent occupied office or work space.
- Proximity to incident scene should be considered.
- Limited/Secure Access
- Security (based on access points and incident needs)

#### **Structure Type**

- Hard, weather-tight roofed structure
- Separate accessible office space for IRC
- Separate space for administrative needs/personnel
- Non-porous floors, preferably concrete
- Floors capable of being decontaminated (hardwood and tile floors are porous and not usable)

#### **Size**

- Minimal size of 10,000 - 12,000 square feet
- More square footage may be necessary for casket storage or other mission-specific needs

#### **Accessibility**

- Tractor trailer accessible
- 10-foot by 10-foot door (loading dock access (preferable) or ground level)
- Convenient to scene
- Completely secure (away from families)
- Easy access for vehicles & equipment

#### **Electrical**

- Electrical equipment using standard household current (110-120 volts)
- Power obtained from accessible on site distribution panel (200-amp service)
- Electrical connections to distribution panels made by local licensed electricians

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<sup>1</sup> Adapted from DMORT standards at <http://www.dmort.org/dpmupublic/dpmurequirements.htm>

**Water Supply**

- Single source of cold and hot water with standard hose bib connection
- Water hoses, hot water heaters, sinks and connectors

**Communications Access**

- Existing telephone lines for telephone/fax capabilities
- Expansion of telephone lines may occur as the mission dictates
- Broadband Internet connectivity

**Sanitation/Drainage**

- Pre-existing rest rooms within the facility are preferable
- Gray water will be disposed of using existing drainage
- Biological hazardous waste, liquid or dry, produced as a result of morgue operations, will be disposed of according to local/State requirements

**Facility Requirements**

Proximity to incident scene  
Limited/Secure Access  
Security (based on access points and incident needs)

**Communications**

Incoming phone line(s)  
Outgoing phone line(s)  
Fax machine (dedicated line if possible)  
Fax paper and tone

**Information Technology**

Laptop or desktop computers  
Internet access  
Established system access

**Office Supplies**

Notepads/paper  
Sticky notes  
Clipboards  
Pens, pencils, markers, highlighters  
Stapler, staple remover  
Tape  
Duct tape  
White out  
Paper clips  
Pencil Sharpener  
Extension cords  
Power strips  
Surge Protectors  
Printer and copier  
Copier paper  
Toner  
Tables

Chairs

**Autopsy Materials**

Human remains pouches  
Plastic zip-lock bags  
Waterproof marking pens  
Cloth evidence bags with wire tags  
Transfer cases or litters  
White bed sheets  
Personal effects bags  
Rubber gloves  
Surgical masks  
Photographic equipment  
Tags (paper with strings)  
Face masks or respirators

**Forms and Documents**

Mass Fatality Plan  
Decedent Information and tracking form  
Fatality tracking form  
Internal and external contact lists

## Attachment 6 - Guidelines for Temporary Interment

\*Reference New York State Guidance County Mass Fatality Annex, January 2009

One or more temporary interment sites may need to be activated to focus resources required for the rapid interment of human remains. After the emergency has passed, families may choose to authorize disinterment to an alternate site.

During a mass fatality event, burial in a traditional cemetery plot or cremation is a viable solution as long as resources can keep up with demand. When resource tracking indicates that resources are overwhelmed, alternative methods must be deployed.

While refrigeration is considered a viable alternative for single site mass fatality events, it is not recommended during a pandemic influenza emergency. It is unlikely that a sufficient number of trucks meeting the necessary standards would be available to accommodate the volume needed for the time the human remains will need to be stored. Trucks are also susceptible to shortages of fuel and labor to keep the refrigeration functioning properly. Ice rinks and similar facilities are often suggested as alternate storage facilities because they are kept cold to preserve the ice. Social customs, however, make it likely that once a community uses a facility to house the dead, it will no longer use the facility for its original purpose. Therefore, after traditional burial and/or crematory resources are exhausted, temporary interment is the preferred alternative. Several locations should be pre-identified as potential sites for temporary interment. Existing nonsectarian cemeteries, parks, and other available land that could accommodate multiple, uniquely identified graves within a grid pattern that would allow for rapid excavation and burial, and effective disinterment if requested by the family after the emergency is over should be considered. This strategy would focus all supporting resources and processes on a limited number of sites.

Ideally, a selected site(s) should meet the following requirements:

- Cemetery/Crematory should either be those regulated by the NYS Department of State, Division of Cemeteries or should be a municipal nonsectarian cemetery/crematory.
- Cemetery/Crematory should be capable of delivering services 7 days a week.
- Cemetery/Crematory should have a Business Continuity Plan in place, adopted by the trustees of the cemetery/crematory and deliverable to any government agency in both hard copy and electronic format.
- Cemetery/Crematory should have 24 hour on-call administrative staffing.
- Cemetery/Crematory should have roadways (preferably paved or stone) and entrances able to accept heavy equipment, e.g. tractor trailers, refrigerated trailers, excavators, etc.
- Cemetery/Crematory operations should not be publicly visible and preferably be secured by fencing that would allow for security at entrances.
- All utilities should be on-site or able to be quickly brought on-site, including gas, electric, cable, and telephone.

- Cemetery should have an accurate survey of all grounds developed and undeveloped.
- Cemetery should have the ability to survey additional burial spaces and to record spaces and burials quickly and accurately.
- Cemetery/Crematory should have well-maintained equipment and sufficient fuel storage capacity to handle “normal” number of services.
- Cemetery must be able to perform services 12 months a year.
- Cemetery/Crematory should have multiple layers of staffing that can be called upon to provide full cemetery/crematory services, as well as routine property and equipment maintenance.
- Cemetery/Crematory should have capacity to increase all form and manner of electronic communications, as well as standard equipment to process large numbers of interments and cremations, e.g. copiers, faxes, scanners, networked computers, pagers, in-house or secured file server, and typewriters, etc.

The necessary agreements to assure that resources are reimbursed should be established. These resources include, but are not limited to, space, services, equipment, and staffing.

### **Disinterment Considerations**

- While business as usual continues, families will continue to make choices about the disposition of their next of kin and will incur financial liability for services provided.
- Once family choice is curtailed, counties will incur the financial responsibility for temporary interments and any subsequent disinterments.
- Families or prepaid irrevocable trusts should carry the financial responsibility for re-interment costs.
- If a person with a prepaid irrevocable trust is not disinterred, the jurisdiction may claim the funds.