



NEW YORK STATE GUIDANCE
COUNTY MASS FATALITY ANNEX
With Emphasis on Pandemic Influenza Preparedness

JANUARY, 2011

Table of Contents

Preface.....	4
Contributors.....	4
The Planning Process.....	5
Section I: General Considerations and Planning Guidelines	8
A. Introduction	8
B. Purpose	9
C. Scope	10
D. Situation	13
E. Assumptions.....	16
F. Policy and Authorities.....	18
G. Concept of Operations	20
H. Plan Maintenance and Updating	32
Section II: Risk Reduction Guidelines	33
Responsibilities by Provider Type	33
Healthcare Facilities.....	33
Coroners/MEs	34
Local Health Departments.....	35
Local Office of Emergency Management (OEM).....	35
Funeral Firms.....	36
Cemeterians (including crematory operators)	36
Vital Records Local Registrars	37
Law Enforcement	38
State Health Department	38
SOEM	Error! Bookmark not defined.
Section III: Response.....	40
Responsibilities by Provider Type	40
Healthcare Facilities.....	40
Coroner/MEs	40
Local Health Departments.....	41
Local OEM	41
Funeral Firms.....	42
Cemeterians.....	42
Vital Records Local Registrars	43
Law Enforcement	43

State Health Department	44
SOEM	Error! Bookmark not defined.
Section IV: Post Event Recovery	45
Responsibilities by Provider Type	45
Healthcare Facilities.....	45
Coroner/MEs	45
Local Health Departments.....	45
Local OEM	46
Funeral Firms.....	46
Cemeterians.....	46
Vital Records Local Registrars	46
Law Enforcement	47
State Health Department	47
SOEM	Error! Bookmark not defined.
Attachments	48
A. Example Flow Chart: Mass Fatality Response Process Overview.....	48
B. Waivers.....	49
C. Pandemic Influenza Planning Models	56
D. Outside Resources.....	58
E. Guidance for Tracking Mass Fatality Resource Capacity	59
F. Guidance for Death Registration Planning.....	60
G. Guidance for Decedent ID Numbers	62
H. Organ Procurement Guidelines and Recommendations	64
I. General Infection Control Procedures.....	65
J. Infection Control Procedures for Pandemic Influenza	66
K. Guidelines for Residential Recovery Teams.....	68
L. Guidelines for Temporary Morgue Sites	69
M. Guidelines for Decontamination of Refrigerated Vehicles	70
N. Guidelines for Temporary Interment	72
O. Minimum Recommended Specifications for Human Remains Pouches for Interment	74
P. Key Acronyms for Emergency Planning	75
Q. Key Definitions.....	78
R. Key Links	81

The NYS Guidance for Hospital Mass Fatality Planning starts on page 83.

PREFACE

Contributors

The New York State Department of Health and the New York State Emergency Management Office have produced this document in cooperation with representatives from a number of supporting organizations, many who provided their expertise on a volunteer basis. The following members comprised the State's Mass Fatality Workgroup.

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Erie County Department of Health
Glens Falls Hospital
New York State Association of Cemeteries
New York State Association of County Health Officials
New York State Emergency Managers Association
New York State Funeral Directors Association
New York State Association of County Coroners and Medical Examiners
New York State Department of Health, Bureau of Funeral Directing
New York State Department of Health, Health Emergency Preparedness Program
New York State Department of Health, Information Systems and Health Statistics Group
New York State Department of State, Division of Cemeteries
New York State Office of Counter Terrorism
New York State Police
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The Planning Process

This document is a source of guidance to counties within New York State for the preparation and strategies required for potential mass fatality events, with a specific focus on pandemic influenza planning. Members of the Mass Fatality Workgroup have made it clear that drafting an all-hazards mass fatality annex that addresses pandemic influenza is of much greater value than developing a separate pandemic influenza mass fatality annex, and this guidance document is designed to meet that objective.

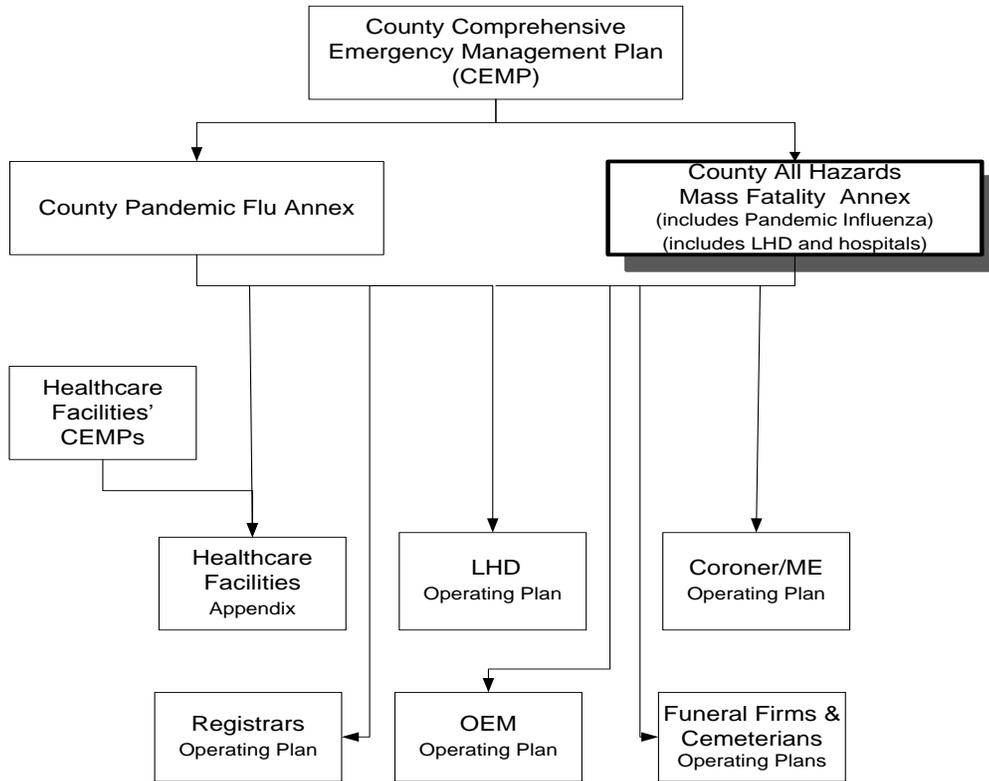
There are more common characteristics than differences among mass fatality events. Depending on the nature of the event, some characteristics require more focus than others. For example, a pandemic influenza event has a less intensive requirement for identifying human remains than an airplane crash. The most significant differentiator may be in how a mass fatality event is managed. In most mass fatality events counties can plan for assistance from outside resources from neighboring counties, from State resources, and if necessary, from Federal DMORT teams. The nature of a pandemic influenza event will require counties to be self-sufficient because typical outside resources are not likely to be available.

During a mass fatality event, county government will maintain their statutory authority and assume responsibility for over-arching policies and authorities outlined in the county Comprehensive Emergency Management Plan (CEMP), and in the county's all-hazards mass fatality annex.

The key to the planning process is interoperability and coordination. The concept of plans and annexes noted above should support or "dovetail" one to another. For example, hospitals should have a complete understanding as to the planning efforts and response activities that will be occurring external to their facilities. Similarly, government should have a knowledge of what their partner organizations are planning to do, and when. More importantly, each organization, public or private, needs to know what the trigger points and response mechanisms are to activate their respective plan or annex.

Each county in the State has a Comprehensive Emergency Management Plan, and most, if not all, include a Pandemic Influenza Annex to the CEMP. The CEMP is primarily a strategy and policy document that identifies the overall direction and control the county will take in a multi-agency setting.

- The COUNTY MASS FATALITY ANNEX supplements the CEMP, converting strategy into tactics that will be used to implement specific mass fatality response activities. The mass fatality annex explains cross-organizationally WHAT the county will do, HOW they will do it and WHO will function as the contact point across organizations.
- An ORGANIZATIONAL OPERATING PLAN or annex for each organization with responsibilities assigned in the County Mass Fatality Annex explains WHAT the organization will do, HOW they will do it and WHO is responsible for each activity.



The structure of this guidance document is intended to assist county planning teams in determining issues to include in their Mass Fatality Annex to the county CEMP, and a possible format. The sections that follow will provide additional information about the purpose of the section, and how the county planning team might approach each subject.

To develop their county-wide mass fatality annexes, counties should form planning teams, rather than have agencies develop multiple disconnected plans. NYS Executive Law, Article 2b, identifies the individuals that should be at the table during the planning process when developing disaster preparedness plans. Counties should leverage the expertise and support from those individuals who may be members of the response organizations to develop the plan. By incorporating the knowledge of others, the process not only provides an accurate reflection of response capabilities, but also fosters team building, which will be invaluable during an emergency. At a minimum, counties should include representatives from the following provider types on their mass fatality planning teams:

- Coroners/Medical Examiners (Coroners/MEs)
- Local Health Departments
- Offices Of Emergency Management

- Healthcare facilities¹
- Funeral Firms
- Cemeterians
- Vital Records Local Registrars
- Law Enforcement

¹ Hospitals are required to develop and execute mass fatality plans. Deaths at long term care facilities will continue to be treated as unattended at-home deaths falling under the responsibility of the coroner/ME. Responsibility for deaths that occur in alternate care sites may vary based on circumstances. If an alternate care site is closely aligned with a hospital, deaths may be managed under the sponsoring hospital's mass fatality plan. If an alternate care site is not closely aligned with a hospital responsibility may lie with county authorities.

Planning teams should include an appropriate number of representatives from hospitals in the county.

SECTION I: GENERAL CONSIDERATIONS AND PLANNING GUIDELINES

This section of the Annex should serve as the preamble explaining the purpose for developing this document. It should include some background information that the county planning team has formulated from its research preparing for developing this annex, and should, at a minimum, include the following sections.

A. Introduction

Purpose:

The introduction is a discussion of the importance of a mass fatality annex.

The language below demonstrates one possible approach that may be adopted all, or in part. Alternatively, the county planning team has the flexibility to adopt different wording for the introduction.

The State of New York is subject to a wide variety of natural, technological and human-caused hazards. The occurrence of such hazards has the potential to impact public and private property and critical infrastructure; they can also cause great economic hardship, and a significant toll in human lives. For example, the crash of TWA Flight 800 off the coast of Long Island in July of 1996 caused all levels of government to review airline crashes / disasters and the effect that these events have on local, county, State and Federal response capabilities. This incident presented challenges in mass fatality management in the debris field, Long Island Sound. During the September 11, 2001 attacks, close to 3,000 people lost their lives in New York City. In this case, the volume of fatalities and the processing of the remains caused significant challenges. New York State and its counties are not alone. On a national scale, the country has endured many tragedies that have resulted in mass fatalities, including Hurricane Katrina, in which 1,836 people died.

While fatalities of any number are disturbing, it is important to note that the events above are single, isolated incidents within a defined geographical area. Other events, such as a pandemic influenza, have the potential to cause more death and illness than any other public health threat². The last three pandemics, in 1918, 1957 and 1968, killed approximately 40 million, 2 million and 1 million people worldwide, respectively. In the absence of any interventions, a pandemic influenza virus with similar virulence to the 1918 strain emerging today could cause the deaths of 1.9 million Americans, with almost 10 million more hospitalized over the course of the pandemic. Such a pandemic may evolve over a year or more. Fatality management in a pandemic could be unprecedented, requiring significant coordination and cooperation to accomplish an extraordinarily difficult task.

² U.S. Department of Health and Human Services *Plan for Pandemic Influenza*; December, 2005.

Attachment C provides additional information on Federal planning models for pandemic influenza that identify interventions to consider and triggers that indicate when to act, based on the severity of the event.

B. Purpose

Purpose of this section:

This section explains the importance for the county to develop a cross-organizational plan, rather than individual operating plans or appendices which are organization-specific.

While the CEMP is primarily a strategy and policy document, the Mass Fatality Annex explains cross-organizationally WHAT the county will do, HOW they will do it, WHO will function as the contact point across organizations and WHEN each component of the plan will be triggered. A specific operating plan or annex (sometimes called a standard operating guide) for each organization explains HOW each organization with responsibilities assigned in the annex will execute their responsibilities.

The language below demonstrates one possible approach that may be adopted all or in part. Alternatively, the county planning team has the flexibility to adopt different wording to explain how they will work together cross-organizationally.

The purpose of this annex is to ensure that there is a mass fatality plan in place that coordinates the activities of all partners in the county to: 1) properly process human remains as efficiently, effectively and respectfully as possible, and 2) protect public health. This document will serve as an annex to the county CEMP which can be used for all-hazards mass fatality management, and includes specific mechanisms in response to mass fatalities that originate from pandemic influenza. This annex will be only as effective as the other plans it uses or supports which are developed by partner organizations engaged in mass fatality management. These include (but are not limited to) operating plans/annexes for:

- Hospital/healthcare providers
- Local health department
- Coroners/Medical Examiners
- Office of Emergency Management
- Funeral firms
- Cemeteries/Crematories
- Registrars
- Law enforcement

C. Scope

Purpose:

This section of the annex identifies the processes this document addresses and who the key organizational partners are that interact during a mass fatality event.

The language below demonstrates one possible approach that may be adopted all or in part. Alternatively the county planning team has the flexibility to adopt different wording to explain the processes and authorities that this annex covers.

Many types of events may result in mass fatalities. Fatalities may stem from a variety of natural, technological or human-caused hazards. As such, an increase in fatalities requires each partner organization, public or private, to have the mechanisms in place to respond to the demands of managing mass fatalities.

Based on severity, all mass fatality events have some common characteristics, while other factors are unique to the type of event. The common characteristics include the need to likely:

- Remove/recover remains when deaths occur outside of hospitals
- Rapidly release remains from hospitals, so hospitals can focus on caring for the living
- Protect the health of workers assigned to handle the dead
- Count and track information about the deceased, including information about unidentified remains
- Maintain the integrity of death records
- Manage remains when funeral firm capacity is exceeded
- Identify additional morgue capacity
- Manage interment of remains when standard cemetery/crematory capacity is exceeded

The potentially high volume of fatalities from pandemic influenza introduces some unique factors to mass fatality planning. The nature of the event will require counties to be self-sufficient because typical outside resources will likely not be available. As the severity of the event increases, State or local-mandated social distancing may require the closing of schools and nonessential work places, and curtail the typical gatherings for funerals/memorial practices.

Organizations typically responsible for handling the dead will continue business as usual for as long as possible. As workers become ill and/or volume increases, some funeral firms, cemeteries and crematories will not be able to keep up with the increasing demand for services. When this occurs, the county will need to implement plans to handle the cases that cannot be accommodated through traditional means:

- Recognizing that funeral firms may run out of capacity temporarily or for the duration of the event, plans should define how supplementary human resources, acting under the authority of the coroner/ME, will be trained to transport remains and process death records.

- One or more temporary morgues may need to be established to relieve healthcare facilities of human remains that exceed their holding capacity, and manage remains from unattended deaths, unidentified remains, and remains requiring autopsies.
- One or more temporary interment sites may need to be activated to focus resources required for the rapid interment of human remains.

During a mass fatality event, it is essential that the county maintain the integrity of death records to enable verification of the identity of the deceased for subsequent legal and estate considerations, as well as reporting of other vital statistics. Careful documentation must occur early in the process, whether the death occurs in a healthcare facility or outside of a healthcare facility.³

Mass fatality planning must also consider the need to support families' informational and bereavement needs. Often mass fatality plans identify a facility dedicated to family assistance. When social distancing is invoked during a pandemic influenza or other mass fatality event, remote forms of family assistance must be established to support families. Families will need to understand the principles behind decisions made by local authorities, especially those related to temporary interment and the family's option to disinter when the community recovers from the event.

Local religious and cultural group leaders can be influential third-party verifiers of public information that must be shared during a mass fatality incident.

The purpose of this annex is to ensure that each county has preplanned how they are going to manage mass fatalities. This mass fatality annex guides how the county will prepare for, respond to, and recover from, issues associated with mass fatalities in a coordinated and consolidated manner.

During a mass fatality event, county government, healthcare facilities and other partners will maintain their statutory authority, and be responsible for over-arching policies and authorities outlined in the county CEMP, and in this annex.

Healthcare facilities: Establish efficient processes to release human remains in order to focus on caring for the living. Amend existing plans to enhance surge capacity for managing mass fatalities.

Coroners/Medical Examiners: Play a leadership role in developing and deploying the county's integrated mass fatality plan and work with the County Office of Emergency Management and the Local Health Department to effectively implement the plan. During a mass fatality event, Coroners/MEs will exercise their statutory authority to direct and oversee alternative processes when organizations typically authorized to handle human remains have exceeded their surge capacity. Develop/update plans to address mass fatalities.

Local Health Departments (LHDs): Exercise statutory authority to protect public health. Develop/update plans to address mass fatalities.

Office of Emergency Management (OEM): Provide leadership and coordination consistent with the CEMP and provide for the overall coordination of county resources in support of the mass fatality annex.

³ This document includes guidance that counties should consider to expedite the processing of death records during a mass fatality event.

Funeral firms: Be familiar with the integrated county plan and understand their role and responsibilities. Report capacity issues to prompt response activities.

Cemeterians, including crematory operators: Be familiar with the integrated county plan and understand their role and responsibilities. Report capacity issues to prompt response activities.

Vital Records Local Registrars: Be familiar with the integrated county plan and prepare to manage expedited procedures for processing death certificates. Develop/update plans to address mass fatalities.

Law Enforcement: Be familiar with responsibilities assigned in the annex, existing waivers and social distancing regulations. Ensure that law enforcement can effectively respond to the number of unattended deaths.

New York State Department of Health (NYSDOH): Use existing plans to provide support for counties regarding mass fatalities.

SOEM: Serve as the State lead, coordinating resources from the State, federal government and other states.

D. Situation

Purpose:

This section structures the plan by providing information and data that frame both planning assumptions and tactical needs which will influence the plan.

It requires careful analysis of threats and resources specific to the county. The guidance and resources discussed below may assist the county as it studies the risk scenarios, and in understanding the available versus required resources.

All Hazards Scenarios

Counties should have already developed a Multi-Hazard Mitigation Plan based on the FEMA requirements related to hazard identification and profiling. Counties should fully profile all natural hazards as appropriate, using various sources of data to identify the hazards which must be profiled in local plans. While not required, the State and FEMA encourage counties to profile technological and human-caused hazards as well. Counties should also examine the potential for mass fatalities from other risk-based planning efforts, e.g. SARA Title III facilities, dam safety planning, CBRNE (chemical, biological, radiological, nuclear, explosive), etc. County planning teams should have access to these plans through the county's Office of Emergency Management.

For more information see the New York State Hazard Mitigation Plan at <http://www.SOEM.state.ny.us/programs/planning/hazmitplan.cfm>.

Planning Tools for Pandemic Influenza

Using the planning models (severity index and pandemic intervals, triggers and actions) discussed in Attachment C, recognize that procedures will change as the severity of the event increases.

There are several estimating methodologies available to help counties establish numeric benchmarks in their plans:

1. FluAid: Provides only a range of estimates of impact in terms of deaths, hospitalizations, and outpatient visits due to pandemic influenza.
2. FluSurge: a spreadsheet-based model which provides hospital administrators and public health officials estimates of the surge in demand for hospital-based services during an influenza pandemic.

Both of these tools can be found at:

<http://www.cdc.gov/flu/pandemic/healthprofessional.htm#tools>

The NYSDOH Health Emergency Preparedness Program has developed a similar model that populates information to make it easier for counties to develop fatality volume estimates. For more information contact mfsurge@health.state.ny.us

3. The NYS DOS Division of Cemeteries has conducted a survey of the capacity and features of all regulated cemeteries and crematories in New York State. For access to this database contact the NYS Department of State Division of Cemeteries at 518-474-6226 or e-mail cemeteries@dos.state.ny.us.

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The language below demonstrates one possible approach that may be adopted all or in part. Alternatively, the county planning team has the flexibility to adopt different wording to explain information and data that frame both planning assumptions and tactical needs that influence the plan.

A variety of hazards could result in mass fatalities. The numbers will vary based on a community’s risk assessment and response capabilities. Mass fatalities are the consequence of events, and not the actual event itself. Scenarios other than an influenza pandemic, such as radiological dispersal devices or a chemical event, present other response challenges that may exhaust a community’s ability to be able to effectively respond to an emergency, including those resources that play pivotal roles in managing mass fatalities. Therefore, it is important for counties to understand the hazards that are present in their community and the impact on the population as a direct result of these hazards. County planners should anticipate a credible, worst-case scenario.

One such scenario that has the potential to produce significant mass fatalities is an influenza pandemic. Case fatality ratios help categorize the severity of a pandemic. Interventions will vary based on the severity of the pandemic at a given time. Mass fatality plans will be triggered by surge capacity being exceeded in key functional areas, e.g. healthcare facilities running out of space to store human remains, and/or funeral firms, cemeteries and crematories declining to accept additional remains temporarily or for the duration of the event.

Mass fatality resource capacity

Resource	Normal capacity per week	Surge Capacity per week
Hospital morgues Refrigerated Non-refrigerated		
Non-hospital morgues Refrigerated Non-refrigerated		
All funeral firms		
All cemeteries		
All crematories		
Other		

High risk scenarios in the county CEMP or organizational Multi-Hazard Mitigation Plans that may result directly or indirectly in mass fatalities

Numeric planning assumptions for Pandemic Influenza

Situation Based On Pandemic Severity Index			
Category	Case Fatality Ratio	Projected Total No.of Deaths in County	Peak Projected No. of Deaths per Week in County
5	≥ 2.0%		
4	1.0 - <2.0%		
3	0.5 - <1.0%		
2	0.1 - <.5%		
1	<0.1%		

Other information that will assist the county planning team

E. Assumptions

Purpose:

The planning assumptions should serve as the technical planning basis for which the county needs to plan. In addition, to the extent practical, the assumptions should encompass what the anticipated impacts of an emergency may be on the county, and should consider the hazard as a worst-case scenario that could stress and overwhelm the response system.

The language below demonstrates one possible approach that may be adopted all or in part. Alternatively, the county planning team has the flexibility to adopt different planning assumptions.

- A mass fatality incident results in a surge of deaths above that which is normally managed by a county's system.
- A variety of hazards may occur with little or no advance warning, resulting in mass fatalities.
- Mass fatality events may be caused by a natural disease process occurring under unsuspecting circumstances, or may be human-caused and/or of a suspicious nature, creating a larger role for law enforcement.
- The county's systems will continue to experience a 'normal' case load, as well as the case load from the mass fatality incident.
- Some counties possess a wealth of resources, public and private, which could be called upon to support mass fatality management, while other counties would be quickly overwhelmed.
- Fatality management is primarily a local responsibility. As such, State and Federal assistance is supplemental to local efforts.
- Depending on the nature/complexity of the event, State and Federal mortuary assistance may be unavailable.
- In some events, fatality management may include the removal of remains in harmful environments, including floods, hurricanes, and incidents involving CBRNE materials. In such cases, removal may need to be delayed to avoid placing emergency workers at unnecessary levels of risk.
- In cases of CBRNE incidents, the nature of the event may put individuals that are called upon to support or implement mass fatality management activities at an increased level of risk. In addition, because of the nature of the materials, the processing of remains may be more complicated, possibly warranting different interment sites, handling procedures, and additional decontamination/storage safeguards.
- Professionals managing the dead will continue business as usual for as long as possible. In some mass fatality events, organizations typically responsible for processing human remains, such as funeral directors and cemeterians, may not have the capacity to process the deceased in a typical fashion, and may run out of capacity, temporarily or for the duration of the event.

- The county will need to produce up-to-date information for official reporting purposes.
- The death registration process will need to be streamlined to assure that paperwork does not limit surge capacity.
- There will be a demand for information from the public.

In addition to the assumptions noted above, a pandemic influenza event poses additional assumptions, including:

- Outbreaks can be expected to occur simultaneously throughout much of the U.S., preventing sharing of human and material resources that usually occurs in response to other disasters. Localities should be prepared to rely on their own resources to respond. The effect of pandemic influenza on individual communities will be relatively prolonged (weeks to months) in comparison to disasters of a shorter duration.
- Because of widespread susceptibility to a pandemic influenza strain, the number of persons affected will be high.
- Healthcare workers and other first responders will be at higher risk of exposure and illness than the general population, further straining the health care system.
- Effective preventive and therapeutic measures, including vaccine and antiviral agents, are likely to be delayed and in short supply.
- Widespread illness in the community could result in sudden and potentially significant shortages of personnel in other sectors that provide critical public safety services.
- Deaths will be occurring at multiple locations, e.g. at hospitals, other treatment facilities and at home. Processes and procedures will be significantly different from a single site mass fatality event.
- To reduce influenza transmission and respond to the large number of deaths occurring over a short period of time, county and/or State authorities will likely mandate social distancing and usual funeral/memorial practices will likely need to be modified.

F. Policy and Authorities

Purpose:

Counties need to know the authorities in State Law and Regulations that empower the State Health Commissioner, LHD, coroners/MEs, law enforcement and others to exercise powers necessary to protect public health, as well as any additional local laws that may affect response to emergencies. Counties should add any such issues that exist in county law.

Key organizations and officials managing a mass fatality event have authority to act based on statute and regulation. The following table lists the source of this legal authority:

Organization <i>Legal Authority</i> ⁴	Key elements related to Mass Fatality Management
Hospitals <i>Public Health Law, Article 28</i>	Planning Death certificates/medical certification Mortality reporting to NYSDOH Security
Nursing Homes <i>Public Health Law, Article 28</i>	Planning Death certificates/medical certification Mortality reporting to NYSDOH Security
Coroners/Medical Examiners <i>County Law, Article 17-A</i> <i>State Sanitary Code, Part 13</i>	Planning Transporting human remains Establishing morgue sites Unattended deaths, unidentified remains, remains requiring autopsies Counting and reporting requirements Death certificates/medical certification Emergency disposition of remains Security

⁴ A more complete list of legal authorities relative to a pandemic influenza event is included in the NYS Pandemic Influenza Plan, Appendix 1G. For the full text go to: http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/docs/pandemic_influenza_plan.pdf

Organization <i>Legal Authority</i> ⁴	Key elements related to Mass Fatality Management
NYS Dept. of Health <i>Public Health Law, Sections 201, 206</i>	Planning Processing of death certificates Requiring planning of authorized agencies Stockpiles
Local Health Departments <i>Public Health Law, Section 2100</i> <i>State Sanitary Code, Part 2</i>	Infection control Management of human remains Emergency measures
County Office of Emergency Management <i>Executive Law, Article 2-B, Sections 23, 24</i>	Planning Centralized coordination of resources Direction and control Requests for assistance
Funeral Firms <i>Public Health Law, Article 34</i> <i>State Sanitary Code, Part 13</i> <i>Public Health Law, Sections 4140-4147</i>	Transporting human remains Death registration
Cemeteries/Crematories <i>Not-for-Profit Corporation Law, Article 15</i>	Interment of human remains Cremation Documentation
Registrars <i>Public Health Law, Sections 4120-4124, 4140-4147</i> <i>County Law Section 673-674</i>	Establishing subregistrars Death certificates
Law Enforcement <i>County Law, Article 17</i> <i>Executive Law, Section 223</i> <i>Military Law, Section 6</i>	Peace and order Security and safety Enforcement of criminal law

G. Concept of Operations

Purpose:

This section defines an anticipated chain of events during an emergency. The logical flow should include the initial recognition of a hazard and the notification and activation of the response organization. Include the response mechanisms that could be activated along the way, what is expected to occur at the height of the response, the demobilization of the response and the transition into post event recovery.

Required explanations of how the county will manage each of the topics are listed in **bold** throughout Section G. The guidance that precedes in yellow text boxes suggests a range of possibilities for the county planning team to consider. When an '*' is included in the guidance, it indicates that there is additional information included in the attachments to this document.

In developing its Concept of Operations the county planning team should define:

- **WHAT is the process?**
- **HOW will cross-organizational activities take place?**
- **WHO will function as the contact point for each cross organizational activity?**
- **WHEN will each part of the plan be put in effect (triggers)?**

Draft the county's response to each topic listed in bold in Section G. Be sure to build the Incident Command System (ICS) into all response processes.

5

⁵ A cross-organizational activity occurs when two separate organizations work together to manage a process. For example, there are cross-organizational interactions between hospital staff and funeral directors, and between coroners/MEs and law enforcement.

NOTIFICATION, RECOGNITION AND ACTIVATION

Overview:

Some mass fatality events occur suddenly without warning, while others, such as weather-related events or pandemic influenza have early warning signs. Some mass fatality events are site-specific, while others are more widespread. For many scenarios, outside resources will be available, while events such as pandemic influenza may require counties to manage the event without additional external resources.

Guidance:

- The alerting mechanism should be the same as that specified in the CEMP. The mass fatality annex should specify WHO will be alerted WHEN.
- Consider how resources will be activated and deployed for an unanticipated single-site event.
- Consider how resources will be activated and deployed for a broad-based event that may have early warning signs, such as a hurricane or pandemic influenza.
- Consider how response teams will be informed that capacity of key resources has been exceeded:
 - Healthcare facilities will continue business as usual for as long as possible, e.g. they will develop plans to surge their capacity to hold human remains. Eventually, capacity at individual healthcare facilities may be exceeded. County plans need to specify the steps healthcare facilities will take to report capacity issues.
 - Funeral firms and cemeteries/crematories will continue business as usual for as long as possible. They will surge their capacity to keep up with demand. Eventually capacity at individual funeral firms or cemeteries/crematories may be exceeded. When this occurs, the funeral firms and cemeteries/crematories will need to report that they are temporarily out of capacity, or are closing for the duration of the emergency. County plans need to specify the steps funeral firms and cemeteries/crematories will take to report capacity issues.
 - As families attempt to engage funeral firms to care for their deceased, they may find that funeral firms are unable to accept additional remains. County plans need to specify the steps families should take to report their need for emergency services.

Explain what steps will be used to monitor for potential mass fatalities, and activate and deploy needed resources. Draft the county's response to each topic listed in bold below.

*See Attachment E for further guidance on how to track mass fatality resource capacity.

- 1. WHO will be alerted WHEN to respond to mass fatalities?**
 - a. For an unanticipated (no notice) single-site event**
 - b. For a broad-based event that has early warning signs, like a hurricane or pandemic influenza**
 - c. How will the response organization stand up?** (This should be consistent with the CEMP.)
- 2. How will key mass fatality resources inform the county response organization that their capacity has been exceeded?**
 - a. When healthcare facilities exceed their capacity to hold human remains**
 - b. When funeral firms and cemeteries/crematories exceed their capacity to accept additional remains**
 - c. When families are unable to find a funeral firm to accept the remains of their deceased**

In the explanation be sure to include:

- WHAT is the process?
- HOW will cross-organizational activities take place?
- WHO will function as the contact point for each cross-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

REMOVAL/RECOVERY

Overview:

Depending on the type of hazard, removal/recovery of remains may be relatively routine or extremely complex:

- When deaths occur at HOSPITALS plans must assure that remains are removed promptly so hospital resources can focus on caring for the living. Many routine procedures for the management of human remains will continue. In addition, the placement of a subregistrar in the hospital to process death certificates and burial permits will streamline the process.
- When deaths occur at HOME, as in a pandemic influenza, the process may require involvement of law enforcement, EMS, funeral directors and/or transport teams. Several additional elements may be required: a process to initiate and certify the death certificate, procedures for handling suspicious deaths, placement of the remains in human remains pouches and transportation to a morgue site.
- When deaths occur at a DISASTER SITE, an evaluation team must establish a plan for the recovery operation managed through the incident command system. Equipment must be acquired, documentation needs met, body/body parts recovered, and remains transported to a morgue site.

Guidance:

- Funeral firms are the organizations authorized to transport human remains. When their capacity is exceeded, the county will need to oversee alternative means of transporting human remains under the authority of the coroner/ME. When additional resources are required, plans should be developed for alternate vehicles and transport teams. These resources may be identified locally, or for some types of events they may be secured from other areas.
- Removal from healthcare facilities
 - Plans should indicate whether the hospital or team will place the remains in human remains pouches, and where a sufficient supply of human remains pouches is available.
 - Depending on the nature of the incident, e.g. during a pandemic influenza event, plans may specify that remains may not be released from a hospital without a death certificate or burial permit. Hospitals should identify and train persons who could be appointed by the Vital Records Local Registrar as subregistrars at each hospital site. These subregistrars are responsible for providing medically certified, registered death certificates and burial permits to funeral directors and/or transport teams.
 - Transport teams must understand the conditions under which they are required to bring the remains to a morgue, and, in the case of temporary interments, the conditions under which they are authorized to deliver the remains directly to a cemetery/crematory.

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- Removal from homes and public places
 - There must be a determination of death by authorized personnel.
 - Remains must be placed in a human remains pouch for transport by personnel assigned to and trained for the task.
 - A sufficient supply of human remains pouches must be available.
 - Identification information must be collected to initiate the death certificate.
 - Remains must be transported, likely to a morgue where the formal medical certification can take place, and the death certificate and burial permit can be issued by an on-site subregistrar.
 - The remains may be released to a funeral firm or, if necessary, a transport team can transport the remains to the designated cemetery/crematory.
 - Consider whether the county should establish collection points for specific types of removals.
- Removal from disaster sites
 - For detailed guidance on removal/recovery from a disaster site review the National Association of Medical Examiners Mass Fatality Plan at <http://www.dmort.org/FilesforDownload/NAMEMFIplan.pdf> .

Explain what steps will be used to remove/recover remains from hospitals, homes and disaster sites by discussing the required elements in bold below.

1. **Often mass fatality plans designate funeral firms to assist in the removal/recovery process. If so, explain the process for enlisting funeral firms to support removal/recovery operations.**
2. **When funeral firms are not a designated resource for removal/recovery or when the capacity of funeral firms to remove and transport human remains is exceeded, explain the steps for alternative means of removing and transporting human remains.**
3. **Explain the process for removing remains from HOSPITALS during a mass fatality emergency.**
4. **Explain the process for removing remains from HOMES and PUBLIC PLACES during a mass fatality emergency.**
5. **Explain the process for recovering remains from a DISASTER SITE.**
6. **Establish and explain the mutual aid agreements in place to provide assistance during a mass fatality event.**
7. **Explain the process for requesting outside assistance.**

In the explanation be sure to include:

- WHAT is the process?
- HOW will cross-organizational activities take place?
- WHO will function as the contact point for each cross-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

MORGUE PROCESSING OF REMAINS

Overview:

During mass fatality events, most remains will be processed through morgues under the authority of the coroner/ME and released to funeral directors. During a pandemic influenza event, coroners/MEs may choose to authorize some remains to be released from hospitals and transported directly to a temporary interment site.

Guidance:

- It is best to select the minimum number of morgue sites possible, considering the features of available facilities, transportation logistics and proximity to temporary interment sites when applicable.
- Counties should identify and train persons who could be appointed by the Vital Records Local Registrar as subregistrars at morgue(s) to enhance the accuracy of, and simplify the process for, registering deaths and procuring burial permits. During some mass fatality events plans may specify that remains may not be released from a morgue without a death certificate and burial permit.
- Coroners/MEs will draft separate operating plans describing the internal operation of morgue services.

*See Attachment L for more information on selecting morgue sites.

Explain what steps will be used for morgue activities that involve interactions beyond the coroner/ME's organization.

For each morgue activity that involves interactions beyond the coroner/ME's organization explain:

- WHAT is the process?
- HOW will cross-organizational activities take place?
- WHO will function as the contact point for each cross-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

DEATH REGISTRATION

Overview:

It is critical that death certificates and burial permits be processed accurately and paced at the same speed as the processing of the remains.

Guidance:

Existing authorities that will streamline the process

- The NYSDOH requires that all healthcare facilities develop a procedure to assure that a physician is always assigned to medically certify death certificates during a declared emergency.
- Hospital authorities and coroners/MEs should identify and train persons who could be appointed by the Vital Records Local Registrar as subregistrars at healthcare facilities and morgue(s) to enhance the accuracy of, and simplify the process for, registering deaths and procuring burial permits. Appointing a subregistrar is a critical element of mortuary surge planning. Subregistrars established at healthcare facilities and morgue(s) should be put in place early, but will become particularly critical if funeral firms begin to run out of capacity. Subregistrars will need workspace, staffing, training, supplies, etc.

Explain the process for rapidly registering death certificates and issuing burial permits by discussing the required elements in bold below.

* See Attachment F for further guidance on the streamlined death registration process.

1. **What are the trigger events and processes that will enable subregistrars to be put in place at hospitals and morgues?**

In the explanation be sure to include:

- WHAT is the process?
- HOW will cross-organizational activities take place?
- WHO will function as the contact point for each cross-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

REPORTING

Overview:

As soon as a health emergency is declared, counties will likely be expected to report the number of event-related and other deaths to the State at specified intervals, e.g. daily. The number of event-related and other deaths during a specified period should be reported to the specified contact at the emergency operation center (EOC) at specified intervals.

Guidance:

- To assure that remains are not double counted, and to help track remains, the county plan may require hospitals and coroners/MEs to assign a unique decedent ID number to event related remains whether the name of the decedent is known or not.
- During a pandemic influenza mass fatality event hospitals and coroners/MEs should always assign a decedent ID number for all fatalities in the county differentiating between event related and non-event related deaths.

Describe how the county will report the number of deaths to designated authorities by discussing the required elements in bold below.

*See Attachment G for more information on Decedent ID numbers.

1. When invoked, how will decedent ID numbers be:

- a. Generated**
- b. Placed on death certificates and burial permits**
- c. Placed on the burial container/human remains pouch and the body**
- d. Placed on records for unidentified remains**

2. What is the process for managing unidentified remains?

In the explanation be sure to include:

- WHAT is the process?
- HOW will cross-organizational activities take place?
- WHO will function as the contact point for each cross-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

TEMPORARY INTERMENT

Overview:

During widespread mass fatality events like pandemic influenza, traditional methods of interment/cremation may not be adequate to accommodate the number of human remains with sufficient speed to protect public health. Under these conditions the county coroner/ME may determine that temporary interment must take place.

Guidance:

- Cemeteries and crematories will conduct business as usual until they notify designated authorities that they lack capacity to accept new remains temporarily or for the duration of the emergency.
- Temporary interments are interments that may or may not be temporary based upon a family's decision once the emergency has passed.
- Because many temporarily interred remains will not be disinterred after the emergency, temporary interment should only take place in cemeteries.
- In respect for religious customs, only nonsectarian cemeteries should be selected for temporary interment.
- It is best to conduct temporary interment at only one cemetery. If that is not possible, the minimum number of temporary interment sites should be selected.
- The temporary interment site may be managed by a combination of the regular cemetery management staff and county resources reporting into the response organization.
- The site should operate 24/7 if necessary, with sufficient staffing, excavation equipment and lighting available.
- Seek additional staffing, equipment and lighting from existing county resources such as the highway department.

Explain the steps the county will take to direct remains to temporary interment site(s) by discussing the required elements below.

* See Attachment N for more information on selection of temporary interment sites.

Explain the steps the county will take to direct remains to temporary interment site(s).

- 1. Where will temporary interments occur?**
- 2. How will the temporary interment sites be managed?**
- 3. What organizations must work together to provide resources to maximize the efficiency of the temporary interments?**
- 4. How will the burial sites be identified to assure effective and efficient disinterment if requested after the emergency is over?**

In the explanation be sure to include:

- WHAT is the process?
- HOW will cross-organizational activities take place?
- WHO will function as the contact point for each cross-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

Family Assistance and Religious and Cultural Considerations

Overview:

Family Assistance Centers (FACs) are typically established during a mass fatality event to support families' information and bereavement needs. They facilitate the exchange of timely and accurate information with family and friends of injured, missing, or deceased disaster victims, the investigative authorities, and the coroner/ME. Types of services generally include: grief counseling; childcare; religious support; facilitation of family needs such as hotel, food, and transportation; antemortem data collection; and notification of death to the next of kin. Family assistance centers can be face-to-face or established remotely through virtual forms of communication.

When social distancing is invoked during a pandemic influenza or other mass fatality event, remote forms of family assistance must be established to support families. Families will need to understand the principles behind decisions being deployed by local authorities, especially those related to temporary interment and the family's option to disinter after the event is over.

Guidance:

Counties should communicate with religious and cultural leaders prior to a widespread mass fatality event such as pandemic influenza. Studies show that during a critical event, communications from religious and cultural leaders serve to reduce social/community disruption and individual psychological trauma as leaders function as third party verifiers of public information. People find it helpful to talk with someone who they know wants what is best for them rather than to talk with someone they don't know who works for their local government.

County mass fatality planning teams and the public information officer assigned in the county's CEMP should:

1. Identify key local or regional religious and cultural leaders who should be informed of plans in advance of an event.
2. Explain the plans for mass fatality management during a widespread event like pandemic influenza.
3. Encourage the religious and cultural leaders to reconfigure information into language that is meaningful for their constituencies.
4. Maintain routine contact with the leaders to assure that the messaging is current.

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GUIDELINES FOR MESSAGING FOR RELIGIOUS AND CULTURAL LEADERS

Why is it important to include religious and cultural leaders in communications for a widespread mass fatality event?

- Religious and cultural leaders function as third party verifiers of public information and help reduce community disruption and individual trauma.

What will happen during a mass fatality event?

- Social distancing may occur early to reduce the spread of disease. This will cause changes to gatherings for religious and cultural death observances. Religious services may have to take place by alternative means, like television, or be postponed.
- Business as usual will prevail for as long as traditional resources, such as funeral directors and cemeteries, can sustain operations. As resources become unavailable or overwhelmed, the coroner/ME may arrange for alternative transportation, disposition, etc.
- When resources are no longer available for final disposition of the family's choice, the county may require *temporary* interment in a nonsectarian cemetery designated by the county. After the event is over, families may, but are not required to, have the remains moved to a *final* disposition of their choice, and conduct preferred death observances.

How can religious and cultural leaders help reduce community disruption?

- Understand the county plan and encourage their constituency to support the plan in words that are meaningful to them.
- Stress that *final* disposition of the family's choice may be delayed, but will be an available option.

Explain how the county will establish physical and virtual family assistance, and communicate with religious and cultural leaders. Required elements are listed in bold below.

For more information on providing relief to families after a mass fatality go to http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf_11_2001/188912.pdf .

- 1. Where are potential sites for physical family assistance centers?**
- 2. How will they be managed?**
- 3. What resources are needed to provide physical, informational and psychological support to families of the deceased?**
- 4. When social distancing is necessary, how will the county provide remote family assistance services?**

Explain how the county will work with religious and cultural leaders in advance of a mass fatality event to assure they understand the county's plan and can function as third-party verifiers of public information.

- 1. Who are the religious and cultural leaders who should be informed?**
- 2. What is the message that the county wants them to receive?**
- 3. How will information be kept current?**

In the explanation be sure to include:

- WHAT is the process?
- HOW will cross-organizational activities take place?
- WHO will function as the contact point for each cross-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

POST EVENT RECOVERY

Overview:

The county CEMP has organizations assigned to support the disaster recovery process. The State CEMP outlines the disaster relief funding and programs that may be applicable for a mass fatality incident.

Guidance:

- When the volume of deaths has started to decrease, demand will be accommodated by business as usual again.
- During a pandemic influenza event, some structures may be kept in place in anticipation of a subsequent wave causing deaths to increase again.
- The county will need to:
 - Begin the process to receive requests for disinterment after temporary interment has taken place
 - Continue to identify unidentified remains
 - Issue correction forms to update death certificates, as needed

Explain the steps the county will take to return to business as usual by discussing the required elements in bold below.

- 1. What structures will be kept in place between waves of a pandemic influenza event?**
- 2. If temporary interment has taken place, what is the process to receive requests for disinterment?**

In the explanation be sure to include:

- WHAT is the process?
- HOW will cross-organizational activities take place?
- WHO will function as the contact point for each cross-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

H. Plan Maintenance and Updating

Plan updates are critical for maintaining effective plans and should be done at least once per year. Include information that was learned from exercises and drills.

Explain the steps the county will take to maintain their mass fatality annex by discussing the required elements in bold below.

- 1. Identify which agency or committee will have custodial responsibility over the all-hazards mass fatality annex.**
- 2. Define how frequently the annex will be updated.**

SECTION II: RISK REDUCTION GUIDELINES

Purpose:

This section of the Annex identifies all of the actions the county is taking to mitigate the effects on public health and social issues related to a mass fatality event in the county. It aligns the responsibilities of each provider type based on their statutory authority, and under the overarching policies and authorities as defined in the county CEMP and in this annex.

Counties must adopt the following requirements and add any additional responsibilities that are identified in support of their Concept of Operations and their Response, as discussed in section III of this document.

Responsibilities by Provider Type

Healthcare Facilities

- Collaborate with partners to develop the county's mass fatality annex
- Participate in informational sessions offered to prepare partners for a mass fatality event
- Update contact lists
- Based on responsibilities assigned to healthcare facilities in this mass fatality annex, develop/update an organizational operating plan or annex⁶ that assigns responsibility and establishes processes for all assigned responsibilities including:
 - Understanding actions required to ensure the health of workers handling the dead
 - Holding, identifying, tracking and releasing human remains
 - Assuring that a physician is always assigned to certify death certificates

⁶ Organizational operating plans, annexes or appendices explain how an organization will manage responsibilities assigned to them in the county's all hazard mass fatality annex. For each activity be sure to indicate:

- WHAT is the intra-organizational process?
- HOW will intra-organizational activities take place?
- WHO will function as the contact point for each intra-organizational activity?
- WHEN will each part of the plan be put in effect (triggers)?

- Assuring a subregistrar is assigned to the facility to register deaths and issue burial permits
- When required, assuring that no remains are released without a registered death certificate and burial permit
- Reporting pandemic influenza deaths to the NYSDOH
- Establishing plans to assure that a sufficient supply of human remains pouches and other supplies is available
- Establishing a security plan to manage public access to holding areas for human remains
- Establishing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
- Reporting the need to have human remains transported
- Surging the capacity to manage human remains
- Maintaining continuity of operations for the healthcare facility

Coroners/MEs

- Collaborate with partners to develop the county's mass fatality annex
- Based on volume projections in the Situation section of the county mass fatality plan, work with the planning partners to determine the location of, and establish MOUs/LOAs for, one or more temporary morgue sites and temporary interment sites
- Participate in informational sessions offered to prepare partners for a mass fatality event
- Update contact lists
- Based on responsibilities assigned to the coroner/ME in this mass fatality annex, develop/update an organizational operating plan⁷ or annex that assigns resources and establishes processes for all assigned responsibilities including:
 - Establishing alternative processes for transporting human remains
 - Establishing and overseeing one or more additional morgue sites
 - Counting and tracking information about the deceased
 - Assuring that subregistrars are established at all morgues to expedite processing of death certificates and burial permits
 - Overseeing remains from unattended deaths, unidentified remains, and remains requiring autopsies
 - Establishing plans to assure that a sufficient supply of human remains pouches suitable for interment and other supplies are available

⁷ See the National Association of Medical Examiners Mass Fatality Plan at <http://www.dmort.org/FilesforDownload/NAMEMFplan.pdf> .

- Directing remains to funeral firms/temporary morgues/cemeteries/crematories/temporary interment sites
- Ensuring adequate systems are in place to track the disposition and location of all remains released for temporary interment
- Identifying actions required to protect the health of workers handling the dead
- Establishing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
- Establishing a security plan to manage public access to collection points and temporary morgue sites where human remains are being processed.
- Surging the capacity to manage human remains
- Maintaining continuity of operations for the coroner/ME's areas of responsibility

Local Health Departments

- Collaborate with partners to develop the county's mass fatality annex
- Provide recommendations to coroners/MEs, funeral firms, cemeterians, registrars and others regarding infection control guidelines to be employed during a pandemic influenza, and provide guidance regarding proper PPE use, infection control precautions and environmental disinfection
- Participate in informational sessions offered to prepare partners for a mass fatality event
- Update contact lists
- Based on responsibilities assigned to the local health department in the mass fatality annex, develop/update an organizational operating plan or annex that assigns responsibility and establishes processes for all assigned responsibilities including:
 - Monitoring mass fatality resource tracking information to determine when the LHD should authorize, or invoke appropriate authorities to authorize measures to protect public health
 - Establishing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
 - Surging the capacity to manage human remains
 - Maintaining continuity of operations for the local health department

Local Office of Emergency Management (OEM)

- Support the county planning team in developing the county's mass fatality annex
- Based on volume projections in the Situation section of the mass fatality plan, work with the planning partners as needed to determine the location of and establish MOUs/LOAs for one or more temporary morgue sites and temporary interment sites

- Participate in informational sessions offered to prepare partners for a mass fatality event
- Update contact lists
- Based on responsibilities assigned to the OEM in the mass fatality annex, develop/update an organizational operating plan or annex to provide coordination for the county's integrated mass fatality plan including:
 - Updating contact information for healthcare facilities, funeral firms, cemeterians, registrars, Coroners/MEs, and the LHD
 - Standing up and manage the county's Emergency Operations Center (EOC)
 - Monitoring healthcare facilities, funeral firms and cemeteries/crematories as they report that capacity will be/is exceeded. With the LHD and coroner/ME, determine when trigger events have occurred so the appropriate authority may authorize the steps identified in the county plan
 - Identifying and deploying resources and supplies as needed
 - Establishing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
 - Maintaining continuity of operations to support the response organization

Funeral Firms

- Collaborate with partners developing the county's mass fatality annex
- Participate in informational sessions offered to prepare funeral firms for a mass fatality event
- Be familiar with the county mass fatality annex and alternative procedures that may/should be used when authorized, including streamlined procedures for processing death certificates
- Establish plans to maximize the capacity of the funeral firm
- Determine how needed supplies will be secured, especially human remains pouches suitable for temporary interment
- Understand actions required when the capacity of the funeral firm will be/is exceeded
- Identify actions required to protect the health of workers handling the dead
- Establish a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
- Identify security risks at funeral facilities
- Update contact lists

Cemeterians (including crematory operators)

- Collaborate with partners developing the county's mass fatality annex

- As needed, assist the coroner/ME and OEM in pre-identifying space available for temporary interment
- Participate in informational sessions offered to prepare cemeterians for a mass fatality event
- Be familiar with the county mass fatality annex and alternative procedures that may/should be used when authorized, including temporary interment
- Establish plans to maximize the capacity of the cemetery/crematory
- Determine how needed supplies will be secured, especially staff and equipment, for rapid excavation of grave sites and availability of adequate lighting to permit 24/7 operation
- Understand actions required when the operating capacity of the cemetery/crematory will be/is exceeded
- Identify actions required to protect the health of workers handling the dead
- Establish a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
- Identify inherent security risks at cemeteries/crematories
- Update contact lists

Vital Records Local Registrars

- Collaborate with partners developing the county's mass fatality annex
- Participate in informational sessions offered to prepare registrars for a mass fatality event
- Be familiar with the county mass fatality annex and alternative procedures that may/should be used when authorized, including streamlined death registration processes
- Update contact lists
- Based on the responsibilities assigned to registrars in the county's mass fatality annex, develop/update an organizational operating plan or annex that assigns responsibility, and establishes processes for all assigned responsibilities including:
 - Establishing additional subregistrars at key locations
 - Determining how needed supplies/forms will be secured, especially staff and equipment
 - Identifying actions required to protect the health of workers
 - Surging the capacity to manage issuance of death certificates and burial permits
 - Identifying actions required when the capacity of the registration office will be/is exceeded
 - Establishing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality

- Maintaining continuity of operations for the registrar/subregistrar(s)

Law Enforcement

- Collaborate with partners developing the county's mass fatality annex
- Participate in informational sessions offered to prepare partners for a mass fatality event
- Update contact lists
- Based on responsibilities assigned to the Law Enforcement in this mass fatality annex, develop/update an organizational operating plan or annex for law enforcement and security services as it pertains to the county's integrated mass fatality plan for all assigned responsibilities including:
 - Being familiar with the county mass fatality annex and alternative procedures that may/should be used when authorized
 - Determining how law enforcement will be informed when trigger events cause additional procedures to be invoked
 - Establishing a security plan to manage public access to collection points and temporary morgue sites where human remains are being processed.
 - Establishing plans to maximize the effectiveness of existing resources
 - Identifying actions required to protect the health of workers
 - Establishing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
 - Planning for surging the capacity to manage law enforcement activities supporting the management of human remains
 - Maintaining continuity of operations for law enforcement

State Health Department

- Provide educational sessions to coroners/MEs, funeral firms, cemeteries/crematories, registrars, LHDs, local emergency managers on the essentials of mass fatality management planning. (Health Emergency Preparedness Program)
- Require hospitals and local health departments to participate in the development/updating of the county mass fatality annex and supporting organizational operating plans for their organizations (Health Emergency Preparedness Program)
- Require LHDs and healthcare facilities receiving funding under Article 6 to develop/update emergency staffing plans (COOPs) to handle the anticipated surge in volume during a mass fatality event, and encouraging funeral firms and cemeterians to do the same (Health Emergency Preparedness Program)
- Compile a list of State regulatory and statutory barriers necessary for regulatory relief to enable the rapid disposition of human remains (Health Emergency Preparedness Program)

- Communicate guidance for a streamlined county process for completing and filing death certificates during a mass fatality event (Bureau of Vital Statistics)
- Develop a Commerce reporting template to collect pandemic influenza mortality information from healthcare facilities (Division of Epidemiology)
- Review requirements for autopsy and post-mortem testing in the context of a pandemic (Division of Epidemiology)
- Provide guidelines to enable counties to establish relationships with faith-based and cultural group leaders so they can understand the plan and provide public information and support to their communities (Health Emergency Preparedness Program)
- Develop stockpiles of supplies needed to support the mass fatality plan to supplement local supplies (Health Emergency Preparedness Program)
- Establish a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality (Health Emergency Preparedness Program)

SOEM

- Continue to provide mass fatality planning guidance to county officials in coordination with agencies that comprise the State's Disaster Preparedness Commission (DPC)
- Provide direction and support in developing, maintaining and implementing the State's Mass Fatality Annex (when developed)
- Establish a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality

SECTION III: RESPONSE

Purpose:

This section of the Annex identifies the roles, responsibilities and the interagency coordination of the local response network. Planning teams should recognize and be consistent with the response levels that are identified in their CEMP and appropriate accompanying annexes.

Counties must adopt the following requirements and add any additional responsibilities that are identified in their Concept of Operations. Also include how each organization will integrate with the State response.

Responsibilities by Provider Type

Healthcare Facilities

- As required, implement the operating plan for:
 - Implementing procedures communicated by the LHD to protect the health of workers handling the dead
 - Implementing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
 - Holding, identifying, tracking and releasing human remains
 - Expediting medical certification of death certificates
 - Reporting deaths to the NYSDOH
 - Assuring a sufficient supply of human remains pouches and other supplies is available
 - Managing access to holding areas for human remains
 - Reporting the need to have human remains transported
 - Surging the capacity to manage human remains
 - Maintaining continuity of operations for the healthcare facility
- Maintain contact with the county's emergency operations center (EOC)

Coroner/MEs

- As required, implement the operating plan for:
 - Directing alternative processes for transporting human remains
 - Establishing and overseeing one or more additional morgue sites

- Counting and tracking information about the deceased
- Implementing position-specific processes to promote efficient and effective processing of death certificates and burial permits
- Overseeing remains from unattended deaths, unidentified remains, and remains requiring autopsies
- Assuring a sufficient supply of human remains pouches suitable for interment and other supplies
- Directing remains to funeral firms/cemeteries/crematories/temporary interment sites
- Implementing procedures communicated by the LHD to protect the health of workers handling the dead
- Implementing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
- Implementing the security plan to manage public access to collection points and temporary morgue sites where human remains are being processed
- Surging the capacity to manage human remains
- Maintaining continuity of operations for the coroner/ME's areas of responsibility
- Maintain contact with the county's emergency operations center (EOC)

Local Health Departments

- Update providers regularly as an influenza pandemic unfolds and provide recommendations from NYSDOH on infection control and PPE
- As required, implement the operating plan for:
 - Monitoring the tracking of mass fatality resources to determine when the LHD should authorize or invoke appropriate authorities to launch measures to protect public health
 - Implementing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
 - Surging the capacity to manage human remains
 - Maintaining continuity of operations for the local health department
- Maintain contact with the county's emergency operations center (EOC)

Local OEM

- Coordinate county response activities among local and county resources as appropriate
- Serve as the lead county agency in requesting State and Federal assistance

- As required, implement the operating plan for:
 - Monitoring when healthcare facilities, funeral firms and cemeteries/crematories report that their capacity will be/is exceeded. With the LHD and coroner/ME, determine when trigger events have occurred so the appropriate authority may authorize the steps identified in the county plan
 - Responding to requests for transportation, staffing or other assets in accordance with ICS
 - Implementing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
 - Maintaining continuity of operations to support the response organization

Funeral Firms

- Implementing procedures communicated by the LHD to protect the health of workers handling the dead
- Implementing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
- Implementing alternative procedures when authorized, including the streamlined death registration process
- Reporting the need for additional supplies as specified in the county plan
- If the funeral firm anticipates or becomes unable to accept additional remains temporarily or for the duration of the emergency, reporting the situation according to the procedure specified in the county plan
- As required
 - Implementing plans to maximize the capacity of the funeral firm
 - Increasing security measures
- Maintaining contact with the county's emergency operations center (EOC)

Cemeterians

- Implementing procedures communicated by the LHD to protect the health of workers handling the dead
- Implementing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
- Reporting the need for additional supplies as provided in the county plan
- Implementing special procedures for temporary interment if so designated
- As required, implementing plans to
 - Maximize the operating capacity of the cemetery/crematory

- Increase security measures
- If the cemetery/crematory anticipates or becomes unable to accept additional remains temporarily or for the duration of the emergency, reporting the situation according to the procedure provided in the county plan
- Maintaining contact with the county's emergency operations center (EOC)

Vital Records Local Registrars

- As required, implement the operating plan for:
 - Establishing additional subregistrars at designated locations
 - Securing needed supplies, especially staff and equipment
 - Implementing actions required to protect the health of workers
 - Implementing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
 - Surging the capacity to manage issuance of death certificates and burial permits
 - Implementing actions required when the capacity of the registration office will be/is exceeded
 - Maintaining continuity of operations for the registrar/subregistrar(s)
- Maintain contact with the county's emergency operations center (EOC)

Law Enforcement

- As required, implement the operating plan for providing law enforcement and security services:
 - Assuring law enforcement is informed when trigger events cause additional procedures to be invoked
 - Maximizing the effectiveness of existing resources
 - Implementing procedures communicated by the LHD to protect the health of workers handling the dead
 - Implementing a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality
 - Surging capacity to manage law enforcement activities supporting the management of human remains
 - Maintaining continuity of operations for law enforcement
- Maintain contact with the county's emergency operations center (EOC)

State Health Department

- Develop and submit to SOEM any waivers that are identified as needed to effectively respond to a declared emergency (Legal Affairs)
- Analyze fatality data reported by hospitals, and report as required. (Division of Epidemiology)
- Deploy stockpiles of supplies per plan (Health Emergency Preparedness Program)
- Implement a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality (Health Emergency Preparedness Program)

SOEM

- Serve as the State lead in coordinating State resources in support of local government efforts
- Serve as the State lead in providing coordination with Federal resources that may be available be through the activation of the National Response Framework and accompanying emergency support functions
- Serve as that State's conduit to coordinate resource support, as appropriate, that may be available through the Emergency Management Assistance Compact (EMAC)
- Provide direction and assistance in the coordination of statewide communications among the various response disciplines in an emergency
- Serve as the State lead in coordinating requests for waivers with the Governor's office
- Implement a comprehensive mental health plan to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality

SECTION IV: POST EVENT RECOVERY⁸

Purpose:

This section identifies responsibilities for demobilization of the mass fatality response and transition to the recovery phase. This section includes mass fatality concepts not already found in the county CEMP.

Counties must adopt the following requirements and add any additional responsibilities that are identified in their Concept of Operations.

Responsibilities by Provider Type

Healthcare Facilities

- Maintain special processes until the local health department advises that a pandemic event is subsiding
- Prepare for the next wave(s) of a pandemic, e.g., supplies, staff, etc.
- Conduct contingency planning in the event current capabilities/capacities are exceeded
- Recover naturally as capacity to manage and hold human remains is no longer exceeded
- Report resumption of business as usual according to the procedure specified in the county plan

Coroner/MEs

- Maintain special processes until the local health department advises that a pandemic event is subsiding
- Prepare for the next wave(s) of a pandemic, e.g., supplies, staff, etc.
- Conduct contingency planning in the event current capabilities/capacities are exceeded
- With law enforcement, support the process to continue to identify human remains and issue correction forms
- Recover naturally as capacity to manage and hold human remains is no longer exceeded

Local Health Departments

- Prepare for the next wave(s) of a pandemic, e.g., supplies, staff, etc.

⁸ In this context the term "recovery" refers to returning to normal operations after the event.

- Conduct contingency planning in the event current capabilities/capacities are exceeded.
- Based on information from the NYSDOH, communicate to county mass fatality partner organizations that a pandemic event is subsiding and special processes may be curtailed

Local OEM

- Maintain special processes until the local health department advises otherwise
- Prepare for the next wave(s) of a pandemic, e.g., supplies, staff, etc.
- Conduct contingency planning in the event current capabilities/capacities are exceeded
- Recover naturally as requests for assistance subside
- Coordinate State/Federal disaster assistance as appropriate

Funeral Firms

- Maintain special processes until the local health department advises otherwise
- Prepare for the next wave(s) of a pandemic, e.g., supplies, staff, etc.
- Conduct contingency planning in the event current capabilities/capacities are exceeded
- Recover naturally as funeral firms resume business as usual
- Report resumption of business as usual according to the procedure specified in the county plan
- Provide disinterment/re-interment services in accordance with the county plan

Cemeterians

- Maintain special processes until the local health department advises otherwise
- Prepare for the next wave(s) of a pandemic, e.g., supplies, staff, etc.
- Conduct contingency planning in the event current capabilities/capacities are exceeded
- Recover naturally as cemeteries/crematories resume business as usual and temporary interment is no longer required
- Report resumption of business as usual according to the procedure specified in the county plan
- Provide disinterment/re-interment services in accordance with the county plan

Vital Records Local Registrars

- Maintain special processes until the local health department advises otherwise

- Prepare for the next wave(s) of a pandemic, e.g., supplies, staff, etc.
- Conduct contingency planning in the event current capabilities/capacities are exceeded
- Process correction forms to update death certificates

Law Enforcement

- Maintain special processes until the local health department advises otherwise
- Prepare for the next wave(s) of a pandemic, e.g., supplies, staff, etc.
- Conduct contingency planning in the event current capabilities/capacities are exceeded
- With the coroner/ME, support the process to continue to identify human remains and issue correction forms

State Health Department

- Prepare for the next wave(s) of a pandemic
- Conduct contingency planning in the event current capabilities/capacities are exceeded
- Communicate to local health departments that the pandemic event is subsiding and special processes may be curtailed
- Assure that death certificates are complete (Vital Records section)

SOEM

- When requested provide direction and support in obtaining damage assessments, individual and public assistance, and federal recovery support

B. Waivers

Overview

Planning for waivers to existing laws and regulations is a key component of advance planning for emergencies.

There is no guarantee that the Governor will issue any planned waiver, or that its content will be entirely consistent with a waiver that was drafted in advance. As a result, **no action in an emergency should be taken in reliance on waivers drafted in advance**; any actions must be based on the content of any waivers that the Governor actually orders during the emergency. Requests for waivers of State laws and regulations should be submitted to the State regulatory agency by the county agencies that are responsible for enforcing the law at the county and local level.

Localities may also have ordinances or regulations that would need to be waived by the local executive to efficiently respond to the emergency. In addition, please note that the bulk of Article 4100 of the Public Health Law does not apply in New York City. The process for requesting waivers for county laws and regulations varies among counties.

Advance Drafts of State Law Waivers

Only one advance waiver of state law is currently being drafted for potential consideration by the Governor during a mass fatality emergency. This waiver would address the conditions under which the requirement to conduct autopsies on all inmates who die in custody may be waived during a public health emergency. Other potential waivers may be developed over time if needed. The NYSDOH Division of Legal Affairs will also maintain a list of waivers for consideration. Items on this list will have received preliminary research on the applicable laws or regulations, but require clarification about the exact nature of the waiver request at the time of the emergency before they can be drafted and submitted to the Governor for approval. In addition, counties may identify additional needs during their planning process; if that is the case, the county should submit that information to NYSDOH for consideration.

In the course of determining what waivers were necessary or appropriate for consideration, a number of specific issues were identified for discussion. A chart detailing these issues as well as comments from NYSDOH Division of Legal Affairs is below.

Mass Fatality Waiver Issues

The chart below identifies issues that the workgroup felt could require legal waivers in the event of a mass fatality. The NYSDOH Division of Legal Affairs has reviewed these concerns and offers comments and suggestions as to whether a waiver should be considered going forward.

Please note that the issues discussed below are based on state law and regulation. Localities may have additional or corresponding ordinances or regulations that would also need to be waived. Each locality should identify additional or corresponding local ordinances, rules, etc., that might also need to be waived.

Key:

DLA = Division of Legal Affairs of the New York State Department of Health

PHL = Public Health Law

NPCL = Not For Profit Corporation Law

NYCRR = New York Codes, Rules and Regulations

Citation	Rule	Problem	DLA Comments	Proposal
1. No citation	"Under normal circumstances, only licensed funeral directors are authorized to move human remains"	"The coroner/ME will need to authorize supplemental resources to move remains."	10 NYCRR Part 13, section 13.1 allows for the transportation of human remains via common carrier, as long as certain precautionary measures are taken. 10 NYCRR section 13.2 allows for transportation by means other than common carrier when a funeral director "or his agent" assumes responsibility, takes the steps necessary to prevent leakage of body fluids and the inside of the transporting vehicle is maintained in a clean and sanitary manner. It appears that a funeral director need only name an "agent" for the purpose of transporting bodies if transportation occurs via means other than common carrier.	No waiver required
2. No citation	"Under normal circumstances human remains are moved across state lines when requested."	"During a severe mass fatality . . . the logistics to move human remains across state lines will constrain needed surge capacity."	There is no requirement specifying that remains must be moved across state lines during an emergency.	No waiver required

Citation	Rule	Problem	DLA Comments	Proposal
3. PHL, various provisions in Articles 41 and 42		<p>“Counties will need to initiate temporary interment when cemeteries exceed their short-term capacity to dispose of human remains and/or need to temporarily or permanently cease operations”</p> <p>“Management of death records should match the pace of the processing of human remains.”</p>	<p>PHL § 4200 requires that bodies be either buried or cremated “within a reasonable time after death.” “Temporary interment” should meet this requirement, after which the rules relating to moving of human remains would apply. In fact, PHL § 4218 refers to temporary places of interment; as a result, it would appear that no waiver is required to allow for temporary interment. Consider using the burial transfer permit as a means for tracking and transferring bodies to temporary interment sites.</p> <p>PHL § 4144, however, requires a permit if the body is to be temporarily held for more than 72 hours, and 4140 requires filing of a death certificate within 72 hours. A waiver might be needed to allow more time to register a death certificate and apply for a permit. Other statutes follow this same 72-hour limit.</p>	Under consideration
4. PHL § 4120	Generally, each city, village and town in the state shall constitute a separate primary registration district	Local vital records registration districts may not be able to accommodate the demand for their services	<p>PHL § 4120 permits the commissioner, with the approval of the legislative body of the county in which each affected district is located, to combine two or more primary registration districts into a single primary registration district.</p> <p>If he were to do so, however, would that increase the burden on that registration district? If a waiver instead created a single registration district in each county, and allowed reporting to any of the offices from the previous registration districts (which are then part of that single district), then could that place an unreasonable burden on the unlucky</p>	Unclear whether waiver is needed, and if so, what waiver would best suit the state’s needs.

Citation	Rule	Problem	DLA Comments	Proposal
			<p>district that is nearest the largest/busiest funeral director?</p> <p>PHL § 4122 allows for the appointment of subregistrars within any existing district; this provision could be used to meet increased demand.</p> <p>See also the following two issues.</p>	
5. PHL §§ 4120, 4140	Death certificates must be filed with the registrar of the district in which the death occurred or the body was found.	Funeral directors will be able to improve surge capacity more effectively by registering death certificates and securing burial permits at one location rather than traveling among multiple locations.	<p>PHL § 4120 allows the commissioner, with the approval of the legislative body of the county in which each affected district is located, to combine two or more primary registration districts into a single primary registration district.</p> <p>If he were to do so, however, would that mean that the funeral directors might have to travel farther to that single district? See also the issue above and the issue below.</p>	Unclear what waiver would best suit the state's needs.
6. PHL § 4140	Death certificates must be filed in person.	Funeral directors will be able to improve surge capacity by faxing rather than registering in person.	<p>It is unclear whether this waiver and the waivers directly above would all be necessary. If faxing were allowed, then the waiver for § 4120 may not be necessary.</p> <p>Is faxing the only means of electronic transfer? Would it be preferable to broaden the waiver to include scanning and secure e-mail or other secure electronic transfer?</p>	Unclear what waiver would best suit the state's needs.
7. Per state Commissioner of Health	Current requirement to transmit copies of all birth and death certificates received during the week each Friday.	Management of death records should match the pace of processing human remains.	The commissioner may alter this requirement at will.	No waiver required

Citation	Rule	Problem	DLA Comments	Proposal
8. No citation	"Currently the Department of Environmental Conservation may limit the hours of operation of crematories."	Crematories will need to operate at maximum capacity	<p>Is it possible that such limitations may be triggered by violation of air quality standards?</p> <p>Given the limited number of crematories and the logistical problems relating to their use (e.g., need for frequent relining due to the extreme temperatures), is there a realistic expectation that maximum capacity would exceed such limitations?</p>	No waiver likely needed
9. NPCL § 1517	Law has "requirements for documentation and signatures for certain steps within the process and precludes crematory operators from opening containers without the assistance of a funeral director."	Requirements might limit the ability of crematories to operate at maximum capacity	<p>Requirements for documentation and signatures are part of the recordkeeping for insuring proper identification of the deceased. Policymakers at NYSDOH and Division of Cemeteries should be consulted as to what level of relaxation of this requirement is advisable.</p> <p>Note that 19 NYCRR § 203.7 contains a related provision that precludes the transfer of remains delivered to a crematory to an alternative container without the presence of the licensed funeral director who delivered the remains.</p>	Under consideration
10. NPCL § 1517(j)	Crematory operators are required to be certified within the first year of employment	Requirement may limit the ability of crematories to operate at maximum capacity; may need to allow for on-the-job certification	<p>Consider whether waiving a provision that carries a one-year time frame is necessary given the probable limited duration of any severe mass fatality incident.</p> <p>Note that 19 NYCRR § 204.2 contains additional certification requirements for crematory operators – if one provision is waived, the other should be waived as well.</p>	Under consideration

Citation	Rule	Problem	DLA Comments	Proposal
11. NPCL § 1510-b 19 NYCRR § 201.8	"Cemeteries are required to operate on a six-day-per-week basis." (Inaccurate)	1. Cemeteries may need to operate 7 days/week to meet demand. 2. Cemeteries may need to operate fewer days per week or close due to illness of operators.	1. Allowed under current law: Cemeteries must be open "at least" six days per week; however, it also says that they are not required "to provide grave openings and/or interments if they are otherwise unable to do so as to [sic] direct consequence of severe weather conditions or other similar conditions." 2. While it is not clear that a pandemic would meet those criteria, it is also not clear whether a waiver that would allow them to open less than six days per week is what would best meet the needs of the moment.	1. No waiver needed. 2. Unclear what waiver would best serve the state's needs.
12. PHL § 4145	Cemeteries and crematory operators must provide a body tracking receipt to the funeral director who delivers remains for interment.	During a mass fatality incident, counties may specify alternative tracking methods, creating duplication of paperwork.	If there is a system that should be implemented statewide that is simpler than that in the current statute, it would be better to avoid conflicting local rules and waive the state statute in favor of that simpler system.	Unclear what waiver would best serve the state's needs.
13. NPCL § 603	Annual meeting of cemetery lot owners is required.	Such meetings may reduce the ability of cemeteries to manage the demand for burials.	Waiver of annual requirements may not be necessary. In addition, it is unclear what consequences would be avoided by failure to hold such a meeting on the anticipated date.	No waiver likely needed.
14. NPCL § 1507(a)	Allotments to the permanent maintenance and current maintenance funds	There may be a gap between the time a grave is sold and the time it is paid for. Cemeteries may need to use all capital resources to continue operations during an ongoing health crisis	Any payment delay authorized by a waiver would end with the expiration of the emergency, in which case all the monies would be due at once. In the end, this could create a greater burden on the cemeteries.	Unclear what waiver would best serve the cemeteries' needs

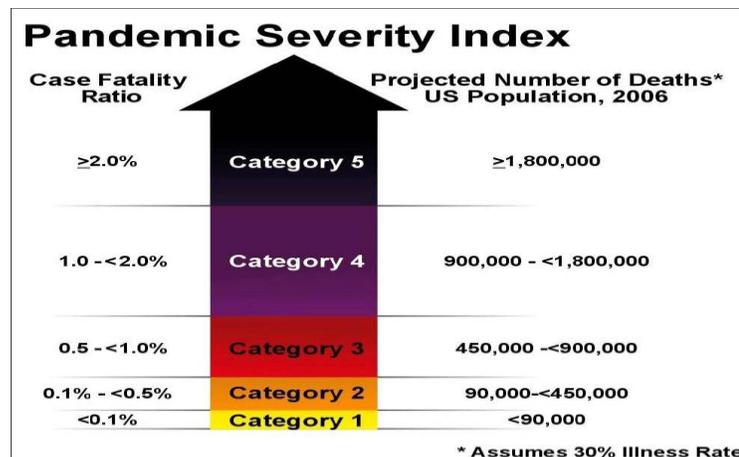
Citation	Rule	Problem	DLA Comments	Proposal
15. NPCL § 1507(h)(2) 19 NYCRR § 200.11(b)	Law requires cemeteries to pay five dollars per interment to the fund for the maintenance of abandoned cemeteries	Interments may not be paid for right away and cemeteries may need to focus all capital resources on the operation of the cemetery during a health crisis.	Per 19 NYCRR § 200.11, cemeteries/crematories must make designated monetary contributions to the fund for the maintenance of abandoned cemeteries “[o]n or before March 15th of each year.” Consider whether waiving an annual requirement is necessary given the probable limited duration of any severe mass fatality incident.	No waiver likely needed
16. NPCL § 1508(c)	Three-dollar fee is required for each interment or cremation after the first 15 – due on March 15 th .	Payment for interments may be delayed and cemeteries/crematories may need to focus all capital resources on necessary operations.	Consider whether waiving an annual requirement is necessary given the probable limited duration of any severe mass fatality incident.	No waiver likely needed
17. NPCL § 1508(a), 19 NYCRR § 200.3	Annual cemetery reports are required.	Reporting requirements may reduce ability of cemeteries to manage the demand for burials.	Cemeteries have 75 days after the end of their fiscal year to file such report. In addition, section 1508(d) provides that “the cemetery board may extend the time for filing any such report.” Consider whether waiving an annual requirement is necessary given the probable limited duration of any severe mass fatality incident.	No waiver likely needed
18. NPCL § 1508	Penalties may be imposed for failure to meet reporting requirements.		The cemetery board has the authority to extend reporting times and waive penalties	No waiver required

C. Pandemic Influenza Planning Models⁹

Severity Index

The *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States* (February 2007) features the Pandemic Severity Index (Figure 1) which uses case fatality ratios as critical drivers for categorizing the severity of a pandemic. Interventions will be recommended based on the severity of pandemic, including: isolation and treatment of ill persons with antiviral drugs; voluntary home quarantine of members of households containing confirmed or probable cases; dismissal of students from school; closure of childcare facilities, and use of social distancing measures to reduce contacts between adults in the community and workplace. State and local pandemic plans should take into account implementation of these mitigation strategies and their possible secondary effects.

Figure 1. Pandemic Severity Index

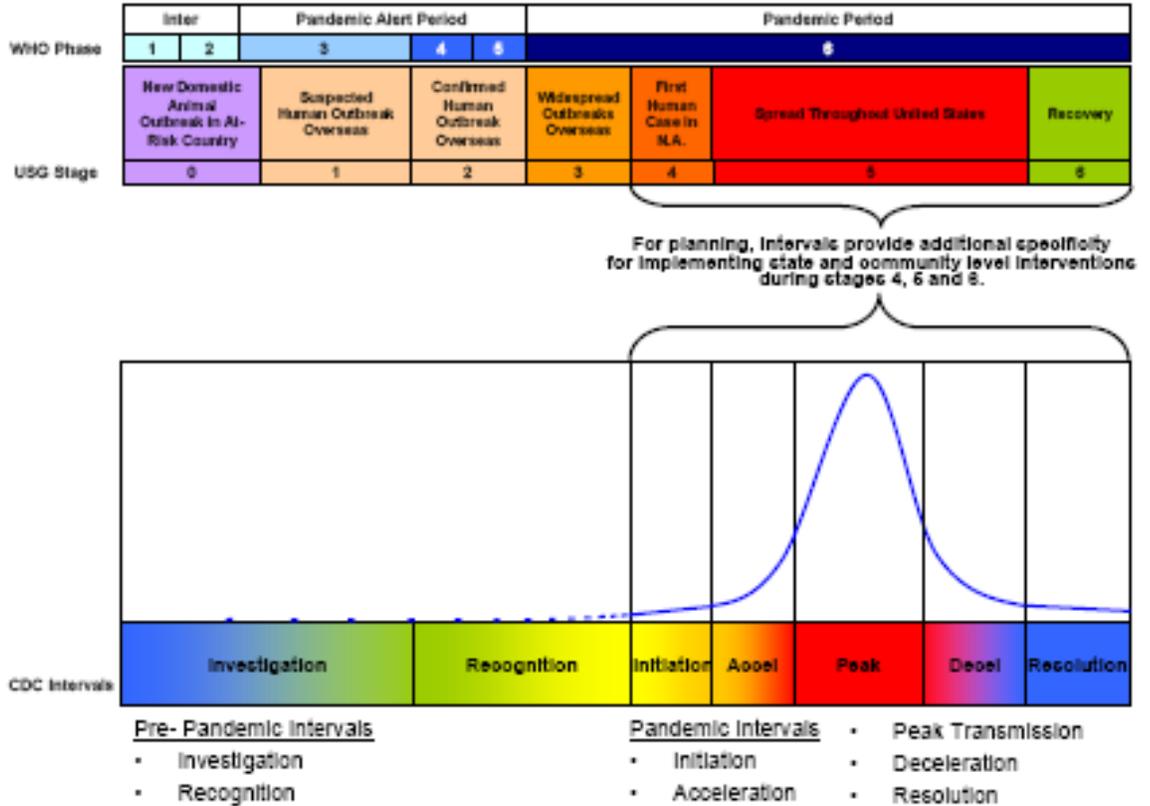


Pandemic Intervals, Triggers and Actions

Pandemic intervals are designed to inform and complement the use of the Pandemic Severity Index (PSI) for choosing appropriate community mitigation strategies. The PSI guides the range of interventions to consider and/or implement given the epidemiological characteristics of the pandemic. The intervals are more closely aligned with triggers to indicate when to act, while the PSI is used to indicate how to act.

⁹ Information on the Severity Index and Pandemic Intervals has been excerpted from *Federal Guidance To Assist States In Improving State-Level Pandemic Influenza Operating Plans*, March, 2008, <http://www.pandemicflu.gov/news/guidance031108.pdf> .

Figure 2: Periods, Phases, Stages, and Intervals



These hypothetical models may be particularly valuable prospectively for anticipating conditions and identifying the key actions that could be taken at certain points in time to alter the epidemic or pandemic curve.

While it is difficult to forecast the duration of a pandemic, we expect there will be definable periods between when the pandemic begins, when transmission is established and peaks, when resolution is achieved, and when subsequent waves begin. While there will be one epidemic curve for the United States, the larger curve is made up of many smaller curves that occur on a community by community basis. Therefore, the intervals serve as additional points of reference within the phases and stages to provide a common orientation and better epidemiologic understanding of what is taking place. State health authorities may elect to implement interventions asynchronously within their states by focusing early efforts on communities that are first affected. The intervals thus can assist in identifying when to intervene in these affected communities. The intervals are also a valuable means for communicating the status of the pandemic by quantifying different levels of disease, and linking that status with triggers for interventions.

D. Outside Resources

In most mass fatality events, counties can plan for assistance from outside resources such as other counties, the State, and if necessary, from the Federal government when local resources are exhausted. Below is a summary of resources that may/will be involved in a mass fatality event.

Other Counties

Counties may call on other counties through mutual aid agreements. LOAs/MOUs may be put in place in advance of the event.

State assistance available through SOEM

State assistance is supplemental to local efforts.

- All non-mutual aid assistance is requested through SOEM. SOEM may identify sources of assistance from the State, from other states or from the Federal government.
- Federal resources include (but are not limited to) Disaster Mortuary Operations Response Teams (DMORT) that can provide temporary morgue facilities, victim identification, and assistance with processing, preparation and disposition of remains.
- Counties should be prepared to:
 - Describe the type of assistance that is needed, e.g. transporting volunteers rather than requesting buses.
 - Counties will need to have the structure in place to interact with the incoming resources.

Agencies with special authority during a disaster

Some events may warrant an immediate State or Federal involvement, consistent with legal authority, e.g.:

- NTSB – National Transportation Safety Board
- FBI – Federal Bureau of Investigation
- NYS Police

E. Guidance for Tracking Mass Fatality Resource Capacity

Healthcare facilities, funeral firms and cemeteries/crematories will continue business as usual for as long as possible. Eventually, capacity may be exceeded. Some partner organizations may be required to report that they are out of capacity temporarily or for the duration of the emergency. They will need to know who to contact when their capacity is strained. Alternatives include combinations of:

- Phone – Counties should establish a phone number other than 911 to report constraints, ideally to Incident Command. These phones should have the functionality to “queue” callers rather than give them constant busy signals. Some organizations/businesses in the area may be able to provide these queuing services and manpower under contract to the county. Also consider whether voicemail is available on the line. If so, it should be true voicemail that can accommodate multiple messages at one time, not an answering machine that can only accommodate one call at a time.
- E-mail - Electronic communications should not be used as the sole form of reporting capacity constraints because organizations do not all have access to e-mail. However, e-mail does provide the ability to get information through without waiting for a person to be immediately available.

Families that cannot find funeral firms to accept their deceased, or the public reporting remains that need to be removed, will need to know where to call.

- Families may be directed to use the same communications venues as healthcare facilities, funeral firms and cemeteries/crematories, or the county may decide to direct them to other communications channels. However, many people will still choose to call 911 even if there are alternative channels in place.

Counties should:

- Determine who will collect and summarize the information coming in, and what they should do.
- Manage information about capacity constraints through the emergency operations center (EOC).
- Seek additional staffing and technology resources from existing county organizations that may not be functioning after social distancing is implemented, e.g. Economic Development resources.

F. Guidance for Death Registration Planning

During a mass fatality event it is essential that counties maintain the integrity of their death certificates and burial permits processing to enable verification of the identity of the deceased for subsequent legal and estate considerations, as well as other vital statistics reporting. Counties must also assure that managing this documentation appropriately does not affect the rapid disposition of human remains. There are a number of provisions within the public health law that support both of these objectives.

In the event of a declared state of emergency, the NYS Commissioner of Health may request waivers to modify certain existing public health procedures that relate to death registration process.

Completing the forms

Existing death certificate forms in use at the time of the event must be used to ease the post-pandemic reconciliation of records.

The minimum information required to file a death certificate is indicated in the following table. If additional information is available and can be provided without compromising the rate of processing human remains, it must be included.

To file a death certificate during a mass fatality emergency the following fields must not be blank.

Field	Description	Comments
I D E N T I F I C A T I O N S E C T I O N		
None	Decedent identification number, if required for the incident. <i>Always enter the decedent name if known.</i>	Enter on the top of the death certificate form ensuring that it appears on the under copy. Do not use the Register Number or State File number fields.
4a-4g	Place of death and location details	Specifics relating where death occurred or body was found.
19 a 19 b	Informant name Informant address	This is the name of the person filling out the death certificate form.
D I S P O S I T I O N S E C T I O N		
20a 20b 20c	Disposition Place of burial, cremation, removal/or other disposition Location (city,town,village)	This information is required to generate a burial permit. If the disposition is standard burial, temporary interment or cremation, a burial permit will be issued. If the disposition is for storage, not temporary interment, a holding permit will be issued.
C E R T I F I E R S E C T I O N		
25a- 29b	Information relating to the medical certifier	The medical certification may be signed by the attending physician or any other physician assigned by a hospital administrator, or the coroner/ME or their designee.*

Field	Description	Comments
C A U S E O F D E A T H S E C T I O N		
30-33b	Cause of death information	If unknown, enter "pending", "under investigation," etc.
A L L O T H E R I N F O R M A T I O N I F A V A I L A B L E		

* In their operating plans, healthcare facilities should designate physicians to certify the cause of death if the attending physician is not available.

* In their operating plans, coroners/MEs should designate physicians who are authorized to certify the cause of death on their behalf.

Delivering the forms

Subregistrars

With the approval of the State Commissioner of Health, local registrars may appoint one or more subregistrars. In their annexes, counties should plan for activation of subregistrars in hospitals and morgues to facilitate the processing of death certificates and burial permits. Hospitals and coroners/MEs should prepare appointment forms in advance and submit them to the registrar, who will submit them to the State Commissioner of Health, as appropriate.

Other information

Registered death certificates must be sent by registrars to the Vital Records Bureau for recording and filing per standard procedures.

Registrars will continue to be responsible for maintaining burial/cremation/storage records.

G. Guidance for Decedent ID Numbers

To assure that remains are not double counted, and to help track remains, counties may assign a unique decedent ID number to event related or all remains whether the name of the decedent is known or not. During a pandemic influenza mass fatality event counties should always assign a decedent ID number for all fatalities in the county.

The numbering system should use:

- A prefix followed by a dash to indicate the county in which the death occurred. (See the following list.)
- Five (5) numeric digits followed by a dash
- A suffix assigned by the county to indicate the event

To facilitate the reconciliation of records within the county the decedent ID number should be referenced on:

- Death certificates
- Human remains pouches and the body
- Burial permits
- Records for unidentified remains¹⁰

The process of assigning numbers may vary based on the needs and resources of a county, e.g.:

- Some counties may choose to supply hospitals and morgues with a list of sequential five-digit numbers that can be crossed off as used
- Other counties may be able to develop a web based program that generates complete decedent ID numbers as needed

¹⁰ Unidentified remains should be tracked using the locality's current process.

Prefixes for Decedent ID Numbers

County Code	County Name	County Code	County Name
01	Albany County	30	Oneida County
02	Allegany County	31	Onondaga County
03	Broome County	32	Ontario County
04	Cattaraugus County	33	Orange County
05	Cayuga County	34	Orleans County
06	Chautauqua County	35	Oswego County
07	Chemung County	36	Otsego County
08	Chenango County	37	Putnam County
09	Clinton County	38	Rensselaer County
10	Columbia County	39	Rockland County
11	Cortland County	40	St. Lawrence County
12	Delaware County	41	Saratoga County
13	Dutchess County	42	Schenectady County
14	Erie County	43	Schoharie County
15	Essex County	44	Schuyler County
16	Franklin County	45	Seneca County
17	Fulton County	46	Steuben County
18	Genesee County	47	Suffolk County
19	Greene County	48	Sullivan County
20	Hamilton County	49	Tioga County
21	Herkimer County	50	Tompkins County
22	Jefferson County	51	Ulster County
23	Lewis County	52	Warren County
24	Livingston County	53	Washington County
25	Madison County	54	Wayne County
26	Monroe County	55	Westchester County
27	Montgomery County	56	Wyoming County
28	Nassau County	57	Yates County
29	Niagara County		

H. Organ Procurement Guidelines and Recommendations

Under current federal and New York State law, hospitals must report the potential availability of organs for procurement to designated Organ Procurement Organizations (OPO). This legislation includes guidelines to determine which patients are considered likely candidates for organ transfer.

Review of these regulatory documents has led to the opinion by the Center for Donation and Transplant that the requirements to process these reviews will not substantially incur hardships upon hospitals during pandemic influenza. However, to mitigate potential complications during pandemic influenza, hospitals should collaborate with regional organ procurement organizations to develop expedited planning guidelines.

I. General Infection Control Procedures

Measures should be taken to reduce the risk of transmission of disease associated with handling human remains.

Standard precautions are essential for those handling human remains. This set of infection prevention practices assumes that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting. When handling human remains, these precautions include:

- Personal protective equipment (PPE)
 - Gloves should be worn when it can be reasonably anticipated that hand contact with blood, other potentially infectious material (OPIM), mucous membranes, and/or non-intact skin may occur and when handling or touching contaminated items or surfaces.
 - Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, should be worn whenever splashes, spray, spatter, or droplets of blood or OPIM may be generated and eye, nose, or mouth contamination can be reasonably anticipated.
 - Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments should be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated (see Attachment J for information on infection control procedures for pandemic influenza.).
 - PPE should be disposed of appropriately.
 - Avoid cross-contamination. Personal items should not be handled while wearing soiled PPE.
- Hand hygiene
 - Should be performed immediately after removing PPE.
 - Can be accomplished by hand washing with soap and warm water if hands are visibly contaminated. When hands are not visibly contaminated, or when soap and warm water are not available, hand sanitizing may be performed using an alcohol-based hand rub, gel, or foam.
- In HazMat or WMD events, the appropriate level of PPE is required depending on the agent.
- Vehicles used for transportation should be cleaned and decontaminated as indicated.
- Human remains pouches will further reduce the risk of exposure to blood or other potentially infectious material and are useful for the transport of decedents who have been badly damaged. Wrapping with plastic and a sheet may be an economical and practical containment solution.
 - If the body is not contained in a fluid impervious bag, appropriate PPE should be used when handling the body, and surfaces in contact with the body during transport should be cleaned and decontaminated (see Attachment M).

J. Infection Control Procedures for Pandemic Influenza

11

Mortuary care and postmortem examination

G.1 Packing and transport of dead body to mortuary, crematorium and burial

- Before removal from the isolation room/area, the body should be fully sealed in an impermeable human remains pouch to avoid leakage of body fluid. The outside of the bag should be kept clean. When properly packed in the human remains pouch, the body can safely be transferred to pathology department or the mortuary, sent to the crematorium, or placed in a coffin for burial. (See Attachment O for recommended minimum specifications for human remains pouches used for burial without a coffin/vault.)
- Transfer to the mortuary should occur as soon as possible after death.
- If an autopsy is being considered, the body may be held under refrigeration in the mortuary until a safe environment can be provided for the autopsy.

G.2 Recommended PPE for workers handling human remains

- Disposable long-sleeved, cuffed gown, (waterproof, if the outside of body is visibly contaminated with body fluids, excretions or secretions). If no waterproof gown is available, a waterproof apron should be used in addition to the gown.
- Non-sterile, latex gloves (single layer) should cover cuffs of gown.
- If splashing of body fluids is anticipated, use facial protection (see Attachment I).
- Perform hand hygiene after removal of PPE.

G.3 Recommended PPE during autopsy

G.3.1 PPE to be provided

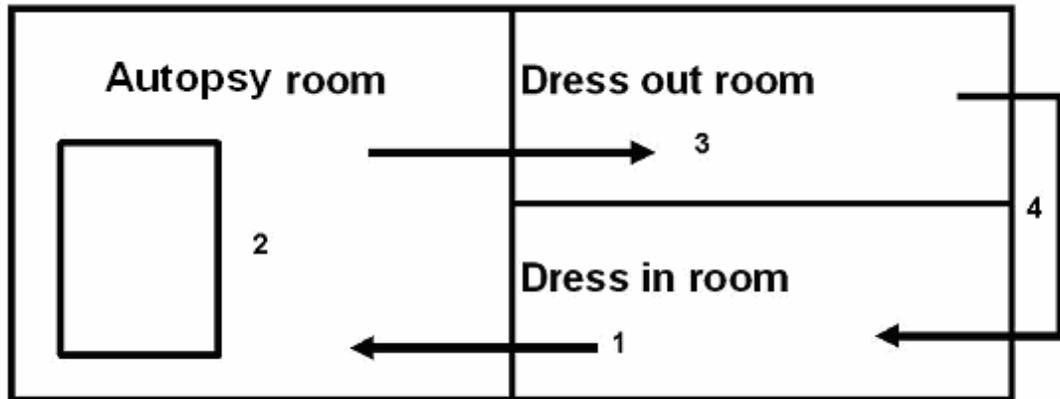
- Scrub suits: tops and trousers, or equivalent garments.
- Single-use, fluid-resistant, long-sleeved gowns.
- Surgical masks, or if small particle aerosols might be generated during autopsy procedures, a particulate respirator at least as protective as a NIOSH-certified N95, EU FFP2 or equivalent.
- Face shield (preferably) or goggles.
- Autopsy gloves (cut-proof synthetic mesh gloves) or two pairs of non-sterile gloves.
- Knee-high boots.

G.3.2 PPE placement

- Workers should put on PPE in the dress in room (see Figure 10) before proceeding to the autopsy room where the body is located.
- In the dress in room, workers should replace their outer street clothes and shoes with scrub suits (or equivalent coverall garments) plus boots.
- Proceed to the autopsy room where the body is located.

¹¹ Adapted from Infection prevention and control of epidemic- and pandemic-prone acute respiratory diseases in health care WHO Interim Guidelines, June 2007 and OSHA guidance.

Figure 10. Movement of the autopsy team undertaking a postmortem examination



G.3.3 PPE removal

- Exit the autopsy room to the dress out room as suggested in Figure 10.
- Remove PPE in designated dress out room, dispose of the PPE in accordance with CDC recommendations (available at <http://www.cdc.gov/ncidod/sars/pdf/ppeposter148.pdf>) and perform hand hygiene.

G.4 Methods to reduce HCW exposure to aerosols during autopsy

- An airborne infection isolation room should be used. Exhaust systems around the autopsy table should direct air (and aerosols) away from healthcare workers performing the procedure (e.g., exhaust downward).
- Containment devices should be used whenever possible (e.g. biosafety cabinets for the handling and examination of smaller specimens).
- Vacuum shrouds should be used for oscillating saws.
- High pressure water sprays should not be used.
- Open intestines under water.

For information on PPE for biologic terrorism go to CDC Medical Examiners, Coroners, and Biologic Terrorism: A Guidebook for Surveillance and Case Management at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5308a1.htm>

K. Guidelines for Residential Recovery Teams¹²

If fatalities occurring at home increase beyond the capacity of funeral firms, coroners/MEs should consider using Residential Recovery Teams. These teams are typically comprised of law enforcement for scene investigation and removal/transport personnel. Residential Recovery Teams should be equipped with a specialized vehicle capable of transporting several decedents at time.

Residential Recovery Teams may be responsible for:

- Performing a cursory external exam.
- Obtaining interim decedent identification.
- Obtaining next of kin identification.
- Gathering information to help determine cause and manner of death.
- Taking scene and decedent photos, if appropriate.
- Placing an identification tag with a decedent ID number on the decedent.
- Placing the remains in a human remains pouch (body bag).
- Obtaining general final disposition information from the next of kin, if present, regarding predetermined arrangements made with a funeral director, crematory or cemetery.
- Coordinating social services for special needs next of kin who are left without a caretaker.
- Coordinating with Animal Control for pets left without a caretaker.
- Contacting the County Public Administrator to manage decedent estate property, if applicable.
- Transporting the remains to the appropriate destination.

¹² Adapted from the New York City Office of the City Medical Examiner mass fatality planning.

L. Guidelines for Temporary Morgue Sites¹³

One or more temporary morgues may need to be established to relieve healthcare facilities when human remains exceed their holding capacity and to manage remains from unattended deaths, unidentified remains, and remains requiring autopsies.

The following guidelines will help the county 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.

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

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

¹³ Adapted from DMORT standards at <http://www.dmort.org/dpmupublic/dpmurequirements.htm>

M. Guidelines for Decontamination of Refrigerated Vehicles

Preface:

These directions were intended to provide information and references that could be used for the decontamination of refrigerated trucks which were designated for the temporary preservation of human remains following the terrorist attack in New York City on September 11, 2001. The US Food and Drug Administration (FDA) in consultation with other federal agencies have developed these directions.

Directions:

The decontamination of refrigerated trucks that have been used to preserve human remains needs to be carried out by a contractor qualified to provide such services. All vehicles used for this purpose need to be decontaminated whether being placed back in service to transport food, used for other purposes, or decommissioned and placed in salvage. Upon completion of decontamination written documentation should be provided to the owner of the vehicle identifying the procedure used and giving assurance that effective decontamination has been carried out. Several types of disinfectant agents may be used (e.g., chlorine, iodine, phenolic and quaternary ammonium compounds, aldehydes). Since the internal surfaces of the vehicle may vary (e.g., wood, steel, aluminum, fiberglass, etc.) a specific disinfectant is not identified in this guidance. At concentrations known to be effective for proper disinfection some disinfectants may also react with the inner surfaces of the vehicles. Therefore, it is recommended that owners of the vehicles first consult with the company providing the service. In addition:

- Trucks should not contain any interior wood surfaces. If such vehicles are used, then prior to placing these vehicles back in service, the wood must be removed and disposed of in a manner consistent with standards for removal of hazardous materials, and the trucks refitted with new wood or another suitable material.
- Attention should be given to decontamination of refrigeration units (e.g. ductwork and coils). Assure that filters are decontaminated and/or replaced (if equipped).
- Decontamination procedures for handling medical and/or infectious waste and antimicrobial pesticides (disinfectants and sanitizers) must adhere to all applicable requirements established by the Occupational Safety and Health Administration (OSHA), the Environmental Protection Agency (EPA), and the Department of Transportation (DOT). This includes adherence to procedures designed to both sanitize and provide for worker protection.
- Applicable State and local standards must be met.
- The decontamination must be accomplished in a manner which destroys or inactivates any human pathogen that may be present, and removes chemical and/or any other incidental environmental contaminant.
- The decontamination must remove all offensive odors.

For questions concerning implementation of this guidance call the Food and Drug Administration, Center for Food Safety and Applied Nutrition, Office of Field Programs at 202-260-3847.

Resources:

The Occupational Safety and Health Administration (OSHA)
29 CFR 1910.1030 "Occupational Exposure to Bloodborne Pathogens":
http://www.osha-slc.gov/OshStd_data/1910_1030.html

The Environmental Protection Agency (EPA)
Office of Pesticide Programs – "What are Antimicrobial Pesticides?"
http://www.epa.gov/oppad001/ad_info.htm

Office of Solid Waste – Medical Waste Web Page:
<http://www.epa.gov/epaoswer/other/medical/>

National Antimicrobial Information Network – links to the OSHA bloodborne pathogen standard & accompanying information:
<http://ace.ace.orst.edu/info/nain/topics/bbp.htm>

The Department of Transportation (DOT)
Office of Hazardous Materials Safety:
<http://hazmat.dot.gov/rules.htm>

Hazardous Materials Regulations (Title 49 CFR Parts 100-185)

An Overview to the Federal Hazardous Materials Transportation Law (federal hazmat law):
<http://hazmat.dot.gov/pubtrain/overhml.pdf>

The Centers for Disease Control and Prevention (CDC)
Sterilization & Disinfection link:
<http://www.cdc.gov/ncidod/hip/sterile/sterile.htm>

U.S. Army Environmental Hygiene Agency: TG 195, April 1993 "Guidelines for protection graves registration personnel from potentially infectious materials"
<http://chppm-www.apgea.army.mil/documents/TG/TECHGUID/TG195.pdf>

N. Guidelines for Temporary Interment

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. Based on population, the county plan should identify one or several nonsectarian cemeteries within the county 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. 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 NYS DOS Division of Cemeteries has conducted a survey of the capacity and features of all 1900 regulated cemeteries¹⁴ and crematories in New York State. For access to this database contact the NYS Department of State Division of Cemeteries at 518-474-6226 or cemeteries@dos.state.ny.us .

County plans should establish the necessary agreements to assure that resources are reimbursed as county subcontractors. These resources include, but are not limited to, space, services, equipment and staffing. Resources should be made available by the State to help the county identify pandemic flu cemeteries/crematories and develop a business continuity plan for their use.

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 county may claim the funds.

¹⁴ Religious, municipal and private cemeteries are not regulated by the Division of Cemeteries.

O. Minimum Recommended Specifications for Human Remains Pouches for Interment

During a pandemic influenza emergency, supplies for preparing human remains for burial will become exhausted quickly. When this happens, it is likely that embalming will cease and caskets/vaults will be unavailable. The preferred alternative is to bury human remains in human remains pouches (body bags) that, at a minimum, meet the following specifications.

- Complies with OSHA 3130 universal precautions
- 14 oz. – 18 mil vinyl coated 1350 denier scrim material or equivalent
- All zippers/grommets, etc., must be made of stainless steel or other non-corrosive material
- Envelope style access panel with dual locking zipper pulls allowing bag to open from either end
- Six handles of 1000 lb. test heavy duty propylene webbing or equivalent static lift tested to 450 lbs.
- Impervious to blood, fats and other normal body fluids
- Shelf life in excess of 5 years
- Temperature use to at least 140 degrees F (60 degrees C)
- Remains flexible to 32 degrees F (0 degrees C)
- Adult size

Although New York State is establishing stockpiles of supplies needed to support the mass fatality planning, because of the broad scope of a pandemic influenza emergency, localities should plan to establish local stockpiles as well.

P. Key Acronyms for Emergency Planning¹⁵

A	
AAR	After Action Report
AI	Avian Influenza
B	
BCP	Body Collection Point
BT	Bioterrorism
C	
CBRNE	Chemical, biological, radiological, nuclear, explosive
CDC	Centers for Disease Control and Prevention
CEMP	Comprehensive Emergency Management Plan
COOP	Continuity of Operations Plan
CP	Command Post
D	
DMORT	Disaster Mortuary Operational Response Team

DNA	Deoxyribonucleic acid
DOT	Department of Transportation
DPMU	Disaster Portable Morgue Unit
DVI	Disaster Victim Identification
E	
EMS	Emergency Medical Service
EPA	Environment Protection Agency
EOC	Emergency Operation Center
ESF	Emergency Support Function
F	
FAC	Family Assistance Center
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
G	
H	
HAN	Health Alert Network
HCF	Healthcare Facility

¹⁵ Adapted from the New York City PI Surge Plan to Manage Decedents

HEPP	Health Emergency Preparedness Program
HERDS	Health Emergency Response Data System
HICS	Hospital Incident Command System
HRP	Human Remains Pouch
I	
IAP	Incident Action Plan
IC	Incident Commander
ICP	Incident Command Post
ICS	Incident Command System
ILI	Influenza-Like-Illness
IMS	Incident Management System
J	
JIT	Just-in-Time
K	
L	
LHD	Local Health Department
LOA	Letter of agreement
M	

ME	Medical Examiner
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MFI	Mass Fatality Incident
MFM	Mass Fatality Management
MRC	Medical Reserve Corp
N	
NDMS	National Disaster Medical System
NG	National Guard
NOK	Next of Kin
NTSB	National Transportation Safety Board
NYS	New York State
NYS DOH	New York State Department of Health
O	
OEM	Office of Emergency Management
OPIM	Other Potentially Infectious Material
OPO	Organ Procurement Organization

OSHA	Occupational Safety and Health Administration
OSM	Off-Site Morgue
P	
PE	Personal Effects
PI	Pandemic Influenza
PLI	Pandemic-Like Illness
POD	Point of Dispensing
PPE	Personal Protective Equipment
Q	
R	
S	
SARA	Superfund Amendments Reauthorization Act of 1986.
SARS	Severe Acute Respiratory Syndrome
SOEM	New York State Office of Emergency Management
SME	Subject Matter Expert
SOP	Standard Operating Procedures
T	
U	

UCP	Unified Command Post
UCS	Unified Command Structure
UHC	Unified Health Command
US DHS	United States Department of Homeland Security
US DHHS	United States Department of Health and Human Services
USAMRIID	United States Army Medical Research Institute of Infectious Disease
UVIS	Unified Victim Identification System
VWXYZ	
WHO	World Health Organization

Q. Key Definitions

911 - 911 is the official emergency number. Dialing 911 should quickly connect the caller with a dispatcher trained to route the call to local emergency medical, fire, and law enforcement agencies as appropriate. A live operator answers all calls to 911, 24 hours a day, seven days a week.

Annex – A planning document that explains and narrows the scope of the CEMP, converting strategy into tactics that will be used to implement specific response activities.

Autopsy - An autopsy is a medical procedure consisting of a thorough examination of a corpse to determine the cause and manner of death and to evaluate any disease or injury present. It is usually performed by a specialized medical doctor called a pathologist. Autopsies are performed for legal or medical purposes.

Body Collection Point (BCP) - A temporary storage location used to expand healthcare facility (HCF) morgue capacity. BCPs are intended to provide temporary refrigerated storage of remains until the coroner/ME can recover bodies and process them appropriately. HCFs placing bodies in a BCP are responsible for signing the death certificate, providing the coroner/ME with as much information as appropriate regarding the next of kin (NOK), creating a manifest of those bodies placed in the BCP, and securing the site appropriately.

Comprehensive Emergency Management Plan (CEMP) - A strategy and policy document that identifies the overall direction and control the county will take in a multi-agency setting.

Concept of Operations – Explains the anticipated chain of events during an emergency. The logical flow should include the initial recognition of a hazard and the notification and activation of the response organization. These include the response mechanisms that could be activated along the way, what is expected to occur at the height of the response, the demobilization of the response and the transition into recovery.

Coroner – A public official who typically has statutory authority to investigate any death not the result of natural causes.

Disposition human remains – The transfer of control of remains from one entity to another.

Disaster Portable Morgue Unit (DPMU) - A fully equipped, portable morgue established in a field setting. A DPMU is often established at or near an incident site. A DPMU comes complete with equipment and supplies necessary for performing a full external and internal examination (autopsy) and assessing decedents' identification by means of fingerprinting, photographing, obtaining dental and body x-rays, and gathering deoxyribonucleic acid (DNA) samples. A DPMU can be used as a whole unit or can be used to support limited morgue operations such as DNA and fingerprinting.

Emergency/Disaster Declarations - An official emergency declaration made by specified elected officials to authorize and empower the executive to use any and all equipment, supplies, personnel and resources in a manner as may be necessary or appropriate to cope with the disaster or any emergency. The declaration of an emergency on the local level may result in funding, support, and access to additional State or Federal assets. Such officials make a formal

declaration of an emergency when the event requires more assets and resources than exist within the county. Emergency/disaster declarations can be made at the local, State and Federal levels.

Emergency Operations Center - The EOC serves as a centralized management center for emergency operations. Here the emergency management group makes decisions based upon information provided by incident command and other personnel. Regardless of size or process, every facility should designate an area where decision makers can gather during an emergency.

Family Assistance Center (FAC) - A family assistance center facilitates the exchange of timely and accurate information with family and friends of injured, missing, or deceased disaster victims; the investigative authorities; and the medical examiner/coroner. Types of services generally include: grief counseling; childcare; religious support; facilitation of family needs such as hotel, food, and transportation; antemortem data collection; and notification of death to the next of kin. Although FACs can differ from one another, the coroner/ME's role at the FAC includes gathering antemortem data and notifying the next of kin regarding the deceased. FACs can be actual or virtually established.

H5N1 Virus - A specific strain of influenza virus. The World Health Organization (WHO) anticipates H5N1 could mutate and become transmissible between humans.

Healthcare Facilities (HCFs) - HCFs include public and private hospitals, nursing homes, retirement facilities, prison health clinics, public health clinics, and mental health hospitals.

Incident Command System (ICS) - A method of command, control, coordination and communication that enhances agency operations when responding to a disaster event. Typically, ICS refers to management of people performing specific functions within a leader's span of control.

Incident Command Post – The field location where all management of the incident is provided by the Incident Commander,

Mass Fatality - Any incident that results in a surge of deaths above that which is normally managed by a community's medicolegal system.

Medical Examiner (ME) - A medical examiner is a physician who is appointed by the government to oversee and/or perform medicolegal death investigations.

Medicolegal – Pertaining to medicine and law.

Missing persons - Missing persons are those persons whose whereabouts are unknown to family or friends following an incident.

Office of Emergency Management – The agency responsible for the planning, response, recovery and mitigation of natural and human-caused disasters at the county level. The office interfaces between local government and the State Emergency Management Office.

Operating Plan - For each organization with responsibilities assigned in the County Annex, the operating plan explains WHAT the organization will do, HOW they will do it and WHO is responsible for each activity.

Point of Dispensing (POD) - A specific location where appropriate medical or trained staff dispense medications to large numbers of persons for the purpose of preventing them from contracting a specific infection, illness or disease.

Process human remains – As used in this document, processing refers to the physical and documentary preparation of human remains for disposition (transfer of control). During mass fatality emergencies this may include overseeing remains from unattended deaths, unidentified remains, and remains requiring autopsies.

Registrar – The local registrar of vital records files birth and death records for the locality in which the event occurred.

Residential Recovery Team - A coroner/ME recovery team typically comprised of law enforcement and a transport team. This Team may investigate residential deaths, recover decedents, and transport the bodies to the appropriate coroner/ME. The Team may tag and track bodies as appropriate using designated coroner/ME methods.

Resource Typing - A uniform means by which to name resources and package them with specific equipment, supplies, personnel, services and facilities so resources have consistent capabilities. Resource typing involves identifying the resource name, category, kind, components, metrics, type and additional information. The United States Department of Homeland Security is currently developing a national resource typing model as part of the National Incident Management System (NIMS).

Social distancing - Canceling public gatherings and closing businesses and schools in an attempt to slow the spread of disease.

Temporary Interment - Interments that may or may not be temporary based upon a family's decision once the emergency has passed.

Unidentified Persons - Unidentified persons include those persons, both injured and deceased, who require the application of scientific methods to verify their identification. Scientific methods for identification include DNA, fingerprints, dental, radiographs, or medical record examination.

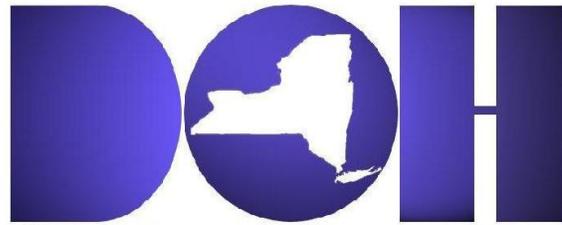
Unified Victim Identification System (UVIS) - A database system used by New York City 311 operators, NYPD and coroner/ME to gather key information to facilitate compiling an accurate list of missing persons and enhance missing persons' investigation efforts during and after disaster events. UVIS is also used by the coroner/ME to track decedents, collect antemortem information, and collect postmortem findings to facilitate the identification process during a disaster event.

Waiver – During an emergency, a suspension by the appropriate authority of provisions of State and local laws that could prevent, hinder, or delay action necessary to cope with the disaster.

R. Key Links

Description	Link
NYS Pandemic Influenza Plan	http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/docs/pandemic_influenza_plan.pdf
NYS Emergency Management Office	http://www.SOEM.state.ny.us/
National Association Of Medical Examiners Mass Fatality Plan	http://www.dmort.org/FilesforDownload/NAMEMFIplan.pdf
Providing Relief to Families After a Mass Fatality	http://www.ojp.usdoj.gov/ovc/publications/bulletins/prfmf_11_2001/188912.pdf
DMORT	www.dmort.org
SOEM New York State Standard Multi-Hazard Mitigation Plan	http://www.SOEM.state.ny.us/programs/planning/hazmitplan.cfm
SOEM Tutorial for developing Comprehensive Emergency Management Plans	http://www.SOEM.state.ny.us/uploads/NYS%20Emergency%20Mgt%20and%20Business%20Continuity%20Plan%201.06.06.pdf
New York State Hazard Mitigation Plan	(http://www.SOEM.state.ny.us/programs/planning/hazmitplan.cfm)
Flu Aid/FluSurge	http://www.cdc.gov/flu/pandemic/healthprofessional.htm#tools
Severity Index and Pandemic Intervals has been excerpted from <i>Federal Guidance To Assist States In Improving State-Level Pandemic Influenza Operating Plans</i> , March, 2008,	http://www.pandemicflu.gov/news/guidance031108.pdf
The Occupational Safety and Health Administration (OSHA) 29 CFR 1910.1030 "Occupational Exposure to Bloodborne Pathogens":	http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051
The Environmental Protection Agency (EPA) Office of Pesticide Programs – "What are Antimicrobial Pesticides?"	http://www.epa.gov/oppad001/ad_info.htm
Office of Solid Waste – Medical Waste Web Page:	http://www.epa.gov/epaoswer/other/medical/
National Antimicrobial Information Network – links to the OSHA bloodborne pathogen standard & accompanying information:	http://ace.ace.orst.edu/info/nain/topics/bbp.htm

Description	Link
The Department of Transportation (DOT) Office of Hazardous Materials Safety:	http://hazmat.dot.gov/rules.htm
An Overview to the Federal Hazardous Materials Transportation Law (federal hazmat law):	http://hazmat.dot.gov/pubtrain/overhml.pdf
The Centers for Disease Control and Prevention (CDC) Sterilization & Disinfection link:	http://www.cdc.gov/ncidod/dhqp/sterile.html
U.S. Army Environmental Hygiene Agency: TG 195, April 1993 "Guidelines for protection graves registration personnel from potentially infectious materials"	http://chppm-www.apgea.army.mil/documents/TG/TECHGUID/TG195.pdf
SOEM Pandemic Influenza Annex – Sample Plan for Counties	http://www.SOEM.state.ny.us/uploads/Empire_County_Pandemic_Influenza_Annex.doc
CDC Medical Examiners, Coroners, and Biologic Terrorism A Guidebook for Surveillance and Case Management	http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5308a1.htm
Interim Health Recommendations for Workers Who Handle Human Remains	http://www.bt.cdc.gov/disasters/tsunamis/handlerremains.asp
Standard Precautions Guidelines	www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html
Radiation Event Medical Management: Management of the Deceased	http://www.remm.nlm.gov/deceased.htm
Health and Safety Recommendations for Workers Who Handle Human Remains	http://www.osha.gov/OshDoc/data_Hurricane_Facts/mortuary.pdf
Guidelines for Protecting Mortuary Affairs Personnel from Potentially Infectious Materials	www.apgea.army.mil/documents/TG/TECHGUID/TG195a.pdf
Management of Dead Bodies After Disasters: A Field Manual for First Responders	http://www.paho.org/english/dd/ped/DeadBodiesFieldManual.htm
Management of Dead Bodies in Disaster Situations	http://www.paho.org/english/dd/ped/ManejoCadaveres.htm
International Mass Fatalities Center	http://www.massfatalities.com/
National Mass Fatalities Institute	http://www.nmfi.org/



NEW YORK STATE GUIDANCE
HEALTHCARE FACILITY
MASS FATALITY PLANNING

JANUARY, 2009

Table of Contents

Introduction.....	86
Purpose of this Guidance.....	86
Assumptions for this Guidance.....	86
Writing the Plan.....	87
Sample Table of Contents for the Healthcare Facility Plan.....	87
Purpose, Scope and Assumptions.....	87
Concept of Operations.....	87
Mass Fatality Incident Management.....	88
Mass Fatality Incident Management Team.....	88
Procedures for Decedent Identification and Tracking.....	89
Reporting.....	89
Procedures for Death Certificate and Burial Permit Processing.....	89
Procedures for Custody of Personal Property and Evidence.....	90
Human Remains Management.....	90
Staffing Needs and Assignments.....	90
Morgue Capacity.....	90
Infection Control Procedures.....	91
Procedures for Removal of Remains from the Healthcare Facility.....	92
Psychosocial Considerations.....	92
Security.....	92
Plan Evaluation.....	92
Training & Exercise Program.....	92
Revision Process.....	93
Attachments.....	94
AA. Flow Chart: Death at a Healthcare facility.....	94
BB. Flow Chart: Pandemic Influenza Death at a Healthcare facility.....	95
CC. MFI Team Leader Job Action Sheet.....	96
DD. MFI Management Team Equipment and Supplies Checklist.....	99
EE. Decedent Information and Tracking Card.....	100
FF. Fatality Tracking Form.....	101
GG. Guidance for Death Registration Planning.....	102
HH. Recommended Methods of Storage for Healthcare Facilities.....	102
II. Morgue Surge Equipment and Supplies Checklist.....	105
JJ. Infection Control Procedures for Pandemic Influenza.....	106

Acknowledgement

The New York State Department of Health wishes to acknowledge the valuable information found in the Los Angeles County Mass Fatality Incident Management: Guidance for Hospitals and other Healthcare Entities from which much of this material is adapted.

The Los Angeles County plan can be found at:

<http://ems.dhs.lacounty.gov/ManualsProtocols/MFIM/MFIGuidanceForHospitals808.pdf>

INTRODUCTION

Purpose of this Guidance

Healthcare facility mass fatality plans¹⁶ are an element of a broader planning context within each county:

- Each county in New York State has developed a COMPREHENSIVE EMERGENCY MANAGEMENT PLAN (CEMP). The CEMP is a strategy and policy document that identifies the overall direction and control the county will take in a multi-agency event.
- The COUNTY MASS FATALITY ANNEX explains and narrows the scope of the CEMP, converting strategy into tactics that will be used to implement specific mass fatality response activities. The County Mass Fatality Annex explains cross-organizationally WHAT the county will do, HOW they will do it, WHO will function as the contact point across organizations and WHEN each part of the plan will be put into effect.
- An ORGANIZATIONAL OPERATING PLAN or ANNEX for each organization with responsibilities assigned in the County Mass Fatality Annex explains WHAT the organization will do, HOW they will do it, WHO is responsible for each activity and WHEN each part of the plan will be put into effect.

Similarly, the New York State Department of Health (NYSDOH) requires healthcare facilities to develop plans that guide their planning process:

- Each hospital in New York State has developed a CEMP.
- Hospitals have also developed annexes and/or appendices to the CEMP.

This document provides guidance for developing an all hazards mass fatality plan for healthcare facilities. The plan must integrate with both county plans and other planning documents for the healthcare facility.

The objective of this guidance is to enable healthcare facilities to plan for the mortuary surge associated with a mass fatality event, including an influenza pandemic. When a healthcare facility's mortuary surge capacity is exceeded, the county plan will specify the method for reporting the need for other resources to remove remains.

Assumptions for this Guidance

- The healthcare facility already has a CEMP in place. It may also have an existing mass fatality plan. If so, the existing mass fatality plan will need to be modified based on the guidance in this document and must be consistent with other hospital and county plans.
- The county in which the healthcare facility resides has developed a County All Hazards Mass Fatality Annex that clarifies how other county agencies will interact with healthcare facilities during a mass fatality event.
- The healthcare facility has participated in county planning and/or participated in informational sessions about the county's all hazards Mass Fatality Annex. It understands the role healthcare facilities are expected to play and understands the contact points between the healthcare facility and other entities assigned responsibilities in the mass fatality plan.
- Hospitals are required to develop and execute mass fatality plans. Deaths at long-term care facilities will continue to be treated as unattended at-home deaths falling under the authority of the coroner/ME. If an alternate care site is closely aligned with a hospital, deaths may be managed under the sponsoring hospital's mass fatality plan. If an alternate care site is not

¹⁶ In this document, the term mass fatality "plan" refers to appendices and/or annexes.

closely aligned with a hospital, care for the deceased may be the responsibility of county agencies.

WRITING THE PLAN

A mass fatality annex for a healthcare facility expands on the responsibilities assigned to healthcare facilities in the County Mass Fatality Annex. The following sample Table of Contents and explanations that follow are intended to guide the planning process.

Sample Table of Contents for the Healthcare Facility Plan

1) Purpose, Scope and Assumptions

2) Concept of Operations

3) Mass Fatality Incident Management

- a) Mass Fatality Incident (MFI) Management Team
- b) Procedures for Decedent Identification and Tracking
- c) Reporting
- d) Procedures for Death Certificate and Burial Permit Processing
- e) Procedures for Custody of Personal Property and Evidence

4) Human Remains Management

- a) Staffing Needs and Assignments
- b) Morgue Capacity
- c) Infection Control Procedures
- d) Procedures for Removal of Remains from the Healthcare Facility
- e) Psychosocial Considerations
- f) Security

5) Plan Evaluation

- a) Training and Exercise Program
- b) Revision Process

6) Attachments

Purpose, Scope and Assumptions

Review the Purpose, Scope and Assumptions in the County Mass Fatality Annex and adapt them based on responsibilities assigned to healthcare facilities.

Concept of Operations

To develop a mass fatality plan the healthcare facility should convene a team of staff members who have the necessary skills and authority to establish the internal operating plan for a mass fatality response.

A healthcare facility should first acquire an in-depth familiarity with the county mass fatality annex. A facility should be familiar with the Concept of Operations, the roles of all entities in the plan, and the responsibilities assigned to healthcare facilities in the Risk Reduction, Response, and Recovery sections of the county plan.

Planning teams may benefit by developing a high-level flow chart that describes how the management of human remains will function during a mass fatality event, both for pandemic influenza and non-pandemic events.

* Attachments AA and BB are examples of high-level flow charts.

Review the County Mass Fatality Annex for procedures, triggers and activation protocols. Incorporate other procedures specified in the healthcare facility incident management procedure including:

- The person(s) authorized to implement the plan and the organizational structure that will be used.
- The trigger to activate the Mass Fatality Incident (MFI) plan
- The delegation of authority to carry out the plan 24/7

In developing its Concept of Operations the healthcare facility planning team should define:

- WHAT is the process?
- HOW will activities take place?
- WHO will be responsible for each activity?
- WHEN will each part of the plan be put in effect (triggers)?

Mass Fatality Incident Management

Mass Fatality Incident Management Team

Establishing a MFI Management Team for each healthcare facility creates a centralized location where the facility can process all mass fatality information in response to a mass casualty event, pandemic outbreak, terrorist attack, or large natural disaster. Mass fatality planning team members should be considered for assignment to the mass fatality incident management team. This would assure the development of practical plans and will foster team building that will be invaluable during response to an emergency.

Functions would likely include:

- Identifying decedents (if not already done upon admittance)
- Notifying next of kin
- Notifying the coroner/ME, county morgue or mortuary
- Tracking removal of decedents who die in the healthcare facility
- Managing morgue surge capacity

The mass fatality incident management team should be built into the Healthcare Facility Incident Command System (HICS). The MFI Team could, but is not required to be located in the HICS Operations Section, Medical Care Branch, and the MFI Team Leader¹⁷ could report directly to the Medical Care Branch Director. The MFI Team will coordinate information with the Patient Registration Team and the Casualty Care Team, particularly for those patients identified as expectant. The MFI Team will also coordinate information with the Planning Section Situation

¹⁷ The MFI team leader is not currently a HICS position.

Team Patient Tracking Manager. During a disaster, it may not be possible for a facility to staff all positions, but the roles and responsibilities identified below should be addressed.

A MFI Team Leader should oversee the following mass fatality units:

Administrative Unit	Morgue Unit
<ul style="list-style-type: none"> • Decedent identification staff • Decedent tracking staff • Liaison to HICS Patient Tracking Officer and other HCC contacts • Data entry staff • Liaison to relevant county agencies, and mortuaries • Liaison to families • Death Certificate coordinator(a physician with responsibility to coordinate with other physicians to ensure death certificates are signed to expedite decedent processing) • IT support 	<ul style="list-style-type: none"> • Morgue supervisor • 1-2 morgue assistants (Minimum of two morgue task force members to safely move decedents) • Infection control staff, as needed • Morgue staff to maintain each morgue area • Facilities/engineering to maintain the integrity of morgue surge areas • Security for all morgues

* Attachments CC and DD are examples of a job action sheet for a MFI Team Leader and a checklist for MFI Management Equipment and Supplies.

Procedures for Decedent Identification and Tracking

For some events, county incident managers may decide to assign a unique decedent ID number either to event-related decedents or to all decedents. Otherwise, healthcare facilities should develop their own procedures for decedent identification and tracking.

* Attachments EE and FF are examples of a Decedent Information and Tracking Card and a Fatality Tracking Form.

Reporting

During a pandemic influenza event, healthcare facilities must report pandemic influenza deaths to the NYSDOH via a HERDS template. For other types of events, the NYSDOH may require specific reporting at the time of the event.

Procedures for Death Certificate and Burial Permit Processing

It is critical that death certificates be processed accurately and paced at the same speed as the processing and removal of the remains. The NYS Guidance for the County Mass Fatality Annex provides the following requirements for healthcare facilities:

- The NYSDOH requires that all healthcare facilities develop a procedure to assure that a physician is always assigned to medically certify death certificates during a declared emergency.
- Healthcare facility authorities should identify and train persons who could be appointed by the Vital Records Local Registrar as subregistrars at healthcare facilities to enhance the accuracy of, and simplify the process for, registering deaths and procuring burial permits. Appointing a hospital subregistrar is a critical element of mortuary surge planning.
- Subregistrars will need advance training, workspace, staffing, training, supplies, etc.
- Depending on the nature of the incident, e.g. during a pandemic influenza event, county incident managers may specify that remains should not be released from a healthcare facility without a death certificate or burial permit.

* See Attachment GG for further guidance on the streamlined death registration process.

Procedures for Custody of Personal Property and Evidence

Depending on the incident, the decedent’s property should be collected for safekeeping or as evidence of a crime, as appropriate, and should be maintained for proper transfer to next of kin or authorities. Healthcare facilities should identify the decedent’s property and document where it is located. The Decedent Tracking Card (Attachment EE) or a similar form can be used to catalog this information.

Human Remains Management

Staffing Needs and Assignments

Determine the roles for human remains management and number of people within the healthcare facility who must be assigned to those roles based on the number of decedents. Because of the sensitive nature of decedent processing, staff should receive psychological support if needed. Be cautious in the use of healthcare facility staff or volunteers who may not have had experience with mass fatality situations.

Morgue Capacity

Each healthcare facility will need to identify sufficient morgue surge capacity to hold human remains until they can be released to a funeral director or the coroner/ME. Consider how to maximize refrigerated storage capacity.

Each facility should document the normal and surge capacity for its morgue in the healthcare facility plan.

Resource	Normal capacity per week	Surge Capacity per week
Healthcare facility morgue capacity Refrigerated		

Non-refrigerated		
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* The attachments to this guidance include:

- Attachment HH - Recommended methods of storage of human remains for healthcare facilities
- Attachment II - Morgue surge equipment and supplies checklist

Infection Control Procedures

Measures should be taken to reduce the risk of transmission of disease associated with handling human remains.

Standard precautions are essential for those handling human remains. This set of infection prevention practices assumes that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting. When handling human remains, these precautions include:

- Personal protective equipment (PPE)
 - Gloves should be worn when it can be reasonably anticipated that hand contact with blood, other potentially infectious material (OPIM), mucous membranes, and/or non-intact skin may occur and when handling or touching contaminated items or surfaces.
 - Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, should be worn whenever splashes, spray, spatter, or droplets of blood or OPIM may be generated and eye, nose, or mouth contamination can be reasonably anticipated.
 - Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments should be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated (see Attachment JJ for information on pandemic influenza.).
 - PPE should be disposed of appropriately.
 - Avoid cross-contamination. Personal items should not be handled while wearing soiled PPE.
- Hand hygiene
 - Should be performed immediately after removing PPE.
 - Can be accomplished by hand washing with soap and warm water if hands are visibly contaminated. When hands are not visibly contaminated, or when soap and warm water are not available, hand sanitizing may be performed using an alcohol-based hand rub, gel, or foam.
- In HazMat or WMD events, the appropriate level of PPE is required depending on the agent.
- Vehicles used for transportation should be cleaned and decontaminated as indicated.
- Human remains pouches will further reduce the risk of exposure to blood or other potentially infectious material and are useful for the transport of decedents who have been badly damaged. Wrapping with plastic and a sheet may be an economical and practical containment solution.
 - If the body is not contained in a fluid impervious bag, appropriate PPE should be used when handling the body, and surfaces in contact with the body during transport should

be cleaned and decontaminated (see Attachment M of the County Mass Fatality Guidance).

Procedures for Removal of Remains from the Healthcare Facility

When a healthcare facility's mortuary surge capacity is exceeded and funeral firms no longer have sufficient capacity to remove remains from healthcare facilities, the county plan will specify a method for reporting the need for other resources to remove remains.

- Plans should indicate whether the healthcare facility or funeral director/removal team will place the remains in body bags, and where a sufficient supply of body bags is available.
- Depending on the nature of the incident, e.g. during a pandemic influenza event, plans should specify that remains cannot be released from a healthcare facility without a death certificate or burial permit. Healthcare facilities should identify and train persons who could be appointed by the Vital Records Local Registrar as subregistrars at each healthcare facility site. These subregistrars are responsible for providing medically certified, registered death certificates and burial permits to funeral directors and/or transport teams, if required.
- Consider whether alternative processes for family viewing are required when processing a large volume of remains. During a pandemic influenza event, a declaration of social distancing would require a moratorium on traditional family viewing.

Psychosocial Considerations

Describe how the healthcare facility will provide a comprehensive mental health program to manage the traumatic reactions of an organization's employees and volunteers during and after response to a mass fatality.

Security

Describe how appropriate security will be provided in healthcare facilities during a mass fatality event.

Plan Evaluation

Training & Exercise Program

Describe how training will be provided and how exercises will be conducted to test the plan in accordance with procedures documented in the county CEMP and Joint Commission requirements.¹⁸

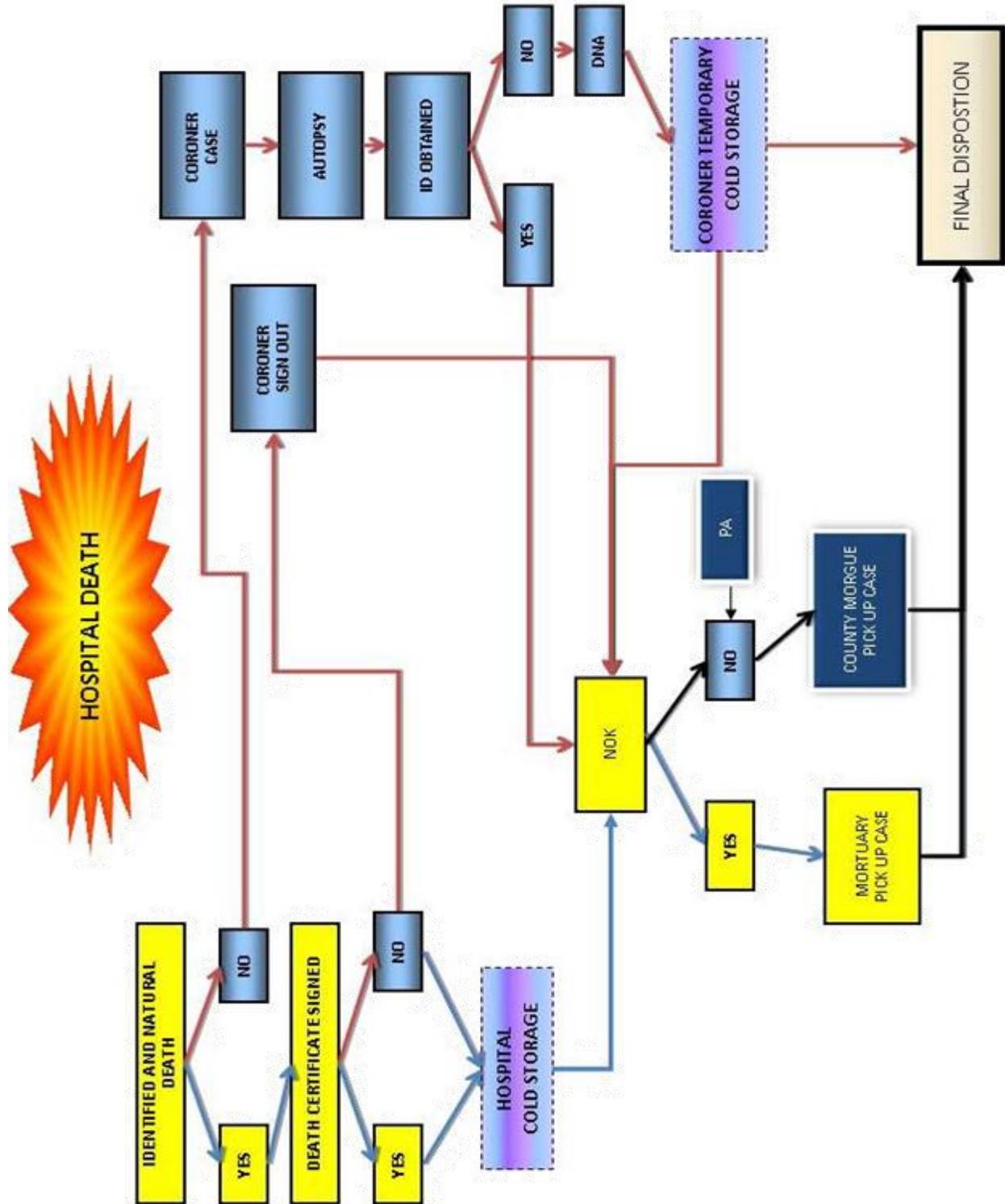
¹⁸ Requires that healthcare facilities develop and exercise their Emergency Operations Plan (EOP) at least twice per year and that they update their EOP in accordance with After Action Report Improvement Plans as applicable.

Revision Process

Plan updates should be done at least once per year, or as indicated to reflect exercise or incident after action reports, in accordance with procedures documented in the county CEMP and Joint Commission requirements. Plan updates should include information learned from exercises and drills.

ATTACHMENTS

AA. Flow Chart: Death at a Healthcare facility



CC. MFI Team Leader Job Action Sheet

Mission: Collect, protect, identify and track decedents.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____		
Position Reports to: Medical Care Branch Director Signature: _____		
Hospital Command Center (HCC) Location: _____ Telephone: _____		
Fax: _____ Other Contact Info: _____ Radio Title: _____		
Immediate (Operational Period 0-2 Hours)	Time	Initial
<p>Receive appointment and briefing from the Medical Care Branch Director. Obtain MFI Team activation packet.</p> <p>Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.</p> <p>Notify your usual supervisor of your HICS assignment.</p> <p>Determine need for and appropriately appoint MFI Team staff, distribute corresponding Job Action Sheets and position identification. Complete a team assignment list.</p> <p>Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.</p> <p>Brief MFI Team staff on current situation; outline team action plan and designate time for next briefing.</p> <p>Confirm the designated MFI Team area is available, and begin distribution of personnel and equipment resources. Coordinate with the Medical Care Branch Director.</p> <p>Regularly report MFI Team status to Casualty Care Team Leader.</p> <p>Assess problems and needs; coordinate resource management.</p> <p>Use your Death Certified Coordinator physician or request an on-call physician from the Casualty Care Team Leader to confirm any resuscitatable casualties in Morgue area.</p> <p>Obtain assistance from the Medical Devices Team Leader for transporting decedents.</p> <p>Assure all transporting devices are removed from under decedents and returned to the Triage Area.</p> <p>Instruct all MFI Team Task Force members to periodically evaluate equipment, supply, and staff needs and report status to you; collaborate with Logistics Section Supply Team</p> <p>Leader to address those needs; report status to Medical Care Branch Director.</p> <p>Coordinate contact with external agencies with the Liaison Officer, if necessary.</p> <p>Monitor decedent identification process.</p> <p>Enter decedent information in information system, if appropriate.</p> <p>Assess need for establishing morgue surge facilities.</p> <p>Coordinate with the Patient Registration Team Leader and Family Information Center (Operations Section) and the Patient Tracking Manager (Planning Section).</p>		

Immediate (Operational Period 0-2 Hours)	Time	Initial
<p>Contact the Medical Care Branch Director and Security Branch Director for any morgue security needs.</p> <p>Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Team.</p>		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
<p>Maintain master list of decedents with time of arrival for Patient Tracking Manager.</p> <p>Assure all personal belongings are kept with decedents and/or are secured.</p> <p>Assure all decedents in MFI Areas are covered, tagged and identified where possible.</p> <p>Monitor death certificate process.</p> <p>Meet regularly with the Casualty Care Team Leader for update on the number of deceased; status reports, and relay important information to Morgue Team staff.</p> <p>Implement morgue surge facilities as needed.</p> <p>Continue coordinating activities in the Morgue Team.</p> <p>Ensure prioritization of problems when multiple issues are presented.</p> <p>Coordinate use of external resources; coordinate with Liaison Officer if appropriate.</p> <p>Contact the Medical Care Branch Director and Security Branch Director for any morgue security needs.</p> <p>Develop and submit a MFI Team action plan to the Medical Care Branch Director when requested.</p> <p>Ensure documentation is completed correctly and collected.</p> <p>Advise the Medical Care Branch Director immediately of any operational issue you are not able to correct or resolve.</p> <p>Ensure staff health and safety issues being addressed; resolve with the Safety Officer.</p>		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
<p>Continue to monitor the MFI Team's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.</p> <p>Coordinate assignment and orientation of external personnel sent to assist.</p> <p>Work with the Medical Care Branch Director and Liaison Officer, as appropriate on the assignment of external resources.</p> <p>Rotate staff on a regular basis.</p> <p>Document actions and decisions on a continual basis.</p> <p>Continue to provide the Medical Care Branch Director with periodic situation updates.</p>		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
<p>Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.</p> <p>Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well-Being Team Leader. Provide for staff rest periods and relief.</p> <p>Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.</p>		
Demobilization/System Recovery	Time	Initial
<p>As needs for the MFI Team decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner, in coordination with the Demobilization Team Leader.</p> <p>Ensure the return/retrieval of equipment/supplies/personnel.</p> <p>Debrief staff on lessons learned and procedural/equipment changes needed.</p> <p>Upon deactivation of your position, brief the Medical Care Branch Director on current problems, outstanding issues, and follow-up requirements.</p> <p>Upon deactivation of your position, ensure all documentation and MFI Team Operational Logs (HICS Form 214) are submitted to the Medical Care Branch Director.</p> <p>Submit comments to the Medical Care Branch Director for discussion and possible inclusion in the after-action report; topics include:</p> <ul style="list-style-type: none"> • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues <p>Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.</p>		
Documents/Tools		
<ul style="list-style-type: none"> <input type="checkbox"/> Incident Action Plan <input type="checkbox"/> HICS Form 207 – Incident Management Team Chart <input type="checkbox"/> HICS Form 213 – Incident Message Form <input type="checkbox"/> HICS Form 214 – Operational Log <input type="checkbox"/> Mass Fatality Incident Activation/Operational Plan <input type="checkbox"/> Mass Fatality Incident / Morgue Team Assignment List <input type="checkbox"/> Fatality Tracking Form <input type="checkbox"/> Decedent Information and Tracking Card <input type="checkbox"/> Healthcare facility emergency operations plan <input type="checkbox"/> Healthcare facility organization chart <input type="checkbox"/> Healthcare facility telephone directory <input type="checkbox"/> Key contacts list (including Coroner, DPH, LAC DMH, ARC, etc.) <input type="checkbox"/> Radio/satellite phone 		

DD. MFI Management Team Equipment and Supplies Checklist

Equipment and supplies for the MFI Team may include the following. Be sure to identify where items are stored and how to access the storage area.

C o n s i d e r a t i o n s	
<p>Distance from the morgue</p> <ul style="list-style-type: none"> • Location of MFI Team: • Distance from Morgue: <p>Notes:</p> <p>Secure with limited access</p> <ul style="list-style-type: none"> • # of security staff required: • Security equipment required: • Description of how access is limited: <p>Notes:</p> <p>Phone lines</p> <ul style="list-style-type: none"> • Incoming phone • Outgoing phone • Fax machine • Fax paper and toner • Total number of phones: <p>Notes:</p> <p>Information system and EDRS access/terminal</p> <ul style="list-style-type: none"> • Laptop or desktop computer • Access to internet • Information system access established • EDRS access established (via internet for authorized individuals) • Total number of computers: <p>Notes:</p>	<p>Tables and chairs</p> <ul style="list-style-type: none"> • # tables procured (based on layout needs) • # chairs procured (based on layout needs) <p>Notes:</p> <p>Office supplies</p> <ul style="list-style-type: none"> • Notepads, loose paper, sticky notes, clipboards • Plastic sleeves • Pens, pencils, markers, highlighters • Stapler, staple remover, tape, packing tape, white out, paper clips, pencil sharpener • Extension cords, power strips, surge protectors, duct tape <p>Notes:</p> <p>Printer and Copier</p> <ul style="list-style-type: none"> • Printer and cables, copier • Paper • Toner <p>Notes:</p> <p>Forms and Documents</p> <ul style="list-style-type: none"> • Healthcare facility MFI Plan • Decedent Information and Tracking Card • Fatality Tracking Form • EDRS "Medical Facilities Users' Guide" (download at www.edrs.us) • Internal and external contact lists <p>Notes:</p>

Legend: • Check boxes to indicate completion

• These bullets require you to add your information

EE. Decedent Information and Tracking Card

First Letter of Decedent Last Name: _____

DECEDENT INFORMATION AND TRACKING CARD

INCIDENT NAME	OPERATIONAL PERIOD
----------------------	---------------------------

MEDICAL RECORD / TRIAGE #	DATE	TIME	HOSPITAL LOCATION PRIOR TO MORGUE	
FIRST	MIDDLE	LAST	AGE	GENDER

IDENTIFICATION VERIFIED BY
 DRIVERS LICENSE STATE ID PASSPORT BIRTH CERTIFICATE OTHER: _____

IDENTIFICATION #: _____

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

LISTED IN REDDINET <input type="checkbox"/> YES <input type="checkbox"/> NO	RECORD CREATED IN EDRS <input type="checkbox"/> YES <input type="checkbox"/> NO	DEATH CERTIFICATE SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO
---	---	---

PHOTO ATTACHED TO THIS CARD <input type="checkbox"/> YES <input type="checkbox"/> NO	FINGERPRINTS ATTACHED TO THIS CARD <input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

NEXT OF KIN NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME	RELATION	CONTACT TEL
STATUS	LOCATION	DATE / TIME IN	DATE / TIME OUT

HOSPITAL MORGUE			
------------------------	--	--	--

HOSPITAL MORGUE			
------------------------	--	--	--

HOSPITAL MORGUE			
------------------------	--	--	--

HOSPITAL MORGUE			
------------------------	--	--	--

FINAL DISPOSITION	DATE / TIME	NAME OF RECIPIENT	SIGNATURE OF RECIPIENT
--------------------------	--------------------	--------------------------	-------------------------------

RELEASED TO: <input type="checkbox"/> CORONER <input type="checkbox"/> COUNTY MORGUE <input type="checkbox"/> MORTUARY <input type="checkbox"/> OTHER: _____	DATE TIME		
---	--------------------------------	--	--

LIST PERSONAL BELONGINGS	STORAGE LOCATION
---------------------------------	-------------------------

ORIGINAL ON FILE IN MFI UNIT
 COPY WITH DECEDENT
 COPY TO MEDICAL CARE BRANCH DIRECTOR

FF. Fatality Tracking Form

FATALITY TRACKING FORM

Adapted from HICS Form 254.

INCIDENT NAME				DATE / TIME PREPARED				OPERATIONAL PERIOD DATE/TIME		
MRN OR TRIAGE NUMBER	NAME	SEX	DOB/AGE	NEXT OF KIN NOTIFIED YES / NO	ENTERED: YES / NO		HOSPITAL MORGUE		FINAL DISPOSITION, RELEASED TO:	
					REDDINET	EDRS	IN DATE/TIME	OUT DATE/TIME	CORONER, MORTUARY, COUNTY MORGUE, OR OTHER (LIST)	DATE/TIME
COMPLETED BY HOSPITAL MFI UNIT				NAME						

Purpose: Account for decedents in a mass fatality disaster **Origination:** Hospital Mass Fatality Unit **Copies to:** Patient Registration Unit Leader and Medical Care Branch Director

GG. Guidance for Death Registration Planning

Note: Not all of the following information applies to processing of death certificates in healthcare facilities.

During a mass fatality event it is essential that counties maintain the integrity of their death certificates and burial permits processing to enable verification of the identity of the deceased for subsequent legal and estate considerations, as well as other vital statistics reporting. Counties must also assure that managing this documentation appropriately does not affect the rapid disposition of human remains. There are a number of provisions within the public health law that support both of these objectives.

In the event of a declared state of emergency, the NYS Commissioner of Health may request waivers to modify certain existing public health procedures that relate to death registration process.

Completing the forms

Existing death certificate forms in use at the time of the event must be used to ease the post-pandemic reconciliation of records.

The minimum information required to file a death certificate is indicated in the following table. If additional information is available and can be provided without compromising the rate of processing human remains, it must be included.

To file a death certificate during a mass fatality emergency the following fields must not be blank.

Field	Description	Comments
I D E N T I F I C A T I O N S E C T I O N		
None	Decedent identification number, if required for the incident. <i>Always enter the decedent name if known.</i>	Enter on the top of the death certificate form ensuring that it appears on the under copy. Do not use the Register Number or State File number fields.
4a-4g	Place of death and location details	Specifics relating where death occurred or body was found.
19 a 19 b	Informant name Informant address	This is the name of the person filling out the death certificate form.
D I S P O S I T I O N S E C T I O N		
20a 20b 20c	Disposition Place of burial, cremation, removal/or other disposition Location (city,town,village)	This information is required to generate a burial permit. If the disposition is standard burial, temporary interment or cremation, a burial permit will be issued. If the disposition is for storage, not temporary interment, a holding permit will be issued.
C E R T I F I E R S E C T I O N		
25a- 29b	Information relating to the medical certifier	The medical certification may be signed by the attending physician or any other physician assigned by a hospital administrator, or the coroner/ME or their designee.*

Field	Description	Comments
C A U S E O F D E A T H S E C T I O N		
30-33b	Cause of death information	If unknown, enter "pending", "under investigation," etc.
A L L O T H E R I N F O R M A T I O N I F A V A I L A B L E		

* In their operating plans, healthcare facilities should designate physicians to certify the cause of death if the attending physician is not available.

* In their operating plans, coroners/MEs should designate physicians who are authorized to certify the cause of death on their behalf.

Delivering the forms

Subregistrars

With the approval of the State Commissioner of Health, local registrars may appoint one or more subregistrars. In their annexes, counties should plan for activation of subregistrars in hospitals and morgues to facilitate the processing of death certificates and burial permits. Hospitals and coroners/MEs should prepare appointment forms in advance and submit them to the registrar, who will submit them to the State Commissioner of Health, as appropriate.

Other information

Registered death certificates must be sent by registrars to the Vital Records Bureau for recording and filing per standard procedures.

Registrars will continue to be responsible for maintaining burial/cremation/storage records.

HH. Recommended Methods of Storage for Healthcare Facilities

All storage options should weigh the storage requirements against the time it takes to collect information that is necessary for identification, determination of the cause and circumstances of death, next of kin notification, and length of time the decedent will need to be stored until release to the coroner/ME morgue or private mortuary.

PROTECTING THE DECEDENT
<ul style="list-style-type: none">• Decedents and their personal effects must be secured and safeguarded at all times until the arrival of the coroner's or mortuary's authorized representative, or law enforcement (if evidentiary).• Place in a human remains pouch or wrap in plastic and a sheet.• If personal effects have been removed from the body, ensure the items have been catalogued and are secure.• Be sure the decedent is tagged with identification information.
REFRIGERATION IS THE RECOMMENDED METHOD OF STORAGE
<ul style="list-style-type: none">• Refrigeration between 38° and 42° Fahrenheit is the best option.• Refrigeration units should be maintained at low humidity.• Existing healthcare facility morgue: most healthcare facility morgues' refrigeration capacity will be exceeded during a disaster, especially if there are many unidentified bodies or remains recovered• Surge Morgues<ul style="list-style-type: none">○ Rooms, tents or large refrigerated transport containers used by commercial shipping companies that have the temperature controlled may also serve as surge morgues○ May be cooled via the HVAC system and/or portable air conditioners○ Refrigerated containers may be used to store up to 30 bodies by laying remains flat on the floor with walkway between○ Refrigerated containers should not have wood interiors• Dry ice is not ideal for short-term storage:<ul style="list-style-type: none">○ Expensive, difficult to obtain during an emergency.○ Dry ice requires handling with gloves to avoid "cold burns." When dry ice melts it produces carbon dioxide gas, which is toxic.
BEDS, COTS OR RACKING SYSTEMS – NOT STACKING
<ul style="list-style-type: none">• Stacking of human remains is NOT recommended• The floor can be used for storing remains, however it may be safer and easier to identify and move remains on beds, cots or racking systems• Consider lightweight temporary racking systems. These can increase each room or container's capacity by 3 times, as well as create a specific storage location for tracking. These may be specifically designed racks for decedents, or converted storage racks (such as large foodservice shelving, 72" wide by 24" deep; ensure that these are secured and can handle the weight load).

II. Morgue Surge Equipment and Supplies Checklist

Equipment and supplies for the morgue surge areas may include the following. Be sure to identify where items are stored and how to access the storage area.

Consideration	Facility Notes/ How to Access Equipment
<p>Staff Protection</p> <ul style="list-style-type: none"> <input type="checkbox"/> Personal protective equipment (minimum standard precautions) <input type="checkbox"/> Worker safety and comfort supplies <input type="checkbox"/> Communication (radio, phone) 	<p>Storage area:</p> <p>How to access:</p> <p><i>Notes:</i></p>
<p>Decedent Identification</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identification wristbands or other identification <input type="checkbox"/> Method to identify each decedent (pouch label, tag or rack location) <input type="checkbox"/> Cameras (may use dedicated digital, disposable, or instant photo cameras) <input type="checkbox"/> Fingerprints <input type="checkbox"/> X-rays or dental records <input type="checkbox"/> Personal belongings bags / evidence bags 	<p>Storage area:</p> <p>How to access:</p> <p><i>Notes:</i></p>
<p>Decedent Protection</p> <ul style="list-style-type: none"> <input type="checkbox"/> Human remains pouches <input type="checkbox"/> Plastic sheeting <input type="checkbox"/> Sheets 	<p>Storage area:</p> <p>How to access:</p> <p><i>Notes:</i></p>
<p>Decedent Storage</p> <ul style="list-style-type: none"> <input type="checkbox"/> Refrigerated tents or identified overflow morgue area <input type="checkbox"/> Storage racks <input type="checkbox"/> Portable air conditioning units <input type="checkbox"/> Generators for lights or air conditioning <input type="checkbox"/> Ropes, caution tape, other barricade equipment 	<p>Storage area:</p> <p>How to access:</p> <p><i>Notes:</i></p>

JJ. Infection Control Procedures for Pandemic Influenza

19

Mortuary care and postmortem examination

G.1 Packing and transport of dead body to mortuary, crematorium and burial

- Before removal from the isolation room/area, the body should be fully sealed in an impermeable human remains pouch to avoid leakage of body fluid. The outside of the bag should be kept clean. When properly packed in the human remains pouch, the body can safely be transferred to pathology department or the mortuary, sent to the crematorium, or placed in a coffin for burial. (See Attachment O in the NYS Guidance for the County Mass Fatality Annex for recommended minimum specifications for human remains pouches used for burial without a coffin or vault.)
- Transfer to the mortuary should occur as soon as possible after death.
- If an autopsy is being considered, the body may be held under refrigeration in the mortuary until a safe environment can be provided for the autopsy.

G.2 Recommended PPE for workers handling human remains

- Disposable long-sleeved, cuffed gown, (waterproof, if the outside of body is visibly contaminated with body fluids, excretions or secretions). If no waterproof gown is available, a waterproof apron should be used in addition to the gown.
- Non-sterile, latex gloves (single layer) should cover cuffs of gown.
- If splashing of body fluids is anticipated, use facial protection.
- Perform hand hygiene after removal of PPE.

G.3 Recommended PPE during autopsy

G.3.1 PPE to be provided

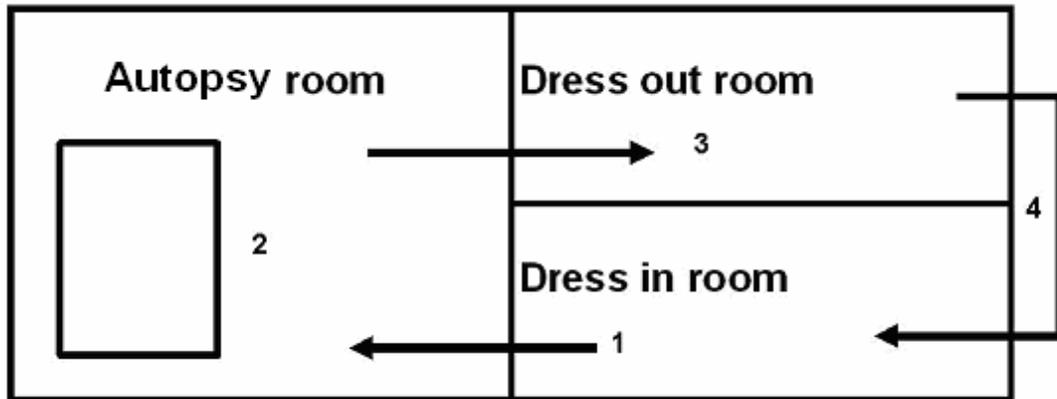
- Scrub suits: tops and trousers, or equivalent garments.
- Single-use, fluid-resistant, long-sleeved gowns.
- Surgical masks, or if small particle aerosols might be generated during autopsy procedures, a particulate respirator at least as protective as a NIOSH-certified N95, EU FFP2 or equivalent.
- Face shield (preferably) or goggles.
- Autopsy gloves (cut-proof synthetic mesh gloves) or two pairs of non-sterile gloves.
- Knee-high boots.

G.3.2 PPE placement

- Workers should put on PPE in the dress in room (see Figure 10) before proceeding to the autopsy room where the body is located.
- In the dress in room, workers should replace their outer street clothes and shoes with scrub suits (or equivalent coverall garments) plus boots.
- Proceed to the autopsy room where the body is located.

¹⁹ Adapted from Infection prevention and control of epidemic and pandemic prone acute respiratory diseases in health care WHO Interim Guidelines, June, 2007 and OSHA guidance.

Figure 10. Movement of the autopsy team undertaking a postmortem examination.



G.3.3 PPE removal

- Exit the autopsy room to the dress out room as suggested in Figure 10.
- Remove PPE in designated dress out room, dispose of the PPE in accordance with CDC recommendations (available at <http://www.cdc.gov/ncidod/sars/pdf/ppeposter148.pdf>) and perform hand hygiene.

G.4 Methods to reduce HCW exposure to aerosols during autopsy

- An airborne infection isolation room should be used. Exhaust systems around the autopsy table should direct air (and aerosols) away from healthcare workers performing the procedure (e.g., exhaust downward).
- Containment devices should be used whenever possible (e.g. biosafety cabinets for the handling and examination of smaller specimens).
- Vacuum shrouds should be used for oscillating saws.
- High pressure water sprays should not be used.
- Open intestines under water.

For information on PPE for biologic terrorism go to CDC Medical Examiners, Coroners, and Biologic Terrorism: A Guidebook for Surveillance and Case Management at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5308a1.htm>