Mass Fatality Management Guide for Healthcare Entities

January 31, 2013

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These resources are available at:

http://ems.dhs.lacounty.gov/

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OVERVIEW

The medical care system will be severely taxed during a disaster. Healthcare entities will have a primary focus on surging to facilitate life-saving operations. At the same time, there will be a myriad of complex issues, which may include a significantly increased number of fatalities. Partners have an opportunity and responsibility to plan for the timely, respectful management of the surge of fatalities that may be caused by a disaster.

This *Mass Fatality Management Guide for Healthcare Entities* was created to aid partners in the development of a detailed plan to manage a surge of fatalities. It was constructed to facilitate the creation of a well organized, realistic plan that supports mass fatality surge, to include the clear delineation of the transition from normal to disaster operations.

SCOPE

The scope of the *Mass Fatality Management Guide for Healthcare Entities* includes guidance for hospitals, medical clinics, and SNFs located in Los Angeles County to effectively manage mass fatality operations within their scope as a healthcare partner. This guide includes directions for mass fatality plan development and successful activation, operation, and demobilization strategies for partners within Los Angeles County. As such, the guide seeks to provide a framework for mass fatality management during large-scale disasters (e.g., earthquakes); smaller, more localized incidents (e.g., explosion, shooting); as well as long-term events, (e.g., widespread disease outbreaks).

Partners should modify practices identified herein based on the unique attributes of their facility and the availability of local resources. Special consideration has been given to the identification of scalable tiered plan activation requirements; methods and considerations for expedited decedent processing; and coordination with family assistance/information resources (e.g., Family Assistance Centers, and Family Information Centers).

BACKGROUND

The previous version of this guide, *Mass Fatality Incident Management: Guidance for Hospitals and Other Healthcare Entities* was originally developed in 2008 by the Los Angeles County EMS Agency in coordination with the Los Angeles County Department of Coroner and the Los Angeles County Department of Public Health. At the time of its original publication, the guide was considered a ground-breaking resource – one of the first of its kind to be developed for partners. To this day, it continues to be cited by numerous agencies and organizations throughout the nation.

As a forward leaning jurisdiction, Los Angeles County initiated the revision and expansion of the guide in 2011. The next generation of guide development included a significant expansion of the Project Oversight Group, to include disaster planners for hospitals, medical clinics, and SNFs; mental/behavioral health; jurisdictional emergency management; law enforcement; and other healthcare providers. The scope of the guide was further enhanced to include lessons learned and best practices from disasters that have occurred since its original publication, to include the 2011 Tohoku earthquake of Japan,[1] the 2011

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[1] The 2011 Tohoku earthquake also included tsunami waves and multiple nuclear reactor accidents.

EF5 multiple-vortex tornado that struck Joplin, Missouri; and numerous others. Significant detail was added to describe the roles of other county agencies, specifically as it pertains to their link to fatality management at healthcare facilities.

WHAT IS MASS FATALITY

The definition of a mass fatality incident/event varies from one agency and jurisdiction to another.[2] For example, one jurisdiction may define a mass fatality incident/event as any situation where more deaths occur than can be handled by the resources available. More important than the definition of a mass fatality incident/event for partners, is the set of parameters that call for mass fatality plan activation and subsequent response, which is detailed herein.

GUIDE DEVELOPMENT PROCESS

The Mass Fatality Management Guide for Healthcare Entities was developed as part of the overarching 2011-2013 Los Angeles County Medical and Health Exercise Program. The Guide is the result of collaborative partnerships and an ongoing commitment to excellence in emergency management. This project was initiated and led by the Los Angeles County EMS Agency and supported by a multi-agency, multi-discipline Project Oversight Group. Input was received from numerous agencies and organizations, to include stakeholders at local, state, and federal levels of government. **This guide is consistent with applicable statutes and regulations in effect as of the date of publication. However, planners should review all legal and regulatory requirements as part of plan development/refinement efforts to ensure compliance.**

In order to develop and refine the *Mass Fatality Management Guide for Healthcare Entities*, in-person Project Oversight Group meetings were conducted, drafts were reviewed and vetted for comment, and interviews were conducted with contributors from across the country. The *Mass Fatality Management Guide for Healthcare Entities* was also vetted via a tabletop exercise and a countywide functional exercise where review and testing of the guide was a primary objective.

HOW TO USE THIS GUIDE

The *Mass Fatality Management Guide for Healthcare Entities* is organized into two primary components, a base guide and appendices. The base guide provides step-by-step direction in the development of mass fatality plans. The base guide is organized into subchapters, to include Plan Development, Activation, Operations, and Demobilization. Appendices provide significant supplemental resources to aid in plan development. Such resources include facts and answers sheets, forms, and a community-wide response matrix showing the role of healthcare partners and all levels of government in mass fatality management. An online toolkit has also been made available on the EMS Agency website at **http://ems.dhs.lacounty.gov/,** which includes an electronic copy of this guide, as well as multiple resources for planners.

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[2] The Los Angeles County Department of Coroner considers a mass fatality incident/event to involve five or more decedents. The Los Angeles County EMS Agency defines a mass casualty incident/event as the combination of numbers of ill/injured patients and the type of injuries going beyond the capability of an entity's normal first response.

ASSUMPTIONS

The following were presumed in the development of this guide:

NIMS/SEMS, as well HICS (for hospitals), ICS (for medical clinics) and NHICS (for SNFs) protocols will be utilized to facilitate the notification and resource request processes.

Plans developed as a result of this guide will be consistent with the U.S. Department of Homeland Security's *National Response Framework,* to include Emergency Support Function # 8; *Comprehensive Preparedness Guide* 101; 2011 Hospital Preparedness Program grant guidance; as well as requirements and best practices that pertain to the State of California and Los Angeles County.

Activation of the mass fatality plan will occur as directed by the healthcare entity Incident Commander or designee, and will support existing emergency operations plans. As such, functions that are typically addressed in an emergency operations plan (e.g., ongoing communications with city/county partners) are not included herein so as not to duplicate or supersede existing emergency operations procedures that to do not directly apply to mass fatality management.

The activating entity assumes liability for mass fatality related costs and operations at their facility.

Every action described in this guide will not necessarily be completed during every plan activation nor is every activity described in this guide. Healthcare partners will use judgment and discretion to determine the most appropriate actions at the time of the incident/event.

A city/county Family Assistance Center will be activated for a mass fatality incident/ event within two hours of the incident/event occurring. Partners and the Los Angeles County EMS Agency will facilitate the sharing of decedent information with the Family Assistance Center as possible, in a manner that is consistent with legal and regulatory requirements. See the *Los Angeles County Operational Area Family Assistance Center Plan* for more information.

Those partners with the capability to activate a facility-based Family Information Center will include Family Information Center planning considerations into their mass fatality plan.

Refrigeration vehicles noted herein refer specifically to temporary storage of human remains, not for transportation, unless otherwise indicated.

In the event of a widespread disease outbreak, local, state, federal, or military assistance in fatality management may be overwhelmed and not readily available.

NOTES:
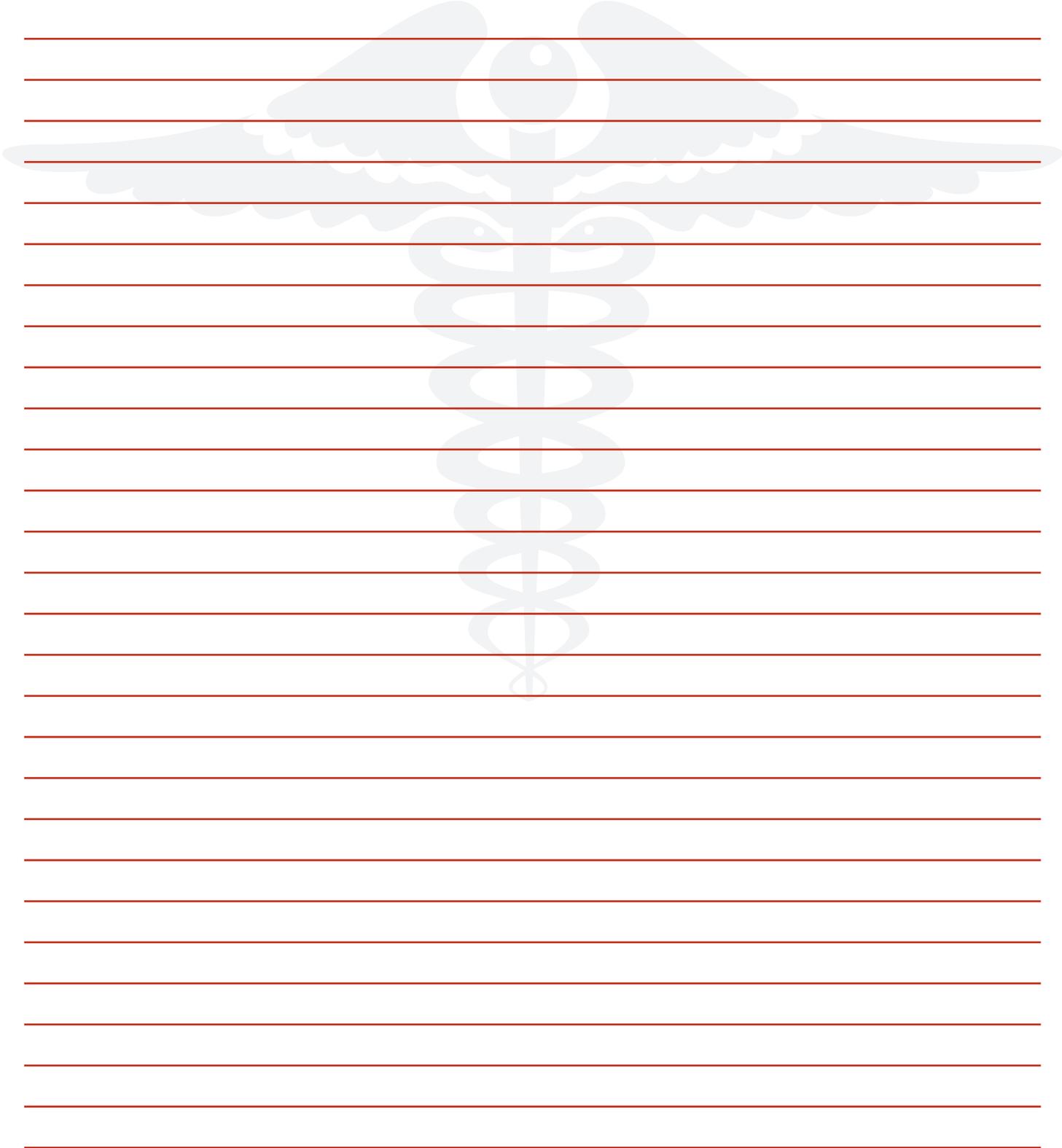
SECTION TWO

Plan Development

PLAN DEVELOPMENT

OVERVIEW OF SECTION

This section describes activities that planners should implement to ensure that mass fatality documentation and practices are current and that all appropriate staff are trained in these procedures. As a cornerstone of any solid emergency management program, planners should ensure that mechanisms are in place to facilitate regular plan review by those who are charged with implementing it. Additionally, training and exercises to practice plan procedures and mass fatality response operations should be carried out on a regular basis so that staff understand and are comfortable with their assigned role.

Facilities should develop plans appropriate for the size of their facility. For example, clinics, SNFs, and smaller hospitals may have simpler plan development procedures. For larger facilities, these plans will be more detailed and complex.

CREATING THE PLAN DEVELOPMENT SECTION

STEP
1

Identify development and maintenance strategies.

Identify maintenance strategies for mass fatality plans and a specific person and/or facility staff position charged with ensuring that these actions are carried out. Some of the most successful maintenance strategies are incorporated into the assigned staff member's job description and annual employee performance review. A list of maintenance strategies is provided here. These should be reviewed, tailored, documented, and carried out as appropriate for the entity.

- Develop a system for storing relevant information between plan updates in one place so that it is easily accessible when it is time to update the plan. Such information may include:
  o Changes to management capability or new decedent storage capacity.
  o Procedure changes.
  o After-Action Reports/Improvement Plans comments/feedback.
- Develop a system for identifying:
  o New mass fatality planning guidance documents,
  o Changes in national, state or local direction, and
  o New lessons learned in the event of a mass fatality in another jurisdiction.
- A list of plan gaps to be addressed as time and budget allow. As an example:
  o Development of memorandums of understanding with support organizations and facilities.
- A list of agencies/organizations that will be provided with a copy of your plan.

Adapted from *Advanced Practice* Centers Managing Mass Fatalities: A Toolkit for Planning

STEP 1 (continued)

Once you have a system for collecting and organizing relevant information in between updates, determine a process for updating the plan.
- Specify how often the plan will be updated—ideally every three years and whenever relevant changes occur.
- Specify staff member(s) who will review the plan. This should include stakeholders who have key roles in carrying out the plan. This may include agencies/organizations external to your facility.
- Identify who is responsible for incorporating all changes into the plan. This should include a primary and alternate contact.
- Identify who is responsible for approval of the plan after it is updated. Ensure that senior administrative staff are briefed on and have approved the plan.

STEP 2

Develop your plan training and exercise strategy.

Exercises provide training and practice for emergency events that test readiness, evaluate the mass fatality management plan, and provide detailed feedback for maintaining the plan for your facility. Even though exercises can be costly and time consuming, they are the best way to test a plan prior to an actual mass fatality incident/event. In this section of your mass fatality plan, present a strategy for training and exercises, including:
- The functions and/or parts of the plan that you will exercise.
- The type of exercises.
- How you will evaluate the exercises.
- A time frame within which each exercise will be done.

Training
All institutions involved in management of decedents should introduce basic training. Personnel should receive specific instruction on different aspects of handling decedents, and social, cultural, religious, legal, and psychological characteristics of the community.

STEP
2
(continued)

Tabletop Exercises

At a minimum, tabletop and other discussion-oriented exercises should be used to familiarize staff with plans, including recent updates.

Drills, Functional and Full Scale Exercises

These exercises provide an opportunity for planners to test mass fatality management in a tactical manner and may include interaction with external partners, such as the EMS Agency, the Coroner, and area mortuaries. *The Annual Statewide Medical and Health Disaster Exercise* provides a solid platform for providing an operational test of the plan.

Exercise Evaluation

The U.S. Department of Homeland Security Exercise Evaluation Program **(https://hseep. dhs.gov.)** includes several tools and practices that can be utilized to evaluate your exercise. As part of the planning process, it is recommended that your facility identify and use relevant exercise evaluation guides and make these tools available to exercise planners. Strengths and improvement items identified during the exercise should be incorporated into the written After-Action Report/Improvement Plan.

The U.S. Department of Homeland Security Exercise Evaluation Program was revised in 2012. This version of the guide reflects these revisions.
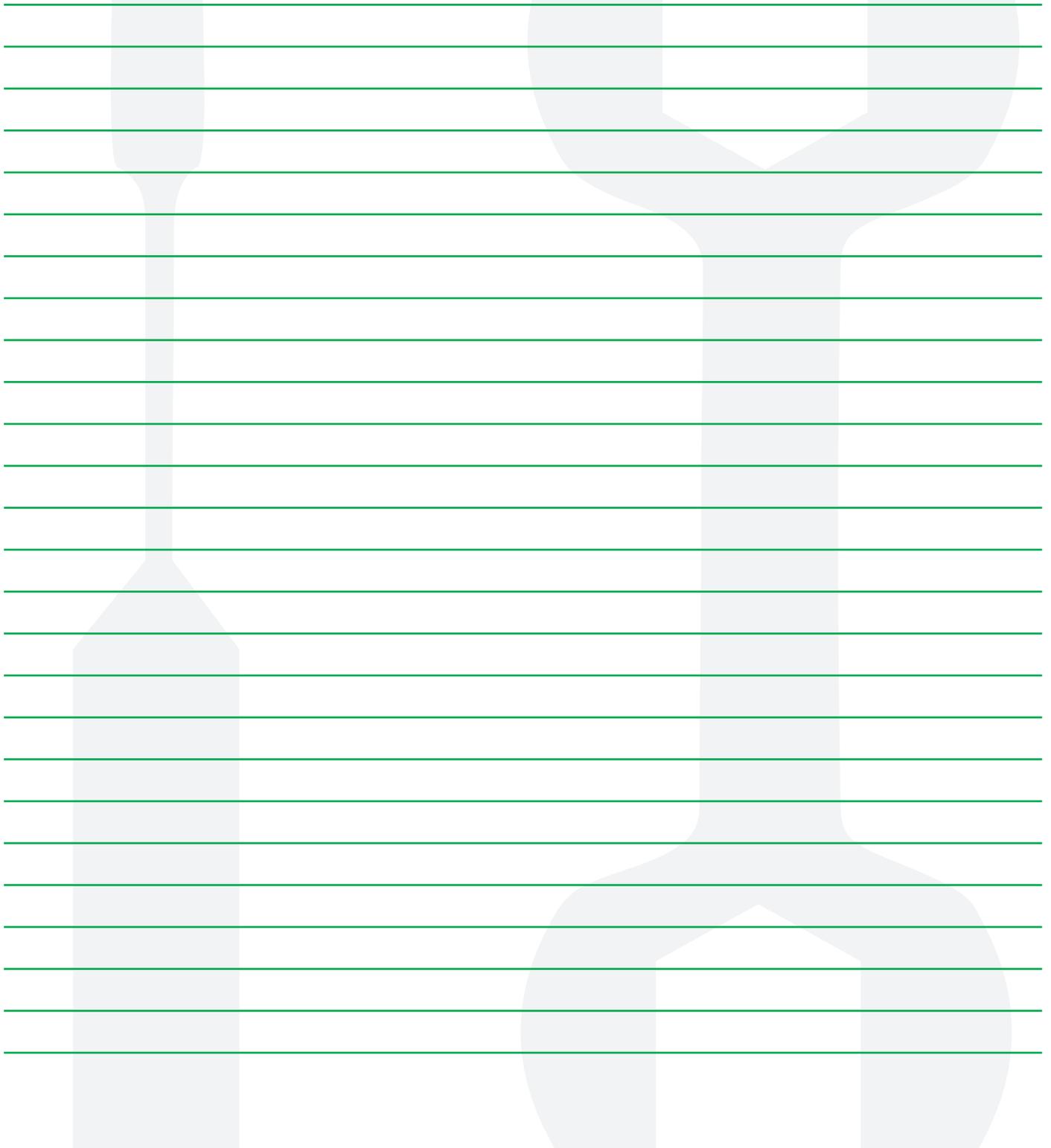
NOTES:

REGULATORY REQUIREMENTS, GUIDES, AND AUTHORITIES

Planners should review regulatory requirements or standards surrounding mass fatality management that apply to their facility. The following information provides an example of regulatory language that may be applicable to Los Angeles County healthcare entities as of the date of publication of this guide.

This guide derives its authority from the legal responsibility and from the related plans with which it is consistent. This guide was developed according to the references listed here:

- The Hospital Preparedness Program grant guidance: All awardees must ensure that facility level fatality management plans are integrated into local, jurisdictional and State plans for disposition of the deceased. **These plans must clearly account for the proper identification, handling and storage of remains.** Awardees should also review the Fatality Management capability as detailed in the *2011 CDC Public Health Preparedness Capabilities* document, and ensure that funded activities that involve integrating hospital plans into larger planning efforts are coordinated with CDC activities. The following must be addressed in the End-of-Year Progress Report: **The current status of fatality management planning, including the need for expanded refrigerated storage capacity, and supplies such as body bags; the role of the State/jurisdictional Chief Medical Examiner/Coroner in the fatality management planning process; the role of participating partners, emergency management, public health and other State/local agencies in the fatality management planning process; and The cultural, religious, legal and regulatory**

issues involved with the respectful retrieval, tracking, transportation, identification of bodies, and death certificate completion

- *The National Response Framework,* which states that the primary management of an incident should occur at the lowest possible geographic, organizational, and jurisdictional level
- NIMS/SEMS, as well HICS (for hospitals), ICS (for medical clinics) and NHICS (for SNFs) protocols
- Department of Homeland Security's *Comprehensive Preparedness Guide 101*
- South Coast Air Quality Management District permits (for human remains cremation restrictions)
- CFR 42 Section 483.75(m). Develop and implement detailed written plans to meet all potential emergencies and disasters
- 45 CFR 164.510(b)(4): A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entitled the uses or disclosures permitted by 45 CFR 164.510(b)(1)(ii). [These are the uses or disclosures permitted to notify or assist in the notification of a family member or personal representative.]
- *The California Coroner Mutual Aid Plan*
- *The California Department of Health Care Services Licensing and Certification Program*
- *The California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan*
- *The California Public Health and Medical Emergency Operations Manual*
- California Code of Regulations Title 22 70741 (a): A written disaster and mass casualty

program shall be developed and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts]

- California Code of Regulations Title 22 72551: Written external disaster and mass casualty plan shall be developed with the advice and assistance of county or regional and local planning offices, and shall not conflict with county/community disaster plans

- California Civil Code 1862.5: Whenever any personal property has heretofore been found in or deposited with, or is hereafter found in or deposited with any licensed hospital and has remained or shall remain unclaimed for a period of 180 days following the departure of the owner from the hospital, such hospital may proceed to sell the same at public auction, and out of the proceeds of such sale may retain the charges for storage, if any, the reasonable expenses of sale thereof and all sums due the hospital from the last known owner

SECTION THREE

Activation

ACTIVATION
OVERVIEW OF SECTION

Identification of distinct triggers for mass fatality plan activation are of the utmost importance. Equally as important, is the healthcare entity's ability to recognize the triggers for plan activation and initiate plan escalation steps. Too often it is observed that disaster plans are not activated when they should be. This can result in missed opportunities to establish a solid command structure, obtain and maintain situational awareness, and track documentation that is needed to expedite decedent processing. As such, it is particularly important to establish realistic activation and escalation protocols, and to practice, both in real-world response as well as in exercise, as they are written. Opportunities for modifications to these triggers should be offered following practice events and real-world emergencies based on lessons learned.

Plan activation and escalation will likely be in concert with Incident Command System (HICS, ICS or NHICS) activation. Position titles listed here reflect such an activation. Those facilities that do not use HICS, ICS or NHICS should modify position titles to correctly identify their staff (e.g. day-to-day titles such as Chief Operating Officer, Chief Medical Officer, or Director of Nursing).

DEVELOPING THE ACTIVATION SECTION

STEP
1

Confirm who is responsible for mass fatality management at your facility.

The person responsible for mass fatality management within your facility may be the person who is authorized to activate the plan and carry out mass fatality operations as described in this guide. At larger hospitals, there may be a Decedent Affairs Group Supervisor assigned to this function. A Mass Fatality Response Team can be pre-designated, and may include non-medical, non-clinical staff (i.e., a Chaplain is encouraged to be assigned and trained to act as a supporting team member). For clarity, the person who is responsible for mass fatality management will be referred to as the Decedent Affairs Group Supervisor. In the HICS, ICS or NHICS organizational structure, this supervised group of individuals will be referred to as the Decedent Affairs Group, and the physical office will be referred to as the Decedent Affairs Office. Additional detail about the Decedent Affairs Group is provided in the Logistics and Staffing Chapter of this guide.

At smaller facilities, this responsibility may be assigned to the nursing or business office. Determine who has this responsibility.

STEP 2

Describe how the responsible person(s) will be notified.

Partners should identify who is responsible and authorized to immediately notify the Decedent Affairs Group Supervisor or person acting in this capacity per existing emergency operations plans. The Decedent Affairs Group Supervisor may also become aware of the incident/event through various media outlets, and/or an emergency notification system. In the event of pandemic influenza or other widespread disease outbreak, notification may be triggered by the status of the pandemic as communicated by the WHO, CDC, California Department of Public Health, and the local Health Officer. Notification should occur as part of your overall emergency response structure.

STEP 3

Describe how Decedent Affairs staff will be notified.

Describe the notification process used at your facility.

For example, Decedent Affairs staff will be notified by landline, cell phone and/or other emergency notification systems.

Partial HICS Chart Showing Decedent Affairs Group
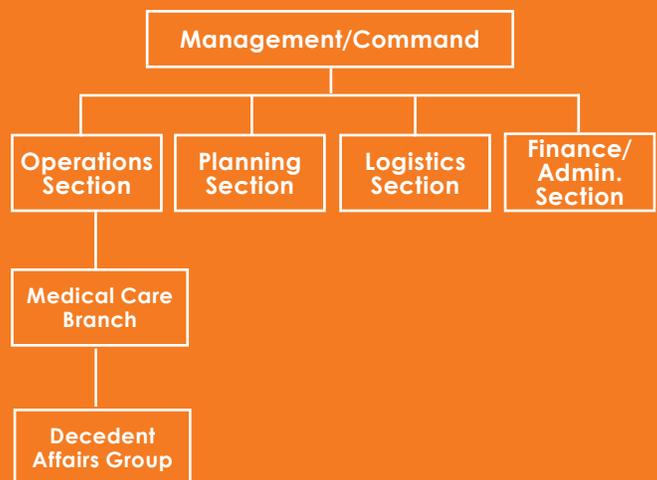
STEP 4

Describe how other stakeholders will be notified.

Develop a system for notifying key partners in the event of a mass fatality incident. Create a table with a description of services, name of provider/organization and contact information. Include e-mail address, and more importantly a 24/7 access phone number for each of these areas and note where this is located in the Decedent Affairs Office in your plan. Your facility may already have this information available.

Examples of key stakeholders include:
- The Los Angeles County EMS Agency and the Los Angeles County Department of Coroner
- Lead agency that provides family assistance services
- Local Registrar for the Vital Records System for death registration and issuance of final disposition permits (Long Beach Department of Health and Human Services, Los Angeles County Department of Public Health, or Pasadena Public Health Department)
- The deathcare industry (e.g. funeral homes, crematoriums, etc.) for final disposition of human remains

Contact local mortuaries to determine whether there are steps that can be taken in the planning process or during a real-world incident to expedite the release and transport of decedents. Mass fatality planners should consider methods that can expedite decedent processing.

STEP 5

Determine who has the authority to activate the mass fatality plan.

The following provides an example of how the individual(s) with the authority to activate the mass fatality plan can be described.

The Decedent Affairs Group Supervisor may activate the mass fatality plan as directed by the Incident Commander or designee. The Decedent Affairs Group Supervisor position will report to the Medical Care Branch Director (or if position is not activated, to the Operations Section Chief or Incident Commander).

Activation of this plan will be considered when the normal decedent storage capacity will not accommodate the number of decedents. All attempts to expedite movement of decedents to mortuaries and/or the Coroner's office will be made prior to activation of this plan. If not already commenced, the Incident Commander, or designee, will facilitate notification of facility emergency command staff and the Medical Alert Center (866-940-4401) by phone or ReddiNet that the mass fatality plan has been activated. Resources should be requested as needed.

STEP 6

Determine and describe escalation levels.

Develop escalation levels that allow for scalability in mass fatality management. Needs will differ for a mass fatality incident/event involving local support and regional mutual aid versus a catastrophic mass fatality event that will require extraordinary support from state, federal, and private resources. It is recommended that a tiered escalation strategy be developed to accommodate the scale of management capability.

The following table provides **SAMPLE** mass fatality plan escalation levels based on the number of decedents and storage capacity. **Numbers reflect percentages over day-to-day decedent storage capacity.**

Partners are encouraged to **modify these escalation levels to accommodate the unique features of their facility** and of the incident/event, to include proximity to incident/event, duration of incident/event, etc.

Activities listed herein should be taken as part of coordinated emergency operations within the healthcare facility and as directed by the Incident Commander or designee.

STEP 7

Devlop facility inspections as pertaining to healthcare facility type.

Develop a concise inspection system that is specific to the facility's morgue. Ths can take the form in a simple checklist of necessary items such as morgue space, tempature maintainance and or supervisors on-call. Alternate morgue areas within the facility can also be included, identified and/or planned for in advance.

SAMPLE PLAN ESCALATION LEVELS

HOSPITALS WITH MORGUES	
Tier Description	**Actions**
Tier 1 **Plan Escalation** **25% over normal** **decedent** **storage capacity**	• Contact mortuary/coroner to discuss methods to expedite decedent release to decompress the morgue. • Advise admissions staff to collect decedent processing information as part of the admissions process, to include preferences regarding mortuaries, burial/cremation, and religious/cultural practices as appropriate. This may also include the use of a Witness Form for those who bring patients to the facility. Such forms should facilitate the collection of as much decedent information as possible. • Ensure that all necessary documentation is completed on the part of the healthcare facility. • Reassign non-medical staff to mass fatality functions as resources allow. • Examine the use of crypt beds. Determine whether two decedents can occupy a single crypt bed without stacking and without exceeding the manufacturer's weight limit. Move decedents as appropriate. • Review policy for entering decedent information into ReddiNet. Advise appropriate staff to enter decedent information into ReddiNet.[3] • Consider activation of your facility's Family Information Center, if applicable. • Prepare for Tier 2 escalation.
Tier 2 **Plan Escalation** **26-50% over** **normal decedent** **storage capacity**	• Carry out applicable activities from Tier 1. • Consider the activation of the "Physician in Charge" death certificate signing method, if practiced and part of facility policy. • Coordinate just-in-time training for key physicians regarding the signing of death certificates. • Prepare for and utilize cooling tents or alternative methods to cool decedents to appropriate temperature. • Activate Emergency Communications Plan. Ensure that messages are provided to staff, patients, and visitors regarding the incident/event. • Prepare for Tier 3 escalation.

[3]This information would be conveyed to a city/county Family Assistance Center via the Los Angeles County EMS Agency.

SAMPLE PLAN ESCALATION LEVELS

HOSPITALS WITH MORGUES	
Tier Description	**Actions**
Tier 3 **Plan Escalation** **51% over normal decedent storage capacity**	• Carry out applicable activities from previous tiers. • Prepare for and utilize refrigeration trucks for temporary storage. • Maintain contact with coroners/mortuaries.

HOSPITAL, MEDICAL CLINIC, SNF WITHOUT MORGUES	
Tier Description	**Actions**
Tier 1 **12 hour delay in mortuaries/ coroner picking up decedents**	• Contact mortuary/coroner to discuss methods to expedite decedent release. • Ensure that all necessary documentation is completed on the part of the healthcare facility. Use the Witness Form to facilitate the collection of information regarding the final resting place. • Reassign non-medical staff to mass fatality functions as resources allow. • Identify (preferably unused) space in the facility that can be converted to a temporary decedent storage. Ideally, this area will be isolated from other patient care areas. Place the decedent in temporary decedent storage. Drop the room temperature as close to 40 degrees Fahrenheit as possible. Bring in portable cooling units (air conditioners) as possible. • Develop and maintain a decedent storage logbook to note identifying information for decedents placed in temporary decedent storage. • Review policy for entering decedent information into ReddiNet. Advise appropriate staff to enter decedent information into ReddiNet, if access and trained staff are available, or notify the Los Angeles County Medical Alert Center by phone.[4] • Prepare for Tier 2 escalation. *(continued)*

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[4] Other procedures may be requested by the county to include reporting this information to the local health department.

HOSPITAL, MEDICAL CLINIC, SNF WITHOUT MORGUES	
Tier Description	**Actions**
Tier 2 **12-24 hour delay in mortuaries/ coroner picking up decedents**	• Carry out applicable activities from Tier 1. • Consider the activation of the "Physician in Charge" death certificate signing method, if practiced and part of facility policy. • Coordinate just-in-time training for physicians regarding signing of death certificates. • Prepare for and utilize cooling tents or alternative methods to cool decedents to appropriate temperature. • Activate Emergency Communications Plan. Ensure that messages are provided to staff, patients, and visitors regarding the incident/ event. • Prepare for Tier 3 escalation.
Tier 3 **Greater than 24 hour delay in mortuaries/coroner picking up decedents**	• Carry out applicable activities from previous tiers. • Prepare for and utilize refrigeration trucks for temporary storage. • Maintain contact with coroners/mortuaries.

Healthcare facilities are encouraged to modify plan escalation levels if:
• Decedents require decontamination
• There is risk of biological, chemical, and/or physical hazards
• Criminal or terrorist involvement may be suspected
• If in the case of a worst-case scenario such as pandemic influenza, external assistance may be very limited or not available

ASSOCIATED TOOLS AND REFERENCES
The following resources provide supplemental information, and can be used to support plan development:
• Los Angeles County EMS Agency and Los Angeles County Department of Public Health. (2006). *Terrorism Agent Information Treatment and Guidelines for Hospitals and Clinicians*

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LOGISTICS AND STAFFING CHAPTER

OVERVIEW OF CHAPTER

This chapter describes the logistics that planners should strive for as part of an ongoing readiness program. The volume of staff, supplies and equipment required to respond to a mass casualty event will vary by several factors, including the size and type of the health facility, the magnitude and nature of the event, whether the event is localized or region-wide, and whether the event is a result of a sudden occurrence (such as an earthquake) or whether it is the result of a prolonged occurrence such as a disease outbreak.

DEVELOPING THE LOGISTICS CHAPTER

STEP 1

Plan for and coordinate staffing.

While the healthcare facilities' first priority is to provide care for the living, non-medical personnel can be reassigned to decedent affairs support roles. Staffing guidelines are "modular", i.e., scaled to the size of the incident/event. Planners should determine what time frame the staffing guidelines are for (e.g., a single operational period, usually 12 hours). This chapter of the guide provides direction for staff that fall under the Decedent Affairs Group. Additional instruction is provided for staff members whose duties will impact mass fatality management, such as physicians (where death certificates can be signed by physicians – non-Coroner cases) and healthcare facility intake staff.

DECEDENT AFFAIRS GROUP

The purpose of a Decedent Affairs Group is to have a team to initiate and manage mass fatality operations for your facility. Functions include:

• Establishment of mass fatality management operations
• Immediate implementation of Witness Form use
• Decedent identification (if not already done upon admittance)
• Family/NOK notification
• Coroner, county morgue or mortuary notification/contact
• Tracking decedents who expire at the healthcare facility to disposition out of the healthcare facility
• Managing surge decedent storage capacity

Planners should also consider the inclusion of "palliative care teams" during a mass fatality incident. This team would provide comfort care for patients while dying, dignity of death, respect for cultural and religious needs, location for palliative care within the healthcare facility, resources and staffing needed to support this function, training for staffing, and the incorporation of standing orders into palliative care. Palliative care team members may include family liaisons, spiritual care providers, and other staff as appropriate and as resources allow.

Due to the sensitive nature of decedent processing, ensure all staff receive psychological support if needed. Be cautious in the use of volunteers who may not have mass fatality experience or training.

DECEDENT AFFAIRS AND HICS/ICS/NHICS

It is suggested that the Decedent Affairs Group be located under the HICS/ICS Operations Chapter Medical Care Branch, and that the Decedent Affairs Group Supervisor reports directly to the Medical Care Branch Director. The Decedent Affairs Group will coordinate information with the Patient Registration Unit and the Casualty Care Unit, particularly for those patients identified as expectant. The Decedent Affairs Group will also coordinate information with the Planning Section Patient Tracking Manager. During a disaster, it may not be possible for your facility to staff all positions; however, they are identified here to help illuminate the roles and responsibilities that should be addressed.

Mass Fatality Management Guide for Healthcare Entities

SUPPORT STAFF TASK FORCE	FACILITIES *WITH* MORGUE - SAMPLE QUANTITY			FACILITIES *WITHOUT* MORGUE - SAMPLE QUANTITY		
	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Identification/Tracking	1	2	3	1	2	3
Spiritual Care	1	1	1	0	1	1
Liaison to HICS/ICS/NHICS Patient Tracking Officer and other command center contacts	0	1	1	0	1	1
Data entry staff to ReddiNet and/or CA-EDRS	1	2	3	NA	NA	NA
Liaison to the local public administrator, Family Assistance Center, other relevant agencies, and mortuaries	1	1	1	1	1	1
Liaison to families	1	1	2	1	1	2
Death Certificate coordinator (person with responsibility to coordinate with other physicians to ensure death certificates are signed to expedite decedent processing)	1	1	1	1	1	1
IT support	0	1	1	0	1	1
DECEDENT STORAGE TASK FORCE						
Decedent storage supervisor	1	1	1	1	1	1
2 decedent storage assistants (Minimum of two task force members to safely move decedents)	2	2	4	2	2	2
Infection control staff, as needed	0	1	1	1	1	1
Decedent storage staff to maintain each decedent storage area	0	1	1	1	1	1
Facilities/engineering to maintain the integrity of surge areas	0	1	1	1	1	1
Security for all decedent storage	0	1	1	1	1	1

Used 9 crypt beds as baseline. Duties assigned to "0" staff must be assigned to other staff. Quantity based on escalation tier. Test these numbers when conducting exercises.

STEP 2

Review logistics considerations.[5]

Given the uncertainty surrounding the need for supplies and equipment, and the issues related to long-term storage and upkeep of supplies and equipment, it is difficult to project the needs of an individual facility with precision. Directions provided herein are meant to serve as a guide in planning and should be tailored to fit the unique needs of each facility. Planners should identify the equipment, supplies, personnel and other resources required for activation.

Examples are included here:
- Using the Staffing Guidelines Table provided in this chapter, determine the number of staff anticipated to be assigned to mass fatality operations for the initial operational period (typically 12 hours) and the number of work stations/areas required.
- Work with the Decedent Affairs Group Supervisor and the Incident/Event Commander[6] to develop/review the physical layout of the decedent storage areas.
- Identify/review quantities and types of supplies/equipment identified in the mass fatality plan.
- From the healthcare entity's own resources, or through vendors, arrange for the acquisition, transport, and installation of supplies and equipment.
- Develop a plan to set-up any work areas or storage areas that are not set-up as part of day-to-day operations.

[5]Logistics for mass fatality management should be evaluated and planned for by healthcare entities as part of emergency preparedness efforts.
[6]Equivalent day-to-day position may be the COO.

STEP
3

Identify and obtain needed supplies/equipment.

Development of the recommended supplies/equipment list is based on a number of planning assumptions:

- Needs will be roughly correlated with the size of the facility.
- Needs will be correlated with the type of facility (i.e., General Acute Care facilities can anticipate a greater need than specialized facilities, or clinics.)
- Mortally injured patients are more likely to present at facilities with emergency medical services than those without.
- Needs will not be uniformly distributed among area facilities.
- Normal clinical supplies should be available (e.g., latex gloves, face masks, disinfectant, etc.).
- In a major disaster, outside assistance may be anticipated within 72 hours. Self sufficiency should be planned for through local supplies, storage and vendors.
- In a major disaster, most fatalities will occur outside of health facilities, and will be handled by other agencies/authorities.

During and immediately following a mass fatality incident/event, it may not be possible to replenish equipment and supplies for some time. Therefore, hospitals, medical clinics and SNFs should plan to pre-stock supplies and equipment in sufficient quantities to have the capability to respond to Tier 3 escalation levels.

SURGE CAPACITY PLANNING TARGETS

For planning purposes, it is suggested that hospitals with decedent storages pre-stock supplies and equipment to be able to respond to a minimum of 100% over normal decedent storage capacity. Facilities without decedent storage should plan to temporarily store two decedents for 3-5 days. In a mass fatality incident/event, the Coroner will place a priority on removal of decedents from facilities without on-site decedent storage.

Recommended supplies/equipment fall into two categories:

- Materials required to support decedent management staff; and
- Materials required to support decedent storage operations.

Decedent Affairs Group will need materials to support record-keeping, identification, death certificates, and decedent disposition activities. Decedent storage operations will require materials to properly store and protect decedents and personal effects until they can be retrieved by the Coroner or mortuary.

Supplies/equipment checklists to support decedent management staff and decedent storage operations are shown on the following pages. The tables are followed by case examples, which can be used to help quantify the needs of individual facilities.

MASS FATALITY MANAGEMENT EQUIPMENT/SUPPLIES CHECKLIST

Supplies/equipment for mass fatality management may include the following items. Planners should be sure to identify where items are stored and how to access the storage area(s).

SUPPLIES/EQUIPMENT CONSIDERATION

Distance from the key areas
- ☐ Location of Decedent Affairs Group
- ☐ Distance from Decedent Storage Area

Secure with limited access
- ☐ # of security staff
- ☐ Security equipment
- ☐ Description of how access is limited

Phone lines
- ☐ Incoming phone
- ☐ Outgoing phone
- ☐ Fax machine
- ☐ Fax paper and toner
- ☐ Total number of phones

ReddiNet and CA-EDRS access/terminal (If facility has ReddiNet and CA-EDRS access AND trained staff)
- ☐ Laptop or desktop computers
- ☐ Access to internet

Tables and chairs
- ☐ # of tables
(based on layout needs)
- ☐ # of chairs
(based on layout needs)

Office supplies
- ☐ 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
- ☐ Sheet protectors (e.g. Plastic sleeves)

Printer and Copier
- ☐ Printer and cables, copier
- ☐ Paper
- ☐ Toner

Forms and Documents
- ☐ Facility Mass Fatality Management Plan
- ☐ Decedent Information Form
- ☐ Decedent Tracking Log
- ☐ CA-EDRS "Medical Facilities Users' Guide" (download at **www.edrs.us**)
- ☐ Internal and external contact lists
- ☐ Form 18
- ☐ Witness Form

SURGE DECEDENT STORAGE SUPPLIES/EQUIPMENT CHECKLIST

Ensure thorough documentation of the storage area, how to access the storage area, and any additional notes, for each of the items listed here.

CONSIDERATION

Staff
- ☐ Personal protective equipment (minimum standard precautions)
- ☐ Worker safety and comfort supplies
- ☐ Communication (radio, phone)

Decedent[7][8][9]
- ☐ Water-proof identification wristbands or other identification
- ☐ Method to identify each decedent (pouch label, tag or rack location)
- ☐ Cameras (may use dedicated digital, or instant photo cameras)
- ☐ Film, digital disks/cartridges, and/or photo paper as required
- ☐ Fingerprint kits or other identification aids
- ☐ Indelible ink marking pens
- ☐ Personal belongings bags/evidence bags
- ☐ Human remains pouches
- ☐ Scissors
- ☐ Full Flat Sheet
- ☐ Vinyl plastic sheet 4 mil thick 72 inches wide
- ☐ 200' cotton rope ¼ inch diameter
- ☐ Refrigerated tents, trucks or identified overflow areas
- ☐ Storage racks
- ☐ Portable air conditioning units
- ☐ Generators for lights or air conditioning
- ☐ Caution tape, other barricade equipment

[7]Instant photo cameras are available in traditional and paper models. The ability to produce paper photos is essential, although it is also desirable to have digital capability for documentation and data transmission purposes. For storage of personal effects, 1-gallon freezer bags work well, since they have space for noting contents. Tall kitchen bags are also useful for storing extra clothing, or other bulky personal effects.

[9]Commercially-available body racks typically store 3 or 4 bodies in a vertical configuration. Rolling racks provide more flexible storage options and facilitate movement of bodies to transport vehicles. Racks should provide full support so that bags can be placed directly on the rack without the need for an autopsy tray or other support apparatus. Fewer racks than body bags are recommended since racks may be used more than once.

[8]Through funding from the HPP grant, the Los Angeles County EMS Agency has provided funding for each Disaster Resource Center to purchase 100 human remains pouches as part of its cache creating a total of 1300 in Los Angeles County. In addition, through additional HPP grant funding, each HPP-participating hospital will receive 100 disaster quality human remains pouches to be pre-deployed at each facility as well as a cache stored by Los Angeles County (total of 8400 in Los Angeles County). The Los Angeles County Department of Coroner also recommends use of clear plastic sheeting, secured by ropes, for body storage.

SAMPLE SURGE DECEDENT STORAGE SUPPLIES/EQUIPMENT CHECKLIST

HOSPITAL WITH A MORGUE

DECEDENT AFFAIRS GROUP SUPPLIES

☐ Personal protective equipment (minimum standard precautions)
☐ Worker safety and comfort supplies
☐ 1 table for staff w/4 chairs
☐ 1 small table for security w/1 chair
☐ 100 copies of each form
☐ 1 computer w/internet connection, ReddiNet & CA-EDRS connection, printer/copier/fax
☐ 2 land-line phones
☐ 6 note pads
☐ 6 pens
☐ 2 extension cords
☐ 2 power strips
☐ Stapler, staple remover, duct tape, box of staples
☐ 3 reams printer/copier paper
☐ 1 spare set of printer ink cartridges
☐ 1 measuring tape

DECEDENT STORAGE SUPPLIES

☐ 6 storage racks
☐ 100 pre-deployed body pouches
☐ 100 water-proof ID tags
☐ 10 boxes of latex and non-latex gloves
☐ 5 boxes surgical masks
☐ 2 indelible marking pens
☐ 1 box of 100 1-gallon freezer bags
☐ 1 box of 100 tall kitchen bags
☐ 1 instant camera w/200 photo papers
☐ 1 digital camera with high capacity digital cartridge/disk
☐ 1 roll of yellow/black "police line" tape
☐ 2 land-line phones
☐ 1 computer w/Internet access
☐ 1 portable A/C unit
☐ 1 measuring tape
☐ 2 containers to hold items (e.g., one for soiled linens, one for debris)

This is an example. Adjust the quantities based on your facility. Be sure to indicate how the supplies may be accessed.

SAMPLE SURGE MORGUE SUPPLIES/EQUIPMENT CHECKLIST
HEALTHCARE FACILITY WITHOUT MORGUE

DECEDENT AFFAIRS GROUP SUPPLIES

- ❐ 2 clip boards
- ❐ 1 table or desk for staff w/1 chair
- ❐ 50 copies of each form
- ❐ 1 land-line phone
- ❐ 2 note pads
- ❐ 10 pens
- ❐ 1 computer w/Internet access
- ❐ Stapler, staple remover, duct tape, box of staples
- ❐ Personal protective equipment (minimum standard precautions)
- ❐ Worker safety comfort supplies
- ❐ 1 ream of printer/copier paper
- ❐ 1 spare set of printer ink cartridges
- ❐ 1 measuring tape

DECEDENT STORAGE SUPPLIES

- ❐ 1 roll of plastic sheet 4 mil thick 72 inches wide or 2 body bags
- ❐ 1 200' roll ¼" cotton rope
- ❐ Scissors
- ❐ 5 water-proof Identification tags or wrist bands
- ❐ 1 box of latex and non-latex gloves
- ❐ 1 box of surgical masks
- ❐ 1 indelible marking pen
- ❐ 1 box of 1-gallon freezer bags
- ❐ 1 box of tall kitchen bags
- ❐ 1 roll of yellow/black "police line" tape
- ❐ 1 land-line phone
- ❐ 1 instant camera w/200 photo papers
- ❐ 1 portable A/C unit
- ❐ 1 measuring tape
- ❐ 2 containers to hold items (e.g., one for soiled linens, one for debris)

This is an example. Adjust the quantities based on your facility. Be sure to indicate how the supplies may be accessed.

PHYSICIAN IN CHARGE CONCEPT

Planners should also explore the "physician in charge" concept, whereby one or more qualified physicians are designated to sign death certificates for patients whose deaths are not deemed Coroner's cases, or are otherwise authorized to sign death certificates. It should be noted, however, that most mass fatality incidents will involve deaths that are identified as Coroner's cases. The physician in charge concept is most notably referenced for widespread disease outbreak planning. Should it be determined that the physician in charge concept will be utilized, planners should ensure that training resources are made available. These training opportunities may include new hire training curriculum and just-in-time training.

ADMINISTRATIVE STAFF

One of the most important opportunities to gather information about a would-be decedent is during intake – that is, the moment that they are received in the healthcare facility. As such, admissions and intake staff should be directed to gather as much information as possible about the patient/decedent upon arrival. This may include interviewing the person who brought them, e.g., "the witness", if possible. A Witness Form has been provided in this Guide. Planners should consider the utilization of the Witness Form and the provision of key information points that should be collected at entry, to include:

- Location found (especially important if name is not known)
- Time found
- Clothing
- Any unusual circumstances
- Religious/cultural preferences, especially as it pertains to final resting place
- Preferred mortuary

CONDUCT JUST-IN-TIME TRAINING

Comprehensive just-in-time training should be provided to all key staff immediately prior to plan activation. Just-in-time training should include role assignment and review. Other resources shared at this time may include flow charts, layout diagrams, a copy of the Incident Action Plan, telephone lists, objectives of the operational period, safety compliance, the utilization of HICS/ICS/NHICS, etc. Just-in-time training will not replace participation in training and exercise events. Rather, it will build on concepts taught and exercised as part of a comprehensive plan implementation program.

ASSOCIATED TOOLS AND RESOURCES

- Decedent Affairs Group Supervisor Checklist (see next pages)
- Witness Form (see next pages)

SAMPLE HICS DECEDENT AFFAIRS GROUP SUPERVISOR JOB ACTION SHEET

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial ____
Position Reports to: Medical Care Branch director Signature:_____
HCC Location: _____ Telephone:_____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Medical Care Branch Director. Obtain Decedent Affairs Group activation packet.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Determine need for and appropriately appoint Decedent Affairs Group staff, distribute corresponding Job Action Sheets and position identification. Complete a unit assignment list.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief Decedent Affairs Group staff on current situation; outline unit action plan and desingate time for next briefing.		
Confirm the designated Decedent Affaris Group area is available, and begin distribution of personel and equipment resources. Coordinate with the Medical Care Branch Director and regularly report status.		
Assess problems and needs; coordinate resources managment.		
Determine need for establishing surge morgue facilites.		
Obtain assistance from the Transportation Unit Leader for transporting decedents (from one area to another withing the facility). Ensure that all transporting devices are removed from under the decedent and returned to the Triage Area.		
Instruct all Decedent Affairs Group members to periodically evaluate equipment, supplies, and staff needs and report status to you; collaborate with Logistic Section Supply Unit Leader to address those needs; report status to Medical Care Branch Director.		
Coordinate contact with external agencies with the Liaison Officer, if necessary.		
Monitor decedent identification process.		
Enter decedent information in ReddiNet, if appropriate.		

Immediate (Operational Period 0-2 Hours)	Time	Initial
Coordinate with the Patient Registration Unit Leader and Family Information Center (Operation Section) and the Patient Tracking Manager (Planning Section).		
Contact the Security Branch Director for any morgue security needs.		
Document all communication (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit in the Planning Section.		

Immediate (Operational Period 2-12 Hours)	Time	Initial
Maintian master list of decedents with time of arrival for Patient Tracking Manager.		
Ensure that all personal belongings are kept with decedents and/or are secured.		
Ensure all decedents are covered, tagged and identified where possible.		
Monitor death certificate process.		
Facilitate regular meetings with Inpatient Unit Leader and Casualty Care Unit Leader for updates on the number of deceased & status reports. Relay information to Morgue staff.		
Implement surge morgue facilities as needed.		
Continue coordinating activities in the Decedent Storage Unit.		
Ensure prioritization of problems when multiple issues are presented.		
Coodinate use of external resources; coordinate with Liaison Officer if appropriate.		
Contact the Medical Care Branch Director and Security Branch Director for any morgue security needs.		
Develop and submit a Decedent Affairs Group action plan to the Medical Care Branch Director when requested.		
Ensure that documentation is completed correctly.		
Advise the Medical Care Branch Director immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues are addressed; resolve with the Safety Officer.		

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

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Ensure your physical readiness through proper nutrition, water intatke, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and adverse behavior. Report concerns to the Employee Health & Well-Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant inicident information		

Demobilization/System Recovery	Time	Initial
Release decedents as per facility policy, ensuring all documentation and proper identification are complete.		
As needs for the Decedent Affairs Group decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader		
Ensure the return/retrieval of equipment/supplies/personnel.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Medical Care Branch Director on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure that all documentation and Decedent Affairs Group Orientational Logs (HICS Form 214) are submitted to the Medical Care Branch Director.		
Submit comments to the Medical Care Branch Director for discussion and all possible inclusion in the after-action report; topics include: • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues		
Participate in stress management and after-action debriefings. Particiapte in other briefings and meetings as required.		

ASSOCIATED TOOLS AND RESOURCES

The following resources provide supplemental information, and can be used to support plan development:
- Incident Action Plan
- Form 207 – Incident Management Team Chart
- Form 213 – Incident Message Form
- Form 214 – Operational Log
- Mass Fatality Plan
- Mass Fatality Incident/Decedent storage Unit Assignment List
- Decedent Tracking Log
- Decedent Information Form
- Healthcare entity emergency operations plan
- Healthcare entity organization chart
- Healthcare entity telephone directory
- Key contacts list
- Radio/satellite phone

WITNESS FORM

INCIDENT NAME		DATE AND TIME	

WITNESS INFORMATION			
FIRST NAME	LAST NAME	PHONE	PHONE (SECONDARY)
RELATIONSHIP TO PATIENT	UNUSUAL CIRCUMSTANCES OR ADDITIONAL INFORMATION		

PATIENT INFORMATION				
MEDICAL RECORD/TRIAGE #	LOCATION PATIENT FOUND		TIME PATIENT FOUND	
FIRST NAME	MIDDLE NAME	LAST NAME	DOB	SEX

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

IDENTIFICATION # (E.G. LICENSE #): _____

☐ HAIR COLOR: _____ ☐ EYE COLOR: _____ ☐ APPROXIMATE WEIGHT/HEIGHT: _____

☐ OTHER IDENTIFIERS (SKIN MARKINGS, PIERCINGS, CLOTHING, BELONGINGS, ETC.): _____

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

MORTUARY PREFERENCES

RELIGIOUS/CULTURAL DEATH PREFERENCES

EMERGENCY CONTACT (NEXT OF KIN): FIRST/LAST NAME	RELATIONSHIP	PRIMARY AND SECONDARY PHONE
CURRENT LOCATION (E.G. UNIT, DEPARTMENT)	NAME AND TITLE OF PERSON COMPLETING THIS FORM	

COLLECT AS MUCH INFORMATION AS POSSIBLE.
STORE FORM WITH PATIENT MEDICAL RECORDS, STAPLE TO DECEDENT INFORMATION FORM IF APPROPRIATE.

SECTION FOUR

Operations

OPERATIONS
OVERVIEW OF SECTION

Operations describes how your facility will carry out key mass fatality management activities. Planners are encouraged to carefully review each of the chapters included herein to determine what key activities are appropriate for inclusion in the plan, and how these activities will be carried out.

DECEDENT PROCESSING

OVERVIEW OF CHAPTER

Decedent processing involves decedent identification, the appropriate bagging and storage of the decedent, management of belongings, completion of the death certificate, and final release.   This chapter of the mass fatality plan should examine methods to expedite any potential areas of bottlenecking across the entire decedent processing spectrum.

DEVELOPING THE DECEDENT PROCESSING CHAPTER

STEP
1

Understand and document the basic parameters for decedent processing.

The processing of a decedent begins at the very moment that the patient enters the healthcare facility. For, at this moment, healthcare staff are provided with their first opportunity to collect vital information about the patient.

Under normal circumstances, the patient is alive and may speak for themselves to provide basic identifying information. Under extenuating circumstances, patients may not be able to speak and such information must be obtained from personal identification documents or whomever brought them to the healthcare facility, or by contacting friends or relatives, if known. Once the patient has expired, several important steps need to take place. A very high level example is provided here:

- The attending physician is notified and asked whether he/she will be signing the death certificate. If physician does not want to sign the death certificate, the case will be referred to the Coroner's office.
- Decedent affairs or cinical staff notifiy NOK if known.
- NOK is notified, and offered time and support for viewing. Religious and cultural preferences are accommodated as possible.
- The decedent is placed in a body bag, or wrapped in plastic sheeting and moved to the morgue or other temporary decedent storage area. The decedent's belongings are cataloged and recorded. If belongings are non-hazardous, they should remain with the decedent. If the death certificate cannot be signed, or if the belongings are hazardous, they are stored in the appropriate container and storage area in the morgue. In the event that the belongings are evidentiary (e.g., involved in a terrorist or other criminal incident) or valuable, they are stored with the Security Department or in a secure location.

STEP
2

- The healthcare facility can begin the death certificate process with a CA-EDRS account. The healthcare staff can complete any known personal information and medical information, obtain medical information review and approval, and then transfer the record to a designated mortuary.
- Alternatively, the decedent's family contacts the mortuary. The mortuary can then start the CA-EDRS record and request the cause of death from the physician. Once the information is received, the mortuary then enters the data into CA-EDRS, where it is submitted to the local registrar for review. If it is approved, the mortuary will ask the physician for their signature to complete the death certificate and submit it to local registrar for final approval.
- The healthcare entity's Nursing Administration Office (or Command Center Support Branch, or other equivalent) will refer the decedent to the Public Administrator or County Morgue in the event that the family/significant other has difficulty resolving burial issues or the decedent is abandoned.
- A Form 18 should be completed for all decedents. If the decedent is a Coroner's case, the Coroner retrieves the body, and the Coroner signs the death certificate.

Determine the steps that can be taken at your facility to expedite decedent processing.

Mass fatality planners have several important opportunities to help expedite the practices associated with decedent processing for special circumstances. Such opportunities include:

- Ensure that an approved, efficient process is in place for the identification of decedents who are admitted without a known/approved identification.
- For any non-Coroner case, the hospital may use CA-EDRS for electronic death certificate origination and registration. (Any trained hospital staff may have the capability to initiate death certificates in CA-EDRS.) Planners should encourage staff responsible for decedent processing to obtain a CA-EDRS account and training.
- Work with admissions staff to collect decedent processing information from patients as part of the admissions process, to include preferences regarding mortuaries, burial/cremation, and religious/cultural practices as appropriate. This may also include the use of a 'Witness Form' for those who bring patients to the facility who have already expired or are expectant. Such forms should facilitate the collection of as much information as possible regarding the decedent.

DECEDENT PROCESSING FLOW CHART

```
IS THE IDENTITY KNOWN?  ──── NO ────  REFERRED TO CORONER
       │                               Hold for Coroner pick up**
      YES
       │
DEATH CERTIFICATE       ──── NO ────  REFERRED TO CORONER
IS SIGNED BY PHYSICIAN                 Hold for Coroner pick up**
       │                               Next of kin should be notified§
      YES
       │
NEXT OF KIN NOTIFIED    ──── NO ────  REFERRED TO PUBLIC ADMINISTRATIOR
       │                               Held at facility or transported to County morgue
      YES
       │
NEXT OF KIN HAS MEANS   ──── NO ────  REFERRED TO PUBLIC ADMINISTRATIOR
TO PAY FOR MORTUARY                    Held at facility or transported to County morgue
SERVICES
       │
      YES
       │
MAY TRANSPORT TO MORTUARY AS DETERMINED BY NEXT OF KIN
```

DEATH CERTIFICATE REGISTRATION AND FINAL DISPOSITION

This is a graphic sample of decedent processing at a healthcare facility. It should be noted that 'Coroner's cases' are those typically associated with an unnatural or suspicious circumstances.

Healthcare facility's responsibility ends when decedent is tranfered to a mortuary, county morgue or Coroners offices.

§ NOK should be notified by healthcare facility whenever possible.

* All deaths associated with an earthquake or terrorism are Coroner's Cases unless otherwise specified. Physicians SHALL NOT sign death certificates on these types of victims. Public Health may authorize Physicians to sign death certificates in cases where the Coroner's Office is overwhelmed, especially during widespread disease outbreaks.

** Healthcare Facilities should be prepared to hold decedents for up to 2 weeks during a mass fatality incident.

DECEDENT IDENTIFICATION

OVERVIEW OF CHAPTER

The establishment or confirmation of the decedent's identity is paramount to expeditious decedent processing. Proper identification allows notification of NOK and facilitation of death certificate completion. Under normal circumstances, patients admitted to healthcare facilities will provide their name, address and other identifying information as part of standard admissions protocols.

During a disaster, patients may be admitted who are unable to provide identification information. In extreme circumstances, community members may bring decedents to healthcare facilities with or without identification. This chapter of the guide provides best practice recommendations for supporting expeditious, accurate decedent identification during a disaster.

DEVELOPING THE DECEDENT IDENTIFICATION CHAPTER

STEP
1

Cross-reference existing decedent identification protocols.

Mass fatality plan contributors should cross-reference information provided in this guide to existing healthcare entity protocols on decedent identification. The mass fatality plan should uphold and supplement, as necessary, existing decedent identification policy.

STEP
2

Supplement existing policy and procedure for mass fatality events.

The following sample protocols were taken from several sources, to include local healthcare entities, the Los Angeles County Department of Coroner, and military protocols. Use these protocols as a guide to determine the practices that best suit the circumstances of your facility. If patient identity cannot be established before death, reasonable and feasible records should be established to identify the decedent, including, but not limited to those identified herein.

DECEDENT IDENTIFICATION METHODS

VISUAL/PHOTOGRAPHIC	SCIENTIFIC	NOK	CIRCUMSTANTIAL
• Take a photo before decomposition sets in • Verify identification with a government issued photograph identification (e.g., driver's license or passport) • Photograph government identification	• Obtain fingerprints • Collect X-rays • Dental records	• NOK visually verifies identity	• Personal effects • Circumstance of death • Height/weight/sex • Hair/eye color • Distinctive physical characteristics • Skin Markings (Tattoos, birthmarks, piercings

STEP
3

Ensure documentation of confirmed identification.

Partners will likely have a formalized process for documenting the identification of decedents. Mass fatality plan contributors should cross-reference information provided in this guide to existing healthcare entity protocols to document the identity of decedents. The mass fatality plan should uphold and supplement, as necessary, existing policy.

STEP
4

Ensure documentation of unconfirmed identification.

Document known patient identifying information. Ensure that a Form 18 and copy of patient chart accompany the patient to the decedent storage area. Ensure that a copy of the Form 18 is sent with the chart to medical records.

STEP 4 (continued)

During a disaster, other resources may be activated to support incident/event management, such as a healthcare entity Family Information Center and a city/county Family Assistance Center. Policy and procedure should include the transfer of positive identifications to the Medical Alert Center via ReddiNet or other means and to the Family Information Center and/or a Family Assistance Center. In support of the Family Assistance Center, procedure should include documentation of the decedent's status in ReddiNet as "expired". Unless specifically directed to do so by appropriate authorities, no information regarding decedents should be released to any person or agency except the NOK, Family Assistance Center and Family Information Center.

NOK NOTIFICATION

NOK notification can be one of the most complex and sensitive issues in fatality management and should be handled with the utmost care and attention to detail, both from an etiquette and administrative perspective. This practice is difficult to carry out under normal circumstances, and is further compounded when planners begin to examine the NOK notification process during a mass fatality incident/event.

OVERVIEW OF CHAPTER

This chapter provides guidance regarding the development of NOK notification policy and procedure during a mass fatality incident/event for non-Coroner's cases. Notification would be made by the healthcare staff if the NOK is there in person, whether a Coroner's case or not. If NOK are not present for those decedent's who are identified as Coroner's cases, NOK will be notified at the Family Assistance Center or otherwise by the Coroner.

DEVELOPING THE NOK NOTIFICATION CHAPTER

Planners should review current NOK notification practices, including existing facility policy and procedures. Those facilities that have a written Family Information Center plan are encouraged to ensure that mass fatality NOK notification practices are included in the plan and during Family Information Center operations, when needed. All healthcare facilities should become familiar with the concept of the Los Angeles County Operational Area Family Assistance Center plan and identify ways that healthcare facility NOK notification practices will support and strengthen resources already available through the Family Assistance Center.

STEP 1

Become familiar with the NOK notification resources that are available at the facility and government levels.

Most healthcare entities have NOK policy and procedure in place that provide direction for the notification process. Facilities should adhere to these policies and practices as much as possible during mass fatality disasters.

STEP 2

Planners should examine existing NOK procedures for gaps and opportunities to streamline given the unique considerations of a mass fatality incident.

A table that outlines these additional considerations is provided on the following page.

IF	THEN
The decedent is at the healthcare facility, and NOK are present	Follow normal facility notification policy and procedure (see below for a sample) unless a Family Information Center has been activated. If the Family Information Center has been activated, the NOK should be notified by Family Information Center staff.
The decedent is at the healthcare facility, and NOK are NOT present	Ensure that Decedent Tracking procedures are followed. This will ensure that NOK who are not present (e.g., Family Assistance Center) can be notified.
The decedent is NOT at the healthcare facility, but NOK are present	Direct NOK to the Family Assistance Center.

ASSOCIATED TOOLS AND RESOURCES

The following is a sample NOK notification policy and procedure. Planners should cross-reference this text to existing material, tailor it for your organization, and address gaps as necessary.

SAMPLE NOK NOTIFICATION POLICY AND PROCEDURE – NOK PRESENT

Definition

For purposes of this policy, NOK is defined as the closest relative of the deceased including spouse, parents, brothers or sisters, and children.

- *An agent under a power of attorney for health care.*
- *The competent spouse.*
- *A competent adult child or children.*
- *The competent parent or parents of the decedent.*
- *The competent adult person respectively in the next degrees of kin.*

PROCEDURES

The following information applies to patients whose death is pronounced at the healthcare facility.

- *If NOK are not present at the time of death, the physician and nurse shall confer to decide who will notify NOK. It is the responsibility of the physician to ensure that NOK are informed. If requested by NOK, the nurse shall notify Chaplain Services, or call a minister, priest, or rabbi according to the religious preference of the family.*
- *NOK will be provided with a reasonably brief period of time to gather family or NOK at the decedent's bedside.*
- *OneLegacy[10] should be notified of every death within one hour. Upon notification, OneLegacy will provide a referral number for each decedent.*

NOK NOTIFICATION BEST PRACTICES[11]

- *Ensure that the meeting location is private and as comfortable as possible (tissue, water, etc). (NOK should not be notified of the passing of their relative over the phone unless there is no other way.)*
- *Greet the NOK and introduce yourself and any other staff present.*
- *Let the person respond and ask questions.*
- *Be prepared for a physical reaction, including fainting, shortness of breath, and nausea. Provide an opportunity for families to 'say their goodbyes' for a fixed amount of time.*
- *Offer to make calls, and call clergy, relatives, and the employer. Provide them with a list of the calls you make, as they will have difficulty remembering what you have told them.*
- *Identify a contact person within the family or social support network. Also, include addresses and telephone numbers of resources. Always follow-up on any commitments.*
- *When appropriate, staff can wait with the NOK.*
- *After the interview, review and refine strategies for future interviews.*

[10]Non-profit organ and tissue recovery organization
[11]Suggestions derived from the California Department of Corrections and Rehabilitation Death Notification Procedures.

DEATH CERTIFICATES AND CA-EDRS

OVERVIEW OF CHAPTER

A death certificate is a legal document that lists the location, time, and manner of death for decedents. Timely registration of deaths and permits for disposition is an important part of mass fatality management. This chapter describes death certificate completion and CA-EDRS, as well as the role of the healthcare entity's Decedent Affairs Office, the Los Angeles County Department of Coroner, and the local registrar in this process.

DEVELOPING THE DEATH CERTIFICATE AND CA-EDRS CHAPTER

STEP 1

**Understand and document the basic parameters for death certificates.**

In order to implement methods that support an expedited death certificate process, there must be a clear comprehension of the process. The following narrative is an example of the death certificate process at a healthcare facility.

- If the decedent is not a Coroner's case, the decedent processing steps are initiated by the decedent's NOK. The healthcare entity can also initiate the record.
- The mortuary is contacted and starts the CA-EDRS record, and requests a cause of death from the physician.
- The mortuary then enters the data into CA-EDRS, where it is submitted to the local registrar (Los Angeles, Long Beach or Pasadena) for review.
- If it is accepted, the mortuary can ask the physician for their signature (either by recorded voice or by fax), then complete the remainder of the death certificate.

- Once the death certificate is complete, it is submitted to the local registrar (Los Angeles, Long Beach or Pasadena) for final approval, which completes the process. If the local registrar (Los Angeles, Long Beach or Pasadena) does not approve it, they will indicate why it is not approved (e.g., need more information).
- If the decedent is a Coroner's case, a Form 18 is completed by healthcare staff. The Coroner retrieves the body, and the physician at the Coroner signs the death certificate.
- During a pandemic, if deaths are not required to be Coroner cases, hospitals may use CA-EDRS for electronic death certificate origination and registration. (Any hospital staff has the capability to initiate death certificates in CA-EDRS if training is completed and account access granted.) Paper certificates may also be used.

DEATH CERTIFICATE PROCESS

The following graphic depicts the death certificate process for deaths occurring in Los Angeles County.

1
DEATH CERTIFICATES

- Death certificate applications filled out either on paper or via the CA-EDRS by funeral directors, hospitals, or by the Coroner.

- Physician or Coroner attests to the cause(s) of death after medical review by the local registrar.

- Once complete, funeral directors or the Coroner file applications (including out-of-state residents with local registrar).

2
LOCAL REGISTRARS

- County of Los Angeles Department of Public Health's Vital Records Office is located in downtown. Additional staff is located at a district office in the city of Commerce. The cities of Long Beach and Pasadena have separate local registration offices.

- Review causes of death.

- Review completeness of death certificate.

- Register death certificate, a legal document thereafter, and issue burial permit.

3
REGISTRAR-RECORDER/ COUNTY CLERK AND STATE OF CALIFORNIA OFFICE OF VITAL RECORDS

- Registrar-Recorder/ County Clerk archives all vital records in Los Angeles County (all three jurisdictions).

- The State of California Office of Vital Records performs final registration and archives original vital records.

Other important planning facts and parameters include:

- The physician is legally responsible to complete the medical portion of the death certificate unless he/she determines that there was possibly something unnatural about the cause of death – these should be referred to the Coroner.

- The causes of death are the physician's[12] opinion regarding the death. The causes of death on the death certificate are not legally binding in and of themselves; the entire death certificate is the legal document.

[12]http://www.cdc.gov/nchs/data/misc/hbcod.pdf

- If the decedent has no known NOK, or is unidentified, they become a Coroner's case. If the Coroner cannot identify NOK, the decedent becomes a Los Angeles County disposition case. For estates with a certain value with no NOK, the Los Angeles County Public Administrator will handle decedent affairs.
- If a pandemic has been declared, healthcare staff can utilize an approved real-time reverse transcriptase polymerase chain reaction influenza diagnostic test to determine diagnosis. If it is then determined that the patient died of pandemic influenza, they will not be identified as a Coroner's case (barring other unusual circumstances), and the death certificate can be signed by the healthcare physician.

STEP
2

Identify and implement ways that support an expedited process for death certificate completion.

Mass fatality planners should consider the following:
- Incorporation of death certificate signing practices into training for new physicians.
- Utilization of just-in-time training on death certificate completion as part of mass fatality plan activation.

- Promotion of CA-EDRS training available through Los Angeles County. Maintain a log of those staff members who are trained to use CA-EDRS.
- Ensure that a paper back-up system exists should the CA-EDRS system be unavailable (e.g., loss of power or internet).
- Consider the utilization of the aforementioned "Physician in Charge" concept, where one or more physicians will serve as the death certificate coordinator(s) (e.g., physician with responsibility to coordinate with other physicians to ensure death certificates are signed to expedite decedent processing).

ASSOCIATED TOOLS AND RESOURCES

See the appendix for the following helpful resources:
- Fact Sheet: Death Certificates
- Fact Sheet: CA-EDRS
- Fact Sheet: County Public Administrator

DECEDENT TRACKING

Healthcare entities may need to store remains until NOK can be identified/notified or final disposition has been determined. A system of knowing who and where the decedents are will be crucial to expedite community-wide decedent processing.

DEVELOPING THE DECEDENT TRACKING PROCESS

STEP
1

Understand the decedent tracking process, and the unique considerations that should be factored into planning for tracking mass decedents.

There are several ways that decedent tracking can occur during a during a mass fatality incident/event. ReddiNet will be utilized to track and report fatality information from facilities that utilize the ReddiNet system. Smaller facilities, and facilities without access to ReddiNet will utilize manual tracking and reporting procedures systems.

The following is an example: The Los Angeles County EMS Agency Medical Alert Center opens a mass casualty event in ReddiNet and directs hospitals to log MCI patients – drop-off/walk-in, transport, or expired – into ReddiNet. This information is accessible to an EMS Agency liaison stationed at the Family Assistance Center if activated, so that any family/NOK who are at the Family Assistance Center can be notified. Facilities that do not have the MCI module in ReddiNet or do not have ReddiNet at all will need to track decedents using an alternative

method. The Decedent Information Form may be used to perform this function. The Medical Alert Center will track information from all affected facilities and may ask for regular updates. Affected hospitals will be contacted directly by the Medical Alert Center for updates. Clinics and SNFs will report decedent tracking information through a designated intermediary point of contact who will then relay this information to the Department of Health Services Department Operations Center through the Medical Alert Center.

Information captured in the ReddiNet MCI module includes:

- Last/First Name
- Hospital Name
- Age/Sex
- Triage Tag (e.g., Tag or EMS Agency run #, walk-in or other information – free text field)
- Disposition (e.g., Expired)

STEP 2

Identify and document a decedent tracking process that meets the needs of the healthcare facility.

Tracking methods should incorporate direct communication between partners and the Department of Health Services Department Operations Center to alleviate gaps in information and clarify ambiguities. It should also ensure that decedent tracking documentation is incorporated into an overall interim records management system. Example considerations are provided here to serve as a launching point for development of an extensive strategy.

HOSPITALS WITH THE REDDINET MCI MODULE

- Ensure that sufficient staff are trained to use the MCI module in ReddiNet (however, the hospital will need to maintain its own records). Ensure that there is a mechanism in place to readily add decedent information into the system as soon as possible.
- Ensure that one MCI is being used per incident by all hospitals in ReddiNet. The Medical Alert Center will create the MCI at the beginning of each incident.
- Note that the field marked for "Triage Tag" in ReddiNet can be used to input free text – this is a solid interim location for putting other information (e.g., wearing red flannel shirt, skin marking on right arm, etc.).
- Develop a form or process to track all decedents. Familiarize staff with the Decedent Tracking Log. Ensure that this form is utilized and maintained properly during a disaster.

You may use a form similar to the Decedent Information Form to consolidate decedent information.

- Cross-reference all decedent tracking methods with the facility Family Information Center plan, if your facility has one.
- As a redundant and supplemental resource to ReddiNet, identify additional personnel (see Staffing Guides under the Logistics Chapter) who can communicate with the Medical Alert Center at (866) 940-4401 (will convey info to Family Assistance Center) via telephone to relay information about the decedent that is not easily communicated via ReddiNet. This may include the "matching" process, whereby unidentified decedents are recognized as other definitive identifying information becomes available.
- Develop an address or locator process to quickly identify where a decedent is being stored (such as Surge Morgue 1, Rack 3, Tier 2). This can also be monitored on the Decedent Tracking Log if the decedent needs to be moved from one decedent storage area to another within the facility.

HOSPITALS WITHOUT REDDINET MCI MODULE

- Familiarize staff with the Decedent Tracking Log. Ensure that this form is utilized and maintained properly during a disaster.
- Develop a form or process to track all decedents (such as the Decedent Tracking Log) or electronic database. You may use a form similar to the Decedent Information Form to consolidate information about each decedent.
- Cross-reference all decedent tracking methods with the facility Family Information Center plan, if your facility has one.
- Identify personnel (see Staffing Guides under the Logistics Chapter) who can communicate with the Medical Alert Center at (866) 940-4401 (will convey info to Family Assistance Center) via telephone to relay information about the decedent. This may include the "matching" process, whereby unidentified decedents are recognized as other definitive identifying information becomes available.
- Cross-reference all decedent tracking methods with the facility Family Information Center plan, if your facility has one.
- Develop an address or locator process to quickly identify where a decedent is being stored (such as Surge Morgue 1, Rack 3, Tier 2). This can also be monitored on the Decedent Tracking Log if the decedent needs to be moved from one decedent storage area to another within the facility.

INFORMATION FLOW GRAPHIC

The following graphic depicts the flow of decedent information from the hospital to the Medical Alert Center to a Family Assistance Center.

Hospital

Medical Alert Center

Family Assistance Center

MEDICAL CLINICS

While it is understood that most patients triaged as "red" or "expectant" will be at hospitals, it can be anticipated that some such patients will present to clinics in disaster situations. As such, it is important that clinics have mechanisms in place to support the successful tracking of decedents. Planners are encouraged to consider the following recommendations as a starting point in the process:

- Familiarize staff with the Decedent Tracking Log. Ensure that this form is utilized and maintained properly during a disaster.
- Designated clinic staff should log on to Red-diNet to enter patient information. If Red-diNet is not accessible/functional, clinic staff may contact the EMS Agency/Medical Alert Center at (866) 940-4401. If the EMS Agency is not reachable, clinics should contact the Community Clinic Association of Los Angeles County at (213) 201-6500. Patient information may be utilied for the "matching" process, whereby unidentified decedents are recognized as other definitive identifying information becomes available. Directions will be provided regarding the frequency of updates.
- Develop an address or locator process to quickly identify where a decedent is being stored (such as Exam Room 1D). This can also be monitored on the Decedent Tracking Log if the decedent needs to be moved from one decedent storage area to another within the facility.

SKILLED NURSING FACILITIES

Of the three types of healthcare facilities addressed in this guide – SNFs, hospitals, and medical clinics, it is estimated that SNFs will experience the least surge of decedents as part of a mass fatality event/incident, based on the nature of the services they provide. In most cases, the decedent's identity will be known. Study of prior disasters indicates that most patients triaged as "red" or "expectant" will not be spontaneously dropped off at SNFs. That said, SNFs need to prepare for a surge of fatalities based on the extenuating circumstance, and any catastrophic disease that may severely impact their patient base. Consider the following recommendations as a starting point in the process:

- Familiarize staff with the Decedent Tracking Log. Ensure that this form is utilized and maintained properly during a disaster.
- Identify personnel (see Staffing Guides under the Logistics Chapter) who can convey decedent information (EMS Agency/Medical Alert Center will provide info to the Family Assistance Center) via telephone. This may include the "matching" process, whereby unidentified decedents are recognized as other definitive identifying information becomes available. SNFs should ensure that their mass fatality management plans direct them to contact the Los Angeles County Department of Public Health - Health Facilities division at (213) 989-7140 to relay fatality reporting information. Directions will be provided regarding the frequency of update.
- Develop an address or locator process to quickly identify where a decedent is being stored (such as Room 1D).

STEP 3

Planners should explore ways to ensure that as many decedents are directed to mortuaries as possible. Key considerations include:

- Contact mortuary/Coroner to discuss methods to expedite decedent release.
- Ensure that all necessary documentation is completed on the part of the healthcare facility.
- For scenarios that call for physicians to sign death certificates (e.g. pandemic), coordinate just-in-time training for physicians regarding the signing of death certificates. Consider the activation of the "Physician in Charge" death certificate signing method, if practiced and part of facility policy.
- Advise admissions staff to collect decedent processing information from patients as part of the admissions process, to include preferences regarding mortuaries, burial/cremation, and religious/cultural practices as appropriate.

STEP 4

Identify methods for accommodating NOK who cannot pay for mortuary services. Planners should explore resources that can be used to accommodate NOK who cannot afford to pay for mortuary services. Key considerations include:

- If the NOK cannot afford to make arrangements for burial or cremation of their loved one, they can contact the Coroner's office to apply for the Indigent Cremation program. Funding may also be available through the local public administrator's office.
- Some healthcare entities have programs available that can supplement costs. Burial benefits may also be available through local Veterans Administration Offices.
- Some facilities already have contracts in place with private mortuaries for disaster management. Check to see if your facility has a contract for disasters in place.
- Consider providing space where a family with a decedent can remain with the decedent in a private setting within the healthcare facility to say their "goodbyes". Include a planning phase to identify an effective area prior to a mass fatality event, and allow the family to be with the decedent for a fixed amount of time (e.g., 2-hours). Additionally, provide security to this area of the facility and any religious and cultural needs.

DECEDENT INFORMATION FORM

Patient's Full Name (Last, First) If Known:_____

INCIDENT NAME		OPERATIONAL PERIOD		
MEDICAL RECORD/ TRIAGE#	DATE	TIME	LOCATION PRIOR TO STORAGE	
FIRST NAME	MIDDLE NAME	LAST NAME	AGE	GENDER

IDENTIFICATION VERIFIED BY
□ DRIVERS LICENSE □ STATE ID □ PASSPORT □ BIRTH CERTIFICATE □ OTHER: _____
IDENTIFICATION #: _____
IF IDENTITY IS UNKOWN, WHAT ARE THE OTHER IDENTIFIERS (SKIN MARKINGS, TATTOOS, ETC.) IF ANY?

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

MAC NOTIFIED VIE REDDINET/PHONE □ YES □ NO	RECORD CREATED IN EDRS □ YES □ NO	DEATH CERTIFICATE SIGNED □ YES □ NO
PHOTO ATTACHED TO THIS FORM □ YES □ NO	FINGERPRINTS ATTACHED TO THIS FORM □ YES □ NO	

NEXT OF KIN NOTIFIED? □ YES □ NO	NAME	RELATIONSHIP	CONTACT TEL
FINAL DISPOSITION	DATE / TIME	NAME OF RECIPIENT	SIGNATURE OF RECIPIENT
RELEASED TO: □ CORONER □ COUNTY MORGUE □ MORTUARY □ OTHER:_____			

□ LIST OF PERSONAL BELONGINGS PROVIDE THE FOLLOWING ORIGINALS AND COPIES OF THIS FORM: □ ORIGINAL ON FILE IN DECEDENT AFFAIRS GROUP □ COPY WITH DECEDENT □ COPY TO MEDICAL CARE BRANCH DIRECTOR	STORAGE LOCATION OTHER RELIGIOUS /CULTURE NOTES:

DECEDENT TRACKING LOG

Adapted from HICS Form 254.

INCIDENT NAME							DATE/TIME PREPARED			OPERATIONAL PERIOD DATE/TIME		
								DECEDENT STORAGE AREA				
MRN OR TRIAGE#	NAME	SEX	DOB	NOK NOTIFIED YES/NO	MAC NOTIFIED VIA REDDINET/PHONE	ENTERED YES/NO EDRS	LOCATION	IN DATE/TIME	OUT DATE/TIME	LOCATION	IN DATE/TIME	OUT DATE/TIME

DECEDENT AFFAIRS STAFF

NAME: _____ INITIALS: _____

NAME: _____ INITIALS: _____

NAME: _____ INITIALS: _____

NAME: _____ INITIALS: _____

NAME: _____ INITIALS: _____

NAME: _____ INITIALS: _____

Purpose: Account for decedents in a mass fatality incident.
Origination: Hospital Decedent Affairs Group
Copies to: Patient Registration Unit Leader and Medical Care Branch Director
Start a new row if the patient is moved more than twice.

DECEDENT BELONGINGS

OVERVIEW OF CHAPTER

Planners should develop written guidance to cover the retention and disposition of decedent belongings and valuables.

Guidance should also comply with California Civil Code Section 1862.5, which addresses unclaimed property that remains in a licensed hospital. 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).

DEVELOPING THE DECEDENT BELONGINGS CHAPTER

STEP
1

Cross-reference existing decedent belonging protocols.

Mass fatality plan contributors should cross-reference information provided in this guide to existing healthcare entity protocols on decedent belongings. The mass fatality plan should uphold and supplement, as necessary, existing policy. Ensure that there are clear and concise procedures for the identification, description, holding and release of decedent belongings. During a mass fatality incident/event, any gaps in this process will quickly exacerbate and complicate the duties of those assigned to Decedent Affairs.

STEP
2

Provide direction for the identification, handling, storage and release of decedent property.

An example of this chapter may include text as described herein.

Ensure that the items have been cataloged and are kept with the decedent, except in cases where there are valuables, hazardous materials, or known evidence. If the property is not considered evidentiary, it will be given to the NOK.

Personal property of Coroner's cases will be turned over to the Coroner upon the Coroner's arrival. Personal property considered evidentiary will be secured as described herein until turned over to appropriate law enforcement.

COLLECTION OF DECEDENT PROPERTY

Decedent personal property and evidence will be handled as follows:

- The Security Department will be notified of all unclaimed patient personal property and/or evidence.
- Personal property, to include clothing, should be placed in a "patient belongings" bag and labeled with the date, time, patient's name and/or identification number. Paper bags should be used for property that may be used as evidence.
- In the event that the property is deemed as evidence, personal property will only be released to the appropriate authorities. Consider chain of custody protocols.

General considerations for the handling of decedent belongings are provided herein. Planners should review these recommendations as part of mass fatality plan development efforts.

1. Safeguards/protective gear:
   - Wear appropriate protective equipment based on the event
   - After handling decedent's property, properly dispose of gloves and wash hands with germicidal soap

2. Documentation of the decedent's belongings in the morgue logbook include:
   - Date/time of collection
   - Patient name, medical record number, DOB and DOE
   - Full name and signature of the two staff members involved in receiving belongings
   - Brief description of the item and how it was packaged (Nalgene®, paper bag, plastic, box, etc.)
   - The general location (e.g. the decedent)

3. Labeling of containers should include:
   - Date/time of collection
   - Patient name, medical record number, DOB and DOE
   - Initials of the staff member who placed the item(s) in the container(s)
   - Brief description of the item enclosed
   - If enclosed matter is caustic or hazardous, indicate with appropriate warning
   - Evidence with potential biological evidence should be stored frozen

Before storing clothing, be certain that all personal property has been collected, including valuables (e.g., jewelry, wallets, money, etc.).

General

- All transfers of property to Security should be logged in the appropriate book or form.
- All patient belongings should be gathered into an appropriately labeled bag and given to the NOK, upon arrival or mortuary, who then sign the belongings list. Inform family of any belongings that have been placed in Security. If family did not take belongings, list items on Record of Death, place items in belongings bag, labeled with name, and send to decedent storage with decedent.
- Mortuary pick up should be monitored by a hospital associate during the time of removal to verify that decedent and appropriate belongings go to the correct mortuary.
- Properly identified belongings not taken by the mortician should be taken to the business office as soon as possible.

NOTES:

DECEDENT HANDLING AND STORAGE

OVERVIEW OF CHAPTER

It has been projected that Los Angeles County Department of Coroner has the capability to accommodate the transfer of up to 500 decedents from healthcare facilities. The time frame for this benchmark is a moving target – it depends entirely on the type of disaster (e.g., consideration of variables associated with an earthquake or explosion, versus a pandemic), the state of the decedents (e.g., charred, contaminated), access to roads (e.g., disaster related road closures),

and the availability of support provided by local fatality management partners, such as mortuaries. Should it be determined that the need for storage and transport exceed the availability of local resources, other resources will be requested per NIMS/SEMS. In consideration of these variables, the Los Angeles County Department of Coroner has recommended that healthcare entities facilitate the capability to handle a surge of fatalities for up to two weeks.

DEVELOPING THE DECEDENT HANDLING AND STORAGE CHAPTER

STEP
1

Determine your facility's storage surge capacity.

To determine your facility's surge capacity, the following should be assessed:
- Number, size and manufacturer's weight limit of crypt beds available in the facility (e.g., if the facility has a morgue)
- Capacity and availability of alternate storage space
- Qualified personnel available
- Availability of equipment and supplies

STORAGE CAPACITY ASSESSMENT

- Begin to determine local capacity by determining your facility's decedent storage capacity and its average census. Determine the average crypt storage space available at any given time by subtracting the average number of deaths in a week from the total refrigerated storage capacity.
- Identify the capacity and availability of alternate sources of surge storage space, such as tents, refrigeration trucks and facility areas that can be transformed into a temporary holding area.

QUALIFIED PERSONNEL CAPACITY ASSESSMENT

- Identify a few key positions that would be needed immediately to begin decedent processing. Identify positions within your facility that could fill these positions to assist with a mass fatality.

EQUIPMENT AND SUPPLIES ASSESSMENT

• For an assessment of equipment and supplies capacity, focus on the most critical supplies and equipment that will be needed. This includes number of body bags, number of decedent storage beds, bags for personal effects, etc. The table on the following page may be utilized as a starting point in this assessment.

STEP
2

Ensure that decedent handling processes are in place.

A mass fatality incident/event may facilitate the need for expedited decedent handling, and a streamlined use of decedent storage supplies. For example, the Los Angeles County Department of Coroner uses simple plastic sheeting and cotton rope (see next page for detail) to store decdents. Determine decedent handling and storage strategies for your facility and plan for decedent surge accordingly. The following images depict the Coroner's use of plastic and cotton rope for mass decedent storage.

A. Place plastic under decedent.

B. Wrap decedent in plastic.

C. Wrap decent with sheet. Tie ends.

D. Tie ropes. Attach identification tag.

SURGE STORAGE CAPACITY ASSESSMENT

ITEM	NUMBER AVAILABLE	ALTERNATE SOURCE AND NUMBER AVAILABLE
Crypt beds		
Vinyl plastic sheet 4 millimeter thick 72 inch width		
Cotton rope 1/4 inch diameter		
Body bags (number and type)		
Personal effects bags (Paper)		
Personal effects bags (Plastic and Biohazard)		
Personal effects bags (jar/other container)		
Portable cooling units		
Cooling tents (ensure that these are made for decedent cooling)		
Refrigerated trucks (for storage, not transport)		
Protective clothing (gloves, boots, suits and respirators, etc., as dictated by the situation)		
Paint for numbering decedent storage area (1, 2, 3; P1, P2, P3; E1, E2, E3…)		
Signage/labels for marking locations		
Plastic toe tags and permanent pens		
Photography and filming equipment (No personal cameras allowed)		
Communication devices, e.g., radios and cell phones		
Writing or computer equipment with software (specified by Coroner) for data maintenance		
Documentation: • Morgue logbooks • Form 18 • Death certificate/EDRS in paper form		

STEP
3

Plan for methods to expand surge capacity.

Options for consideration include:

PRIMARY MORGUE
- Examine the use of crypt beds. Determine whether two decedents can occupy a single crypt bed without stacking and without exceeding the manufacturer's weight limit. Move decedents as appropriate.

UNUSED SERVICE AREAS
- Identify (preferably unused) space in the facility that can be converted to a temporary morgue. Ideally, this area will be isolated from other patient care areas. Decrease room temperature as close to 40 degrees Fahrenheit as possible. Bring in portable cooling units (air conditioners) as possible.
- Develop and maintain a morgue logbook to note identifying information for decedents placed in the temporary morgue.

EXTERNAL MORGUES
- Tents or containers may be used for temporary storage. The floor can be used for storing remains, however it may be safer and easier to identify and move remains on beds or cots. Racking systems may also be considered and 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 hard shelving, 72" wide by 24" deep; ensure that these are secured and can handle the weight load).
- Refrigeration trucks (See appendices for specifications).
- Dry ice (carbon dioxide frozen at –78.5° Celsius) may be suitable for short-term storage. Dry ice precautions and considerations include:
  o Use by building a low wall of dry ice around groups of about 20 decedents, and then cover with a plastic sheet.
  o About 22 lbs of dry ice per remains, per day, is needed, depending on the outside temperature.
  o Dry ice should not be placed on top of remains, even when wrapped, because it damages the body.
  o Dry ice requires handling with gloves to avoid "cold burns."
  o When dry ice melts it produces carbon dioxide gas, which is toxic. The area needs good ventilation.

TEMPORARY BURIAL[13]
- Temporary burial provides immediate storage where no other method is available. Temporary burial should only be conducted at the direction of the Coroner. While not a true form of preservation, this is an option that might be considered when there will be a great delay in final disposition. Temperature underground is lower than at the surface, thereby providing natural refrigeration. All storage

[13]Only done on Coroner's approval on previously identified areas.

STEP
3 (continued)

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, Morgue, or private mortuary.

STEP
4

Ensure that adequate policy and procedure is in place for handling of decedents.

INFECTION CONTROL
- Infection control will be the responsibility of all who handle or come in direct physical contact with decedents. Refer to the appendices of this guide for information on the myths associated with decedents and infection control. Standard precautions should be followed at all times, including use of Personal Protective Equipment, hand sanitizers, and hand washing.
- In HazMat or WMD events, the appropriate level of Personal Protective Equipment will be determined by the Hazardous Materials Specialist in the ICS system and communicated to staff. **Follow existing facility policy regarding hazmat and WMD incidents.**
- Vehicles used for transportation and non-traditional spaces used for morgue purposes should be disinfected or decontaminated after final use, as appropriate.

MEDIA COORDINATION

OVERVIEW OF SECTION

The media play an important role in providing critical information to the affected population and to audiences near and far in the event of a disaster. It is essential to maintain a strong, open and credible relationship with the media during and following a disaster. The media have a right and obligation to report the news. They also serve as the best method for communicating information to the general public and in some cases to families of victims. However, improperly managed media relations can become adverse, and/or result in erroneous information being distributed. It is in the interest of both the media and the healthcare entity to ensure that information disseminated to the public be accurate, current, and as complete as circumstances allow.

Managing information about decedents is of particular importance in this regard.

DEVELOPING THE MEDIA COORDINATION CHAPTER

STEP
1

Follow existing facility policy regarding public information.

Healthcare entities should have existing policy regarding communications with the media, to include the role of a Public Information Officer or other public relations representative. To improve efficiency, healthcare entities should pre-develop templates

for the Public Information Officer to use for external communications that can easily be populated based on the incident. Adherence to approved policy for message development and dissemination will be of the utmost importance. It is anticipated that the affected jurisdiction(s) will activate a Joint Information Center/Joint Information System. Healthcare entities should coordinate with local authorities to **make sure that there are strong, open lines of information sharing and exchange between the Joint Information Center/Joint Information System and the healthcare entity Public Information Officer** or other spokesperson or liaison. This may include regularly scheduled briefings, teleconferences, or ongoing in-person liaison at the Joint Information Center. The following types of communications with the media may be anticipated:

- **Advisories.** Advisories are notifications to media of an upcoming event, such as a the event, time, location, and identification who will appear at the event. The advisory should also state if there are any restrictions (pool coverage only, no Q & A, etc.).
- **Press Release.** Printed, video, or recorded information released to the media. Typically contains updates, statistics, quotes, and similar information.
- **Media Briefings.** Briefings, which may include subject matter experts, designed to provide technical or background information.
- **Press Conferences.** Events open to all media to provide information, answer questions, etc. Press conferences are

generally arranged by the Public Information Officer, but include Incident Management and VIPs.

Copies of all material released to the media should be provided to and approved by the Emergency Operations Center/Command Center or administration. For Emergency Operations Center/Hospital Command Centers, this should include command staff and section chiefs to ensure unified communications. The Public Information Officer should participate in all administrative/command internal staff briefings to advise the staff of the information released to the public through the media.

Media briefings and/or press conferences should be scheduled on a regular basis, or when there is new or important information that should be disseminated. Media briefings/press conferences should be preceded by a media advisory. At the close of each media briefing/press conference, the media should be advised of the time and location of the next scheduled event. All media briefings and/or press conferences should be planned and conducted with local governmental authorities and the Joint Information Center/Joint Information System.

Last, ensure that policy is in place to accommodate high profile cases - that is, expectant patients or decedent who may attract significant media attention. Coordinate with your facility's Public Information Officer or Public Relations contact to identify appropriate communications strategies.

STEP
2

Provide additional specific direction to the Public Information Officer or other public information representative.

As part of the mass fatality planning process, plan writers should include additional specific direction to those who have a key role in managing incoming and outgoing public information.

GUIDELINES FOR THE OFFICIAL SPOKESPERSON

- Do not give names of the dead until NOK have been officially notified. No information regarding the identity, number, or condition of victims will be released without the explicit approval of the Incident Commander AND confirmation that this information has been already provided to NOK. Likewise, NO information concerning the number, condition, and location of the seriously injured will be released without the explicit approval of the Incident Commander.
- Avoid speculation and personal opinion.
- Prepare a brief written statement about the situation and provide it to media representatives (include background information, photographs, and audio tapes or videotapes if appropriate).
- Always tell the truth. If you do not know the answer to a question, admit it.

STEP 2 (continued)

- Do not give exclusive interviews.
- Schedule a press conference with all the media representatives and give them all the same information at the same time. If you are going to read a prepared statement and not answer questions until later, say so at the beginning of the conference.
- Be as accessible as possible to take follow-up questions from the media so they don't think you are avoiding them.
- Stay calm.
- Monitor news coverage of the event to ensure that information provided to the media is being reported accurately.
- Do not wait for the media representatives to contact you. Study the patterns and type of reporting done in your area and determine which media seem to be the best informed, the most responsible, and the most effective, and contact them.
- Write and state clearly and consistently not only the facts, but the message you want to convey.
- Explain in each interview the importance of the issues you have discussed and how they fit into the general context of public health practices.
- Do what you can to maintain an image of sincerity, experience, and candor.
- Respond to the media when they contact you. They remember who helps them and who does not.

- In the case of an incident which is known, or suspected to have resulted from an intentional act, coordinate with law enforcement prior to release of any information to the media. This is necessary to ensure that released information may not impair or compromise the investigation process.
- Work with local authorities to ensure that information is provided in non-English languages and sign language as appropriate.

STEP 3

Coordinate and share information with the Family Information Center.

Some healthcare entities may elect to activate a Family Information Center as part of medical surge operations. Any information being provided to the public should first be provided to those family members waiting in the facility's Family Information Center.

SECTION FIVE

Demobilization

DEMOBILIZATION

OVERVIEW OF SECTION

This section describes considerations that planners should account for when strategizing demobilization of mass fatality operations. The decision to demobilize response operations, to include mass fatality management, should be made in coordination with the healthcare entity's Command Staff.

DEVELOPING THE DEMOBILIZATION SECTION

STEP
1

Review Demobilization Considerations.

Planners should generate a list of considerations that should be addressed during the demobilization process. The list should be reviewed and discussed as part of demobilization planning efforts. Examples of considerations include:

- Current mass fatality plan escalation tier, and anticipated return to below Tier One (i.e., day-to-day) decedent storage capacity needs.
- When mass fatality management operations decrease to the degree that any remaining operations can take place via day-to-day operations.
- Forecasted usage of the Family Information Center (if the facility has one), as the Family Information Center may remain activated to provide other services (counseling, religious/cultural resources) after mass fatality management operations have returned to normal operations.

The Planning Section typically initiates the process for demobilization in consultation with the Incident Commander, and establishes a date/time for demobilization. The Planning Section Chief (or Demobilization Unit, if activated) is responsible for the coordination of demobilization. The Planning Section should develop the demobilization plan based on the nature of the incident and pace of response. The Planning Section should submit the demobilization plan to the Emergency Operations Center Director for approval. The Planning Section executes the approved plan.

STEP
2

Document tasks that should be completed as part of demobilization of mass fatality management operations.

Planners should generate a demobilization task checklist as part of their plan. Ensure that this checklist is shared with the Planning Section Chief, or other person/unit designated to coordinate demobilization at the beginning of response to revise and enhance based on the unique circumstances of the incident/event.

EXAMPLES OF DEMOBILIZATION CHECKLIST ITEMS MAY INCLUDE THE FOLLOWING

❐ The time frame for demobilization reflects length of mass fatality operations, and nature of incident/event.

❐ Notify all participating staff.

❐ Ensure that any open items, to include follow-up commitments to NOK and other agencies/organizations, are carried out.

❐ Collect contact information of all staff that provided services. This should include surge staff.

❐ Ensure that decedent tracking practices are complete. Include documentation of decedent status and other identifying information.

❐ If a Family Information Center has been activated at your facility, ensure that Family Information Center staff have been fully briefed on decedent status and any other pertinent fatality management activity (e.g., anticipated arrival of morgue to pick-up decedents, etc.)

❐ Participate in final transition meeting.

❐ Ensure that all deployed equipment is returned and coordinate equipment issues with the Logistics Section Chief.

❐ Participate in the After-Action Review as directed.

Appendices

COMMUNITY-WIDE RESPONSE MATRIX

The following table provides a high-level summary of the roles of healthcare entities, agencies, and other supporting organizations in the event of a mass fatality incident/event.

This table is provided as a tool for healthcare entity partners to enhance understanding of their role in a community wide response. It is meant to begin to answer the question, "Where does the role of the healthcare entity end, and the role of the county begin?" It should be noted that this table is not all encompassing and does not serve as a response planning resource for any agency/organization other than healthcare entities.

AGENCY/ ORGANIZATION	ROLE
CITY	
City Emergency Management Agency (varies by city)	• Coordinate the local-level response. • Coordinate **non**-medical/health requests for assistance. • Function as a central point of coordination between the involved City agencies. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.
COUNTY	
Los Angeles County Emergency Medical Services Agency	• Notify healthcare entities in Los Angeles County regarding mass casualty incidents. Initiates the mass casualty incident in ReddiNet. • Coordinate medical response to emergencies. Houses the Department of Health Services Department Operations Center. The Medical Alert Center within the EMS Agency is the Coordinated Communication Center for Health Care in the County. • Coordinate patient destination and the transport of patients to appropriate receiving facilities. • Track location of transported victims. • Coordinate healthcare facility requests for medical and health resources as per SEMS. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.

AGENCY/ ORGANIZATION	ROLE
COUNTY	
Los Angeles County Department of Coroner	• Notify the Board of Supervisors of all terrorism-related deaths. Notify all Los Angeles County funeral homes to handle pandemic cases as normal and encourage families to make funeral arrangements. • Handle all fatalities resulting from terrorism as homicides, which will fall under the jurisdiction of the Department of Coroner, Los Angeles County. • Notify the health department (Los Angeles County, Pasadena or Long Beach) of all pandemic deaths that are reported to the Coroner. • Encourage the immediate release of human remains, where possible, to private mortuaries for disposition. • Work with the appropriate health department(s) to determine an appropriate and acceptable primary cause of death for pandemic deaths or deaths from a terrorist attack that will be accepted by the health department Registrars without further Coroner involvement. • Recover deceased human remains from acute and sub-acute care facilities only in the absence of the legal next of kin and documented refusal by the physician of record for signing the death certificate. • Conduct post-mortem limited examinations on specific cases to confirm the diagnosis only upon request of the Director of the applicable health department. • Director of the applicable health department will consult with Department Operations Center staff on the extent of exams on deaths from a terrorist attack. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assisstance Center Plan.*
Health Department: Los Angeles County, Pasadena, and Long Beach (Pasadena and Long Beach have city health departments)	• Notify Los Angeles County physicians of their responsibility to sign death certificates and their ability to certify deaths of persons who, in the opinion of the physician, have died as a result of a pandemic in a timely manner. • Collect test specimens on reported Coroner cases when specifically requested by the health department, or as testing kits are made available to the Coroner. • Have rapid testing capabilities for influenza virus, smallpox, anthrax and other agents in place to assist the Department of Coroner in decreasing delays in decedent handling and death certificate processing.

AGENCY/ ORGANIZATION	ROLE
COUNTY	
Health Department	• Notify the County of Los Angeles Board of Supervisors of all pandemic-related deaths. Handle all media contacts and press releases for pandemic-related deaths. • Register birth and death events occurring in by appropriate jurisdiction. Serve as the primary point of contact (County) for SNFs to report decedents and report this information to the EMS Agency. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.
Los Angeles County Office of Emergency Management	• Coordinate the Operational Area-level response. • Manages **non**-medical/health requests for assistance. • Functions as a central point of coordination between the involved City agencies. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.
Los Angeles County Department of Mental Health	• May be requested to provide, or to assist in securing, mental health professionals to provide counseling or other mental health support for decedent families. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.
Los Angeles County Department of Public and Social Services	• May be requested to assist in providing social services and/or referrals as needed for decedents' family members. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.
Los Angeles County Sheriff's Department[14] (cities may have their own law enforcement)	• Provides security and law enforcement per policy and protocol, and as resources allow. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.
Fire Department[15] (cities may have their own fire department)	• Provides fire protection services. • May also provide search and rescue services, EMS operations and hazard mitigation services. • Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.

AGENCY/ ORGANIZATION	ROLE
COUNTY	
Los Angeles County Department of Children and Family Services	• Provides services related to displaced minors left unaccompanied as a result of a disaster. Prepare to support a Family Assistance Center, as per assigned role in the *Los Angeles County Operational Area Family Assistance Center Plan*.
STATE	
California Emergency Management Agency	• Coordinates response of State agencies, and requests for mutual aid when county resources are inadequate to respond to the incident.
FEDERAL	
Centers for Disease Control and Prevention	• (Via California Department of Public Health) May provide consultation regarding disease epidemiology, assist the local jurisdiction with the diagnosis of biological agents, provide bio-safety and infection control information, and/or provide laboratory assistance for evidence analysis.
Federal Emergency Management Agency	• Responsible for coordinating federal agency response and coordinating the Federal response with local agencies following a Federally-declared disaster or public health emergency. Does not normally work directly with health care facilities, but will provide area-wide support.
NON-GORVERNMENT	
Emergency Network Los Angeles	• Serves as the Los Angeles County *Voluntary Organization Active in Disasters*. It is a coalition of nonprofit organizations, government and private-sector partners, with some disaster function. Provides the forum where organizations share knowledge and resources to help disaster survivors and their communities.
American Red Cross	• May provide shelter, food, and health and mental health services to address basic human needs.

[14]Provides law enforcement in unincorporated and contract cities.
[15]Provides fire protection services in unincorporated and contract cities.

KEY CONTACTS

Planners should develop a key contacts list that is unique to their facility. Considerations should be made to include contact information for the healthcare entity's administration, security, decedent affairs (or equivalent), as well as external contacts for cultural, religious, jurisdictional, and public safety representatives. A partial sample list is provided here.

Los Angeles County Department of Coroner
- 24/7: 323-343-0714
- http://coroner.lacounty.gov

Los Angeles County Department of Health Services EMS Agency
- General: 562-347-1500
- 24/7 Medical Alert Center: 866-940-4401
- http://ems.dhs.lacounty.gov/MAC.MAC.htm

Los Angeles County Department of Mental Health
- 24/7: 800-854-7771
- http://dmh.lacounty.gov

Los Angeles County Morgue Decedent Affairs
- 323-226-7161

Los Angeles County Department of Public Health
- 24/7 Helpdesk: 213-989-7140

Acute Communicable Disease Control
- For biological incident reporting, including suspect pandemic influenza
- Business Hours: 213-240-7941
- After Hours: 213-974-1234

Vital Records Registration & CA-EDRS Training
- General: 213-240-7785
- Vital Records Office: 213-240-7816 (deaths)/213-240-7812 (births)

Los Angeles County Office of Emergency Management
- 323-980-2260
- http://www.lacoa.org

Los Angeles County Public Administrator's Office
- General: 213-974-0404
- Investigation Unit: 213-974-0460
- http://ttc.lacounty.gov/Proptax/PA_opening.htm

Los Angeles County Department of Public Social Services
- 877-481-1044
- http://www.ladpss.org

Los Angeles City Emergency Management Department
- 213-484-4800
- http://www.emergency.lacity.org/

Long Beach Birth and Death Records
- 562-570-4305
- http://www.longbeach.gov/health/records.asp

Pasadena Vital Records
- 626-744-6010
- http://www.ci.pasadena.ca.us/PublicHealth/Vitalrecords/

American Red Cross
- 888-864-3575
- http://www.redcross.org

California Electronic Death Registration System Helpdesk
- 916-552-8123
- https://ca.edrs.us (CA-EDRS login page)
- http://www.edrs.us (CA-EDRS website with training materials)

Emergency Network Los Angeles
- 213-739-6888
- http://www.enla.org

Federal Bureau of Investigation Office of Victims Assistance
- 310-477-6565
- http://www.fbi.gov/hq/cid/victimassist/resources.htm

NOTES:

HIPAA COVERED ENTITIES

One of the key functions associated with fatality management involves the provision of clients with information regarding the status of their loved one, to include whether or not the victim is at a healthcare facility. To ensure that staff understand the application of HIPAA regarding the provision of victim information, and to clarify that HIPAA should not be seen as a barrier to the provision of medical services during disaster response, the following information is provided regarding HIPAA exemptions, especially as they pertain to fatality management.

The following supporting language is provided by the California Department of Public Health:

45 CFR 164.510(b)(4) indicates that a covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entitled the uses or disclosures permitted by 45 CFR 164.510(b)(1)(ii). [These are the uses or disclosures permitted to notify or assist in the notification of a family member or personal representative.]

The following supporting language is provided by the U.S. Department of Health and Human Services:

Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all of the following ways:

TREATMENT

Health care providers can share patient information as necessary to provide treatment. Treatment includes: sharing information with other providers (including hospitals and clinics), referring patients for treatment (including linking patients with available providers in areas where the patients have relocated), and coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services). Providers can also share patient information to the extent necessary to seek payment for these health care services.

NOTIFICATION

Health care providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death. The health care provider should get verbal permission from individuals, when possible; but if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest. Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.

FACILITY DIRECTORY

- Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.
- It is recommended that all facilities keep a back-up of their patient records offsite or electronically duplicated off-site in the event of a building loss. This is particularly important for SNFs as the only identifying information for patients may exist in the available records.
- The HIPAA Privacy Rule does not apply to disclosures if they are not made by entities

covered by the Privacy Rule – healthcare providers, health plans, and healthcare clearing houses. In addition, when a health care provider is sharing information with disaster relief organizations that are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

• HIPAA does not apply to decedents; however, no information can be released until the individual has been identified and the NOK are notified.

HIPAA, PUBLIC HEALTH AND THE CORONER

• Under HIPAA, researchers are permitted to use and disclose protected health information by obtaining a HIPAA-compliant authorization, or without individual authorization under limited circumstances. One way is by waiver of HIPAA authorization, which is roughly analogous to a waiver of informed consent. This provision might be used, for example, to conduct records research, when researchers are unable to use de-identified information, and the research could not practicably be conducted if the research participants' authorization were required, or to access existing databanks or repositories. The Coroner may also obtain decedent information without the restrictions that HIPAA provides for covered entities.

The full HIPAA regulations, background, and technical assistance are available at **http://www. hhs.gov/ocr/hipaa.**

SECURITY
OVERVIEW OF CHAPTER

Security staffing needs will vary greatly based on the type of incident/event and existing resources available at the facility. For example, larger hospitals will likely have security staff available as part of a cadre of 'normal operations' staff. In fact, some larger facilities call upon their security staff to support decedent identification efforts (e.g., obtain fingerprints). All facilities should utilize internal/private security resources before requesting security resources via NIMS/SEMS.

Mass fatality plan security policy should encompass the overall responsibility of managing and staffing internal and external security operations. This includes identification and badging for healthcare staff, support service personnel, visitors, and all other personnel authorized for access. Also, maintaining a visible presence at high security or restricted areas (e.g., refrigeration tents) to make certain that only authorized persons with appropriate credentials are granted access. Research of prior large scale disasters indicate that security will be an issue primarily for larger facilities – not clinics and SNFs. It is recommended that clinics and SNFs conduct normal security procedures unless there are indications that additional security is required. Hospitals should conduct a physical security assessment to determine what, if any, additional security is required.

STEP 1

Develop policy and procedure for external facility security.

Planners should coordinate with onsite security personnel and local law enforcement to develop security policy and procedure that is in alignment with their role and available resources. Consideration should be given to:

- Staff/visitor badging protocols during normal operations as well as disasters
- Identification of areas that are considered restricted or sensitive (e.g., cooling tents, decedent storages, other decedent storage areas, Family Information Centers, etc.)
- Process for requesting additional support if needed (e.g., NIMS/SEMS, private security)
- Modifications to authorized parking areas and expedited vehicular traffic patterns
- Posting of appropriate "No Weapons Allowed on Site" signage per PC 12020(a)(1) and "All persons entering this facility are subject to search"

STEP 2

Develop policy and procedure for internal facility security.

Similar to external requirements, internal security planning may include:
- Methods to prevent unauthorized access to sensitive/restricted ingress/egress points
- Methods to immediately address any potential threats to the safety of those located therein to include:
  - Civil Disturbance
  - Emotionally Disturbed Person
  - Explosive Device, Bomb Threat
  - Hostage Incident
  - Sniper Incident
  - Special Event
  - Suspicious Package

During the aftermath of a mass fatality incident/event, there is a high potential for anxiety and emotional outbursts. Planners should ensure that all considerations be extended to grieving family and friends. For example, security planners may elect to initially refer onsite mental health professionals (if available) to any individual that is inconsolable to the extent of not following direction, and only as a last resort detain the individual and remove them to an isolated area in the facility. This area should be pre-identified by security management and communicated to all sworn law enforcement officers.

STEP 3

Coordinate with security partners when assessing and identifying supplemental decedent storage areas.

Collect the following information, as available, for each site:
- Exterior and interior photos
- Map-wide view
- Map-tight view
- Aerial photo—wide view
- Aerial photo—tight view
- Facility's floor plan diagram
- Parking plan
- Mass transit map
- Back-up storage location

ASSOCIATED TOOLS AND RESOURCES

The following resources provide supplemental information, and can be used to support plan development. These can be found on the following pages.

- Security and Traffic Control Plan Template, available at **http://ems.dhs.lacounty.gov/**
- Physical Security Assessment Form

SECURITY AND TRAFFIC CONTROL PLAN TEMPLATES

OVERVIEW OF PHYSICAL SECURITY ASSESSMENT

A Physical Security Assessment is included as a tool with this chapter. It contains the following:

- Physical security assessment: exterior of the site.
  - o Perimeter.
  - o Lighting.
  - o Parking areas.
  - o Landscaping.
- Physical security assessment: interior of building(s).
  - o Doors, windows, and other openings.
  - o Ceilings and walls.
  - o Emergency power system.
  - o Lighting.
- Physical security assessment: specific security devices, technologies and machines.
  - o Alarms.
  - o Fire protection.
  - o Utility control points.
  - o Attic, basements, crawl spaces, and air-conditioning and heating ducts.
  - o Communications.
- Physical security assessment: roadway access.
- Physical security assessment: neighborhood characteristics (within four blocks of the site)
- Physical security assessment: standard operating procedures.
  - o Public areas (waiting areas, restrooms, and hallways).
  - o Offices within the facility that handle money.
  - o Security procedures.

These questions are followed by a space for any specific security concerns and a summary rating system to present an overview of security issues and requirements.

OVERVIEW OF SECURITY AND TRAFFIC CONTROL PLAN TEMPLATES

A Security Plan Template and Traffic Control Plan Template have also been made available on the EMS Agency website and can be accessed at: **http://ems.dhs.lacounty.gov/**

It includes the following:

- Security plan staffing and postings.
- Security postings, interior.
- Security postings, exterior.
- Site specific security operations plan and comments.
- Diagram and photos of facility utility shut-off controls.

The Traffic Control Plan Template includes the following:

- Traffic control plan staffing and postings.
- Traffic control postings.
- Site specific traffic control operations plan and comments.

Once the security and traffic control plans have been completed, standard operating procedures will be needed. It is expected that law enforcement agencies will modify existing applicable operating procedures as required to implement the security and traffic control plans. The Physical Security Assessment, Security Plan Template, and Traffic Control Plan

NOTES:

Template are provided as tools to assist health facilities in developing mass fatality security and traffic control plans. These assessment tools are very comprehensive, and some items may not be applicable in all situations. However, they provide guidance to ensure that the assessment is thorough and systematic.

These tools are based on the work of the Los Angeles County Department of Public Health Emergency Preparedness & Response Program's multi-disciplined Strategic National Stockpile Force Protection Committee's work on security for Points of Dispensing site Preplans.

PHYSICAL SECURITY ASSESSMENT

SITE NAME		
STREET ADDRESS	CITY	DATE

PHYSICAL SECURITY ASSESSMENT: EXTERIOR OF THE SITE

Perimeter (e.g., fences and gates)
1. Is the perimeter of the facility's grounds clearly defined by a fence, wall, or other type of physical barrier?

2. Briefly describe the barrier and its condition.

3. Does the barrier limit or control vehicle or pedestrian access to the facility?

4. Are gates solid and not in need of repair?

5. Are gates locked properly?

6. Are gate hinges secure?

Lighting
1. Is the entire perimeter lighted?

2. Are lights on all night?

3. Are light fixtures suitable for outside use (i.e., are they weather and tamper resistant)?

4. Are lights and wiring inspected regularly?

5. Are lights controlled automatically (or have the capability for automatic control)?

6. Are control switches inaccessible to unauthorized persons?

7. Do any exterior or perimeter lights have an auxiliary power source?

8. Excluding parking areas, is the lighting of the building grounds adequate?

9. Is the exterior of the building (particularly entry points) sufficiently lighted to discourage unlawful entry attempts or placement of explosives against the walls?

10. Are public areas (including parking spaces and walkways) sufficiently lighted to discourage attacks against persons or vehicles?

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME

STREET ADDRESS	CITY	DATE

Parking Areas

1. Is entry to and exit from parking areas controlled by a guard?
   a. If Yes, who provides the guard service?

   b. If Yes, during what hours are guard services provided?

2. Are parking areas monitored by the use of closed-circuit TV cameras?

3. Are frequent inspections made of parking area and vehicles which are not guarded or monitored through the use of closed-circuit TV?

4. Is a there reserved parking lot on the facility's grounds?

5. Is the reserved area closed or locked during non-business hours?

6. Is the reserved area protected by a fence?

7. Are signs posted there?

8. Who (or what titles) have been assigned reserved parking?

9. Are parking spaces in the reserved section of the lot posted by name, title or neither?

10. Is there a parking garage on the facility's grounds?
    a. If Yes for Question 10, is access to the parking garage strictly controlled?

Landscaping

1. Do landscape features provide places for potential intruders to hide?

2. Are there items such as bricks, stones, or wooden fence pickets which could be used by intruders as weapons, missiles, or tools?
   a. If yes, describe the items:

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME		
STREET ADDRESS	CITY	DATE

PHYSICAL SECURITY ASSESSMENT: INTERIOR OF THE BUILDING(S)

Doors, Windows, and Other Openings

1. Are all exterior doors at least 1 3/4-inch solid core wood, metal clad, or metal?

2. Are all exterior doors properly equipped with cylinder locks, deadbolts, or solid locks and hasps?

3. Are doors with windows equipped with double-cylinder locks or quality padlocks?

4. Are all exterior doors equipped with intrusion alarms?

5. Are windows that could be used for entry protected with locks?

6. Are windows that could be used for entry protected with secondary closures (e.g., screws/pins)?

7. Are window on the ground level secured with bars or steel mesh?
   a. If Yes on Q.#7, are window bars and mesh securely fastened to prevent easy removal?

8. Are openings to the roof (doors, skylights, etc.) securely fastened or locked from the inside?

9. Is internal access to the roof controlled?

10. Have precautions/barriers been used appropriately to make the roof reasonably inaccessible by means of a fire escape, another building, a pole or a tree, or any other uncontrolled means?
    a. If not, then specify weakness:

11. Are openings to the building (e.g., tunnels, utility/sewer manholes, & culverts) properly secured?

12. Is a key-control system in effect?
    a. If Yes, who is responsible for the key control system?

    b. If Yes, are master keys kept securely locked and issued on a strictly controlled basis?

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME

STREET ADDRESS	CITY	DATE

Ceilings and Walls
1. Do all walls extend to the ceiling?

2. Are drop or removable ceilings used in the facility?
    a. If Yes, then where?

Emergency Power System
1. Is there a dependable auxiliary power source for emergencies?

Lighting
1. Is the interior lighting adequate in all regular workspaces for safe movement and inspections?

2. Is there emergency lighting?

3. Are light switches key controlled?

SPECIFIC SECURITY DEVICES, TECHNOLOGIES AND MACHINES

Alarms
1 Does the facility have an intrusion alarm system?

2. Is the system regularly tested?

3. Is the system covered by a service and maintenance contract?
    a. If yes, who provides the service and maintenance for the alarm system?

4. Was the alarm system properly installed?

5. Where does the alarm system terminate? (Mark the appropriate choice(s) below.)
    a. Local police or sheriff's station (List the agency's name):

    b. Commercial alarm company (List the company's name):

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME		
STREET ADDRESS	CITY	DATE

Fire Protection
1. When was the facility last inspected by the fire marshal?

2. Did the fire marshal approve the building?
    a. If not, why?

3. Does the building have fire alarms?

4. Does the building have smoke detectors?

5. Does the building have a sprinkler system?

6. Does the building have fire extinguishers?

7. Does the building have emergency fire hoses?

8. Does the building have standpipes?

Utility Control Points
1. Are utility and plumbing access plates and doors locked or sealed when not in use?

Attic, Basements, Crawl Spaces, and Air-Conditioning and Heating Ducts
1. Do basement doors have intrusion alarms?

2. Are basements, utility rooms, boiler rooms, crawl spaces, and attics locked when not in use?

3. Are air conditioning and heating vent openings, which are in public areas, secure from tampering?

Communications
1. Are communications resources adequate?
    a. If not, what is needed?

2. During tests between this facility and other sites, do CWIRS radios transmit and receive clearly?

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME		

STREET ADDRESS	CITY	DATE

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3. What communications options are available in the facility?
      a. Telephone (describe system):
      b. Radio (describe system):
      c. Public address (describe system):
      d. Internet (describe system):

4. Is there a communications system used exclusively for security purposes (e.g., walkie talkies)?

ROADWAY ACCESS

1. Is there convenient access to more than one major road or highway from the site, including access from any of the site's parking lots?
      a. ALWAYS: Briefly describe the primary approach to the facility's main entrance.

      b. Briefly describe any secondary approaches, and how many lanes of traffic are supported by each one.

2. Are there major highways or freeways nearby?

3. Can all approaches to the site be blocked off if necessary?
      a. Briefly describe how close roadways are in relation to the entrance of the structure.

4. Are roadways well marked and do they have clear signs?

5. Are roadways well lit for nighttime operations?

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME		
STREET ADDRESS	CITY	DATE

NEIGHBORHOOD CHARACTERISTICS (WITHIN 4 BLOCKS OF THE SITE)

1. Are there any facilities nearby which might pose a security threat (prisons, halfway houses, chemical refineries, methadone clinics, nightclubs)?
   a. If Yes, briefly describe any nearby facilities which might pose a security threat to the site.

2. Is the site located in a high crime area?
   a. What information was used as a basis for this determination?

3. Is there evidence of gang activity in the area?
   a. What information was used as a basis for this determination?

4. Are there problems with vehicular traffic congestion in the area?
   a. What information was used as a basis for this determination?

5. Briefly describe the type of neighborhood (i.e. residential, commercial, industrial).

6. How close is the nearest police station?
   a. What is the police or sheriff facility's name and address?

7. How close is the nearest fire station?
   a. What is the fire facility's name and address?

8. How close is the nearest hospital?
   a. What is the hospital facility's name and address?

STANDARD OPERATING PROCEDURES

Public Areas (waiting areas, restrooms, and hallways)
1. Are public waiting rooms routinely inspected?

2. Are public restrooms routinely inspected?

3. Are directions (directories and evacuation plans, if appropriate) clearly posted in all public areas?

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME

STREET ADDRESS	**CITY**	**DATE**

Offices within the Facility that Handle Money
Does the cashier's window have security features?

Is a large amount of cash retained in the office overnight or on weekends?
Is there an adequate safe, vault, or strongbox?

Security Procedures
1. Is there a security procedures manual for the facility?
    a. If Yes, are all elements of the security procedures manual current and reasonable?
 2. Are the facility's emergency plans current?

3. Are all emergency plans subject to a periodic review/update?

4. Is first aid equipment provided within the facility?

5. Is there a designated security officer for the facility?

6. Is there a security officer on duty after normal working hours?
    a. If so, on which days and during what hours?

7. Is there a procedure for routine daily inspection of the facility?

8. Are long-term occupants given periodic instruction regarding the various emergency procedures?

9. Are periodic fire and evacuation drills held?

10. Are security plans coordinated with appropriate local, State, and Federal agencies?

11. Are employee only areas and visitor/customer circulation patterns separated and well defined?

12. Is there a routine inspection process for packages and shipments entering the facility?

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME		
STREET ADDRESS	CITY	DATE

COMMENTS REGARDING ANY SPECIFIC SECURITY CONCERNS:

PHYSICAL SECURITY ASSESSMENT CONTINUED

SITE NAME		
STREET ADDRESS	CITY	DATE

LEVEL OF SECURITY SUMMARY

I. Exterior of the Site

Category I	Very Low	Low	Average	Above Average	High	Points
Rating	(1 point)	(2 points)	(3 points)	(4 points)	(5 points)	

II. Interior of the Building(s)

Category II	Very Low	Low	Average	Above Average	High	Points
Rating	(1 point)	(2 points)	(3 points)	(4 points)	(5 points)	

III. Specific Security Devices, Technologies and Machines

Category III	Very Low	Low	Average	Above Average	High	Points
Rating	(1 point)	(2 points)	(3 points)	(4 points)	(5 points)	

IV. Roadway Access

Category IV	Very Low	Low	Average	Above Average	High	Points
Rating	(1 point)	(2 points)	(3 points)	(4 points)	(5 points)	

V. Neighborhood Characteristics (4 Blocks)

Category V	Very Low	Low	Average	Above Average	High	Points
Rating	(1 point)	(2 points)	(3 points)	(4 points)	(5 points)	

VI. Standard Operating Procedures

Category VI	Very Low	Low	Average	Above Average	High	Points
Rating	(1 point)	(2 points)	(3 points)	(4 points)	(5 points)	

TOTAL SCORE:

INTERNET RESOURCES

Planners should create a list of key web resources that may be helpful in plan development. A partial sample list is provided here.

LOCAL

Los Angeles County Department of Coroner
- http://coroner.co.la.ca.us

Los Angeles County Department of Health Services Medical Alert Center
- http://ems.dhs.lacounty.gov/MAC.MAC.htm

Los Angeles County Department of Mental Health
- http://www.dmh.lacounty.gov

Los Angeles County Department of Public Health
- Acute Communicable Disease Control
http://www.publichealth.lacounty.gov/acd/
- Data Collection and Analysis Unit
http://www.publichealth.lacounty.gov/dca/

Los Angeles County Family Information Center Planning Guide
- http://ems.dhs.lacounty.gov/ManualsProtocols/FamilyInfoCenterPlanningGuide.pdf

Los Angeles County Office of Emergency Management
- http://www.lacoa.org

Los Angeles County Operational Area Family Assistance Center Plan
- http://lacoa.org/PDF/HazardsandThreats/Annexes/LAC%20OA%20FAC%20PLAN%20EMC_12022010.pdf

Los Angeles County Public Administrator's Office
- http://ttc.lacounty.gov/Proptax/PA_openning.htm

Los Angeles County Department of Public Social Services
- http://www.ladpss.org

Los Angeles City Emergency Management Department
- http://www.emergency.lacity.org/epdcu.htm

STATE

California Electronic Death Registration System
- https://ca.edrs.us (CA-EDRS login page)
- http://www.edrs.us (EDRS homepage/general information)

California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan
- http://www.calema.ca.gov/LawEnforcement/Pages/MassFatalityPlan.pdf

California Public Health and Medical Emergency Operations Manual
- http://www.emsa.ca.gov/disaster/files/EOM712011.pdf

FEDERAL

CDC: Disposing of Liquid Waste from Autopsies in Tsunami-Affected Areas
- http://www.bt.cdc.gov/disasters/tsunamis/pdf/tsunami-autopsyliquidwaste.pdf

CDC: Instructions for Completing the Cause-of-Death Section of the Death Certificate
- http://www.cdc.gov/nchs/data/dvs/blue_form.pdf

CDC: Interim Health Recommendations for Workers Who Handle Human Remains
- http://www.bt.cdc.gov/disasters/tsunamis/handleremains.asp

CDC: Standard Precautions Guidelines
- www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html

DHHS: Public Health Preparedness Capabilities: National Standards for State and Local Planning
- http://www.cdc.gov/phpr/capabilities/Capabilities_March_2011.pdf

DHHS Radiation Event Medical Management: Management of the Deceased
- http://www.remm.nlm.gov/deceased.htm

FEMA: Developing and Maintaining Emergency Operations Plans Comprehensive Preparedness Guide 101
- http://www.fema.gov/pdf/about/divisions/npd/CPG_101_V2.pdf

OSHA: Health and Safety Recommendations for Workers Who Handle Human Remains
- http://www.osha.gov/OshDoc/data_Hurricane_Facts/mortuary.pdf

INTERNATIONAL

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

Mass Fatality Plan Checklist for Ministries of Health and National Disaster Offices
- http://www.paho.org/english/dd/ped/deadbodies5checklist.htm

Operational Best Practices Regarding the Management of Human Remains and Information on the Dead By Non-Specialists
- http://www.icrc.org/eng/assets/files/other/icrc-002-858.pdf

OTHER

Advance Practice Centers: Managing Mass Fatalities: A Toolkit for Planning
- http://apc.naccho.org/Products/APC20091595/Pages/Overview.aspx

International Mass Fatalities Center
- http://www.massfatalities.com/

Journal of Homeland Security and Emergency Management: Building Mass Fatality Management at the Regional Level for Pandemic and Catastrophic Response
- http://www.bepress.com/jhsem/vol7/iss1/50/

National Mass Fatalities Institute
- http://www.nmfi.org/

REFRIGERATION TRUCKS FOR STORAGE

In the event of a large-scale disaster, the number of fatalities may overwhelm the ability of the Coroner and funeral homes to retrieve decedents from healthcare facilities in a timely fashion. As a result, the number of decedents in individual healthcare facilities may exceed normal storage capacity. Healthcare facilities may need to retain bodies on site until they can be identified and/or retrieved by funeral homes or the Coroner. Bodies should be stored at 40 degrees Fahrenheit to delay decomposition. Refrigerated trucks are widely and readily available for rental and could fill the need for temporary storage of human remains.

ASSUMPTIONS

1. Temporary storage may be needed when healthcare facilities' decedent storage capacity is exceeded, and due to the scale of the emergency, transport to the Coroner or to a funeral home is delayed.
2. On-site storage will include rented refrigerated trucks if other temporary storage options are not available.
3. A state and/or Federal disaster has been declared.
4. Bodies will not be stacked.
5. Rented refrigerated trucks will be used "as is", i.e., not specially configured for storage or transport of bodies; ensure that all company logos are covered or removed.

CAPACITY REQUIREMENTS

Diesel refrigerated trucks generally come in two widths, 96 and 102 inches (8 feet and 8.5 feet respectively.) Lengths of truck boxes (storage area) varies from 9 to 53 feet. Larger commercial vehicles may provide optimal storage (as depicted) however those facilities that do not readily have commercial drivers may opt

for smaller vehicles - maximum length is 28 feet, with no more than three axles - for practical purposes such as parking, driving and maneuvering, and lesser license requirements.

Refrigeration trucks should be unmarked (e.g., provider names/logos should not be displayed); remove and or cover as necessary.
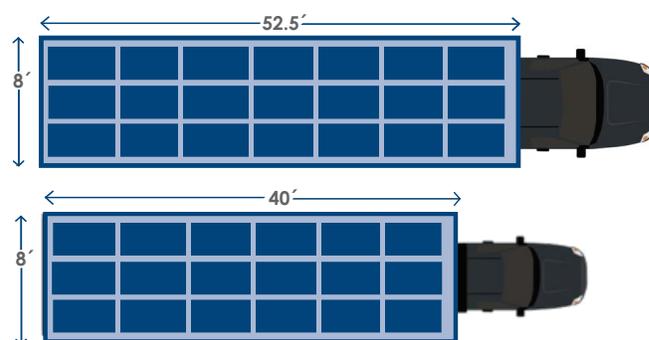
COMMERCIAL TRAILER STORAGE

- **53' refrigerated trailer can store 21 decedents in pouches without shelving**
- **40' refrigerated trailer can store 18 decedents in pouches without shelving**
- **Can double/triple/quadruple capacity with shelving**

Decedents would be placed next to each other perpendicular to the truck/trailer length, with a narrow walk space at head and foot. On average approximately 30 inches (2.5 feet) of truck interior width would be required for each body.

PROCUREMENT

Healthcare entities should obtain decedent storage surge supplies using their own resources. If this is not possible, healthcare entities can submit a Medical/Health Resource Request form to the EMS Agency Department Operations Center. Requests will be fulfilled per NIMS/SEMS.

Requests for diesel refrigerated vehicles may include the following information:
- Number of vehicles required
- Approximate length of truck storage area (available lengths vary by vendor)
- Fully fueled
- Name of facility and location
- Desired pick up time (or delivery, if available)
- Name/title of person authorized to pick up or accept delivery
- Estimated number of days vehicle(s) is required
- Standard insulation
- Lift gates (if desired)
- Confirmation that vehicles can be cleaned – metal, not plastic inside surfaces
- Confirmation that professional logos are covered

COST, PAYMENT AND REIMBURSEMENT

Requesting facilities will be required to pay the vendor directly, and apply for FEMA reimbursement. Non-governmental (i.e., non-profit or for-profit hospitals) will not be eligible for FEMA reimbursement unless a prior agreement such as an agreement or contract is in place with a government agency (in Los Angeles County, an HPP contract may qualify). Daily rental of refrigerated trucks up to 26 feet in length varies with the vendor, but will be approximately $250 per day, including insurance. Fuel costs for vehicles used for temporary storage will be $80 to $100 per day, resulting in a total cost of approximately $350 per day per rented vehicle.

OTHER CONSIDERATIONS

Fueling: Diesel refrigerator trucks must run continuously at idle to power the refrigeration units, using approximately 1 gallon of diesel fuel per hour. Fuel tank capacities vary from 40 to 150 gallons, depending on the size of the vehicle. Refueling will be required periodically to keep the unit operational.

Health Considerations: Diesel exhaust contains several chemicals and compounds that may be hazardous to human health from concentrated or long term exposure. Therefore careful consideration should be given to locating the unit in an area away from regular human activity and air circulation intakes.

Facility Memorandum of Understanding (MOU): Each healthcare facility should have and maintain a MOU if rented trucks are a part of their plan.

Driver License Requirements: A valid California Driver's License is required for anyone driving a vehicle. A basic Class C license is sufficient to legally drive a:
- 2-axle vehicle with a Gross Vehicle Weight Rating of 26,000 lbs. or less
- 3-axle vehicle weighing 6,000 lbs. gross or less.

If the vehicle is to be driven by healthcare staff, the request should specify a vehicle meeting the above criteria. Follow facility policy when operating the vehicle.

MENTAL AND BEHAVIORAL HEALTH RESOURCES

Coping With a Disaster or Traumatic Event

The effects of a disaster, terrorist attack, or other public health emergency can be long-lasting, and the resulting trauma can reverberate even with those not directly affected by the disaster. This page provides strategies for promoting mental health and resilience.
http://www.bt.cdc.gov/mentalhealth/

Listen, Protect, and Connect

The three steps of "psychological first aid" for your child after a disaster. We are very pleased to announce that the "Listen, Protect and Connect" web version for parents (for use with their children) "LPCweb" psychological first aid for children by parents) is available at the University of California Irvine Center for Disaster Medical Sciences at: **http://www.cdms.uci.edu/lpc**

The U.S. Department of Homeland Security link for the parent/child version is available at:
http://www.ready.gov/sites/default/files/documents/files/PFA_Parents.pdf

Neighbor to Neighbor, Family to Family:
http://www.cdms.uci.edu/protect.pdf

Schools: **http://www.ready.gov/sites/default/files/documents/files/PFA_SchoolCrisis.pdf**

U.S. Department of Education Guidelines for Using Listen, Protect, Connect:
http://www.ready.gov/sites/default/files/documents/files/HH_Vol3Issue3.pdf

Spanish version for parents:
http://www.ready.gov/translations/spanish/ninos/_downloads/Eschcar_Proteger_y_Conectar.pdf

Los Angeles County Department of Mental Health Disaster Services

Responds to the community´s disaster service needs by providing emergency psychiatric intervention, clinical services to mental health consumers who are disaster victims, and various other services.
http://dmh.lacounty.gov/wps/portal/dmh/our_services/disaster_services

Managing Response: Tips for Managing and Presenting Stress, A Guide for Emergency Response and Public Safety Workers

Gives organizational and individual tips for stress prevention and management for emergency response workers and public safety workers.
http://store.samhsa.gov/product/Tips-for-Managing-and-Preventing-Stress/KEN01-0098R2

Pediatric Disaster Preparedness in the Medical Setting: Integrating Mental Health

The inclusion of mental health concerns into pediatric disaster preparedness may help prevent further and unnecessary psychological harm to children and adolescent survivors following a disaster.

Gold J.I., Montano Z., Shields S., Mahrer N.E., Vibhakar V., Ybarra T., Yee N., Upperman J., Blake N., Stevenson K., and Nager A.L. (2009). Pediatric Disaster Preparedness in the Medical Setting: Integrating Mental Health. American Journal of Disaster Medicine, Volume 4 (Issue 3), 137-146.

Practitioner perceptions of Skills for Psychological Recovery: a training programme for health practitioners in the aftermath of the Victorian bushfires.

Following the February 2009 Victorian bushfires, Australia's worst natural disaster, the Australian Centre for Posttraumatic Mental Health, in collaboration with key trauma experts, developed a three-tiered approach to psychological recovery initiatives for survivors with training specifically designed for each level. The middle level intervention, designed for delivery by allied health and primary care practitioners for survivors with ongoing mild-moderate distress, involved a protocol still in draft form called Skills for Psychological Recovery (SPR). SPR was developed by the US National Center for PTSD and US National Child Traumatic Stress Network. This study examined health practitioner perceptions of the training in, and usefulness of, SPR.

Forbes D, Fletcher S, Wolfgang B, Varker T, Creamer M, Brymer MJ, Ruzek JI, Watson P, Bryant RA.

Preparing Hospitals and Clinics for the Psychological Consequences of a Terrorist Incident or Other Public Health Emergency

Train hospital and clinic staff about how to prepare for and respond to the psychological consequences of large-scale disasters. Curriculum includes: an overview for administrative and disaster planning staff, a module designed for clinical, mental health, and a third module designed specifically for Los Angeles County disaster mental health staff who may be deployed to support hospitals and clinics following disasters.

http://ems.dhs.lacounty.gov/Disaster/DisasterTrainingIndex.htm

Prioritizing "Psychological" Consequences for Disaster Preparedness and Response: A Framework for Addressing the Emotional, Behavioral, and Cognitive Effects of Patient Surge in Large-Scale Disasters

This framework specifies structural components (internal organizational structure and chain of command, resources and infrastructure, and knowledge and skills) that should be in place before an event to minimize consequences. The framework also specifies process components (coordination with external organizations, risk assessment and monitoring, psychological support, and communication and information sharing) to support evidence-informed intervention.

Meredith, L., Eisenman, D., Tanielian, T., Taylor, S., Basurto-Davila, R., Zazzali, J., Diamond, D., Cienfuegos, B., and Shields, S. (2010). Prioritizing "Psychological" Consequences for Disaster Preparedness and Response: A Framework for Addressing the Emotional, Behavioral, and Cognitive Effects of Patient Surge in Large-Scale Disasters. American Medical Association, Volume 5 (Number 1). doi:10.1001/dmp.2010.47.

Psychological Effects of Patient Surge in Large-Scale Emergencies: A Quality Improvement Tool for Hospital and Clinic Capacity Planning and Response

Novel and practical quality improvement tool for hospitals and clinics to use in planning for and responding to the psychological consequences of catastrophic events that creates a surge of psychological casualties presenting for health care. This paper describes the development of the tool, presents data on facility

preparedness from 31 hospitals and clinics in Los Angeles County, and discusses how the tool can be used as a benchmark for targeting improvement.

Meredith, L., Zazzali J., Shields, S., Eisenman, D., and Alsabagh, H. (March-April 2010). Psychological Effects of Patient Surge in Large-Scale Emergencies: A Quality Improvement Tool for Hospital and Clinic Capacity Planning and Response. Prehospital and Disaster Medicine, Volume 25 (Number 2). Retrieved March 6, 2012, from http://pdm.medicine.wisc.edu.

Psychological First Aid for First Responders

When you work with people during and after a disaster, you are working with people who may be having reactions of confusion, fear, hopelessness, sleeplessness, anxiety, grief, shock, guilt, shame, and loss of confidence.
http://store.samhsa.gov/product/sma11-disaster

PsySTART

Psychological Simple Triage and Rapid Treatment provides methods to link mental health to disaster system of care, mental health triage tag, IT, and ICS/HICS compliant job action sheets.
http://www.cdms.uci.edu/disaster_mental_health.asp

Readiness for Events with Psychological Emergencies Assessment Tool (REPEAT)

REPEAT is designed to help hospitals and clinics assess their capacity to deal with the surge of psychological causalities resulting from large-scale emergencies.
http://ems.dhs.lacounty.gov/Disaster/BW/Tool_REPEAT.pdf

Taking Care of Your Emotional Health After a Disaster

When we experience a disaster or other stressful life event, we can have a variety of reactions, all of which may be common responses to difficult situations. Here is some information on how to recognize your current feelings and tips for taking care of the emotional health of you, your family, and friends.
http://ems.dhs.lacounty.gov/Disaster/CareForEmHealth.pdf

Substance Abuse and Mental Health Services Association 24 Hour Hotline

1-800-662-HELP (4357)

Tips for Survivors of a Traumatic Event: What to Expect in Your Personal, Family, Work, and Financial Life

The effect of a disaster or traumatic event goesfar beyond its immediate devastation. Just as it takes time to reconstruct damaged buildings, it takes time to grieve and rebuild our lives. Life may not return to normal for months, or even years, following a disaster or traumatic event. There may be changes in living conditions that cause changes in day- to-day activities, leading to strains in relationships, changes in expectations, and shifts in responsibilities.
http://store.samhsa.gov/product/Tips-for-Survivors-of-a-Traumatic-Event-What-to-Expect-in-Your-Personal-Family-Work-and-Financial-Life/NMH02-0139

Tips for Talking to Children After a Disaster: A Guide for Parents and Teachers

Children respond to trauma in many different ways. Knowing the signs that are common at different ages can help parents and teachers to recognize problems and respond appropriately.
http://store.samhsa.gov/shin/content/KEN01-0093/KEN01-0093.pdf

RELIGION AND CULTURE RESOURCES

This section contains information on faith and cultural traditions that healthcare facilities can utilize based on the population that they serve. Information on the following pages has been adapted from The Needs of Faith Communities in Major Emergencies: Some Guidelines produced by the United Kingdom Home Office Cabinet. While this helpful resource has been provided as a sample and starting point, planners should coordinate with leaders from local cultural, religious and ethnic groups to ensure that current and preferred practices are included in their plan.

STEP 1

Obtain and include information regarding the death practices and observations of the population that your facility serves.

Meet with your disaster planning committee including social work, chaplain, and decedent affairs staff. Assess which faith and cultural groups are served by your facility. Review normal operational procedures for patient deaths and determine how those procedures may change in a mass fatality disaster where there is a surge of deceased patients and/or surviving family members. Modify this section of your Mass Fatality Management Plan to document and describe how faith and cultural issues will be handled in a mass fatality incident/event. If applicable, document these procedures in the Hospital Family Information Center Plan as well.

STEP 2

Determine with your social work, chaplain, and decedent affairs staff if it would be advisable to create a supplemental cadre of staff that could be activated in a mass fatality incident/event.

These staff members would help support the medical mission of the facility by leading the compassionate and appropriate care of the deceased patients and grieving family members once they are released by the medical team. The staff would augment the Decedent Affairs Group during disasters. Tasks for staff could include assisting with witness statements (especially for people who were brought to the facility unconscious or without identification), form completion, support grieving families, etc.

Documentation for staff should be included in facility Mass Fatality Management and/or Family Information Center plans.

For more information on the Family Information Center plan, please see: **http://ems.dhs.lacounty.gov/ManualsProtocols/FamilyInfoCenterPlanningGuide.pdf.**

STEP 3

Host a tabletop exercise to test policies, procedures and plans to address the faith and cultural considerations in a mass fatality incident/event.

Determine if additional training of staff is needed or whether additional procedures/plans/policies should be developed. Conduct a yearly test of facility plans and procedures for meeting faith and cultural traditions of the deceased (as much as is practical) in a mass fatality incident/event by adding a surge of deceased patients and grieving family members as a part of the exercise scenario.

NOTES:

Bahá'í	
Language	Mainly English
Diet	Bahá'ís abstain from alcohol, but may take medicine.
Fasting	They fast from sunrise to sunset March 2-20. This fast is only practiced by people aged 15 years and over and who are not ill, pregnant, breast-feeding, menstruating or who have been travelling substantial distances.
Dress	There are no special requirements other than moderation and modesty.
Physical contact	Bahá'ís believe in the healing power of modern medicine for both physical and mental illness, while recognizing the role of the spirit, of prayer and of turning to God. There is no objection to being touched or treated by members of the opposite sex.
Medical treatment	Blood transfusions, organ donations, the administration of prescription drugs and the like are acceptable.
Hospital stays	Bahá'í patients will be ministered to by friends, family and those appointed as spiritual caregivers by the community. Because the Bahá'í faith has no sacraments, these spiritual care givers do not have a sacramental or priestly/ministerial role nor do they have any authority over the patient.
Daily acts of faith and major annual events	Every Bahá'í aged 15 years and over must recite daily one of three obligatory prayers, as well as reading a passage from the Bahá'í scriptures each morning and evening. Prayers are said privately and facing the 'Point of Adoration' (the Shrine of Bahá'u'lláh). Before reciting the prayers, Bahá'ís wash their hands and face, but ablutions do not require special facilities. Timing of the Bahá'í day starts at the sunset of the previous day (e.g. Naw-Ruz begins at sunset on March 20 and finishes at sunset on March 21, but the date is always shown as March 21). Bahá'í holy days always fall on the same dates each year and are: Naw Ruz: New Year (March 21) 1st day of Ridvan (April 21) 9th day of Ridvan (April 29) 12th day of Ridvan (May 2) Anniversary of the Declaration of the Bab (May 23) Anniversary of the Ascension of Baha'u'llah (May 29) Anniversary of the Martyrdom of the Bab (July 9) Anniversary of the Birth of the Bab (October 20) Anniversary of the Birth of Baha'u'llah (November 12)

Dying	There are no special religious requirements for Bahá'ís who are dying, but they may wish to have a family member or friend to pray and read the Bahá'í scriptures with them.
Death customs	While there is no concept of ritual purity or defilement relating to the treatment of the body of a deceased person, there are a few simple and specific requirements relating to Bahá'í burial and the Bahá'í funeral service, which the family will wish to arrange: The body is carefully washed and wrapped in white silk or cotton. This may be done by family members or by others, according to the family's preference. The family may choose to allow others to observe the preparation of the body; A special burial ring may be placed on the finger of a Bahá'í aged 15 or over; The body is not cremated but is buried within an hour's travelling time from the place of death; Unless required by law, the body should not be embalmed; It is buried in a coffin of as durable a material as possible; and At some time before interment a special prayer for the dead, the only specific requirement of a Bahá'í funeral service, is recited for Bahá'í deceased aged 15 or over. While it is preferable that the body should be buried with the head pointing towards the Point of Adoration, this is not an absolute requirement, and may be impossible in some cemeteries without using two burial plots. This is a matter for the family.
Resources (texts, community facilities etc.)	The Bahá'í scriptures comprise the Writings of Bahá'u'lláh, Founder of the Faith, and of his forerunner, the Báb. The Writings of 'Abdu'l-Bahá, Bahá'u'lláh's eldest son and successor, are also included in the Bahá'í Canon. Bahá'ís may read the scriptures in any language, so it is preferable to provide English-language editions. The Bahá'í scriptures belong to all and there are no restrictions on who may touch or handle the books, provided they are treated with respect. Larger Bahá'í communities may have a Bahá'í center, but most Bahá'í Communities currently have no such facilities.
Names	Bahá'ís follow the practice of the wider community in naming. There are no specific religious names. It is very important to check the spelling of the names which may be transliterated in different ways. For Example, the name Masoud may also be spelt Massoud or Masood.

Buddhist	
Language	Members speak several languages other than English, including Tibetan, Cantonese, Hakka, Japanese, Thai, and Sinhalese.
Diet	Vegetarian dishes, salads, rice, vegetables, and fruit are acceptable to offer. Some Buddhists do not eat onions or garlic, but this is more a matter of personal choice or cultural habit, rather than religious restriction. Buddhists who are vegetarian may eat fish and eggs.
Fasting	Full moon days and new moon days are often fast days for Buddhists, as are some festival days for various schools of Buddhism. On days of fasting, a Buddhist may eat before noon, but not afterwards.
Dress	Generally, there are no religious requirements for forms of every-day dress for lay Buddhists. Buddhist monks or nuns may shave their heads and wear orange or ochre-colored robes.
Physical contact	In the case of medical examination, treatment, and comforting by strangers, a Buddhist may be touched by a person of either sex.
Medical treatment	There are no religious objections to blood transfusions, or transplants.
Hospital stays	In cases of hospital stays, the use of either a bath or a shower is a personal matter. Provision of a quiet space set aside in a hospital or rest center is not a necessity, but if available it can be used for silent reflection and meditation.
Daily acts of faith and major annual events	Buddhists do not pray in the generally-accepted sense, but meditate regularly. Other than in Zen Buddhism, the Buddhist calendar is lunar; the dates will therefore vary from year to year. Traditional observance days are the full moon, new moon, and quarter days. There are different special events during the year, but those celebrated by all schools of Buddhism are: Wesak Full moon days The calendar observed by Buddhists is not standardized and different traditions within Buddhism may observe the same festival on significantly different dates. It is therefore wise to ask about the practice within the tradition involved, rather than making an assumption that for instance, Wesak, is observed on the same date by all Buddhists.
Dying	Many Buddhists wish to maintain a clear mind when dying. There is respect for the doctors' views on medical treatment, but there may sometimes be a refusal of pain-relieving drugs if these impair mental alertness. This is a matter of individual choice. It is helpful for someone who is dying to have some quiet, and it is customary to summon a monk to perform some chanting of sacred texts in order to engender wholesome thoughts in the mind of the dying person.

Death customs	After death, the body of the deceased may be handled by non-Buddhists. In some cases a monk may perform some additional chanting, but this is not a universal practice. There are no objections to post-mortem activities. Preparation of the body for the funeral is generally left to the undertaker, but in some instances relatives may also wish to be involved. The body may be put in a coffin, or wrapped in cloth (sometimes white), or dressed in the deceased's own clothes. It may be surrounded by candles, flowers, incense, photographs, and colored lights, but this is a matter of individual choice and there are no fixed rules. The body is usually cremated, at a time dependent upon the undertaker and the availability of the crematorium's facilities.
Resources (texts, community facilities etc.)	The Pali Canon contains the teachings of the Buddha and his disciples and is used in the Theravada school of Buddhism. Mahayana schools use texts either in Sanskrit or their own languages, such as Chinese, Korean, Japanese, and Tibetan. Books of Scripture, liturgy etc. should, at all times, be handled with the utmost respect. In many traditions it is considered disrespectful to place them on the ground or to cover them.
Names	Buddhists usually have two or more names. The last name is the family name, and the preceding name(s) is/are given at the time of birth.

Chinese (Confucianism, Taoism, Astrology, Christianity)
Confucianism, Taoism, Astrology, and Christianity are among the religions most practiced.

Language	Cantonese, Mandarin, English
Diet	Southern Chinese (Cantonese and Fujian): seafood, fish, pork, poultry, green vegetables, soup, rice, rice noodles and fresh fruit. Northern Chinese: bread, wheat dumplings, meat dumplings, noodles, pork, lamb, chicken, cabbage, green vegetables. Beef and cheese are least preferred food. Drink: Soya milk is preferred to cow's milk as some Chinese are allergic to cow's milk. China tea (without milk and sugar).
Fasting	Buddhist/Taoist Chinese will eat a vegetarian diet before major festivals.
Dress	Men and women prefer shirt/blouse and trousers/slacks.
Physical contact	Although there is no gender barrier, women prefer to be medically examined by female health professionals. Showers are preferred. Washing is done personally or by a spouse, parent or child of the same gender as the patient.
Medical treatment	Injections are preferred in the belief that they are more effective than pills.
Hospital stays	Chinese food should be offered to patients. Family units stay together and do not like being separated in emergencies, and this includes extended family members.
Daily acts of faith and major annual events	Buddhists and Christian Chinese will pray or meditate in similar ways to their co-religionists. In addition to the two main Christian festivals of Christmas and Easter, Chinese Christians celebrate the Chinese New Year. *Lunar New Year:* The biggest family occasion and honor/reverence is paid to ancestors and parents. A time for family reunions, visiting friends, relatives, and exchanging monetary gifts in red envelopes. Teng Chieh (Lantern Festival at first full moon of the year) Ching Ming: A public holiday in China and Hong Kong - a time for people to visit their ancestral graves (April) Dragon Boat Festival (June) Mid Autumn Festival (September)
Dying	All family members gather at the bedside. A Chinese Christian pastor is called to pray for and to counsel the dying person. Buddhists call for a priest/monk from a Buddhist association or temple with links to Taiwan or Hong Kong.

Death customs	After death, undertakers handle the deceased. Some undertakers in areas with long established Chinese populations are accustomed to Chinese needs such as embalming and the deceased being fully dressed in best clothes including shoes and jewelry. In such areas some cemeteries have a Chinese section.
	Burial or cremation may take place a week after the person has died. Friends and relatives visit the bereaved family, usually in the evenings prior to the funeral when gifts of money or flowers are given and help offered. Sweets are offered to visitors when they leave.
	If the deceased is the head of the family, all children and their families are expected to observe a period of mourning for about a month. Headstones may have a picture of the deceased. If the deceased is a child, parents usually do not want to visit the mortuary. A sibling or close relative would be asked to identify the body in the mortuary.
Resources (texts, community facilities etc.)	Chinese Christians read bilingual bibles printed in English and Chinese. Bibles printed in the traditional script are preferred by Chinese from Hong Kong and Taiwan whilst the simplified script is read by people from China and Singapore. Buddhist scriptures are available in traditional script.
Names	Chinese names start with the family name first, followed by the generation name and the personal name. Chinese Christians usually have Christian names in addition. Always ask the person how (s)he would like to be addressed.

Christian

Christians belong to a number of denominations and some groups, which run across denominations.

Language	Christians in the U.S. may be from any ethnic group. Church services usually take place in English.
Diet	In general, Christians are not religiously forbidden to eat any foods, but this must be checked with the individual. Some will not consume alcohol.
Fasting	Roman Catholics may abstain from meat on Fridays during Lent. Orthodox will abstain from meat in the fasting seasons of Advent and Lent. Those of African and African Caribbean origin may fast at other times.
Dress	There is no special code of dress for Christians except for clergy and members of religious orders.
Physical contact	Most would have no objections to being touched by members of the opposite sex for medical purposes.
Medical treatment	Treatment such as blood transfusions, surgery, organ transplants or the administration of drugs is permissible. Exceptions are noted on later pages of this Appendix. If a person is terminally ill, or dying, they may wish to keep a copy of the Bible nearby. Survivors, their families and friends, should be allocated a quiet place, which can be used for private prayer or to talk to a priest or minister.
Daily acts of faith and major annual events	Many Christians pray daily, and often use the Lord's Prayer. Daily reading from the Bible, and/or other aids to prayer such as a Cross or Crucifix (a Cross with the figure of Christ), a hymnbook or prayer book, a rosary (prayer beads with a small crucifix), or an icon of Christ or the Virgin Mary are all widely used, though preferences should be checked with the individual. All of these could helpfully be provided in a chapel or quiet place. Sunday is the special day, set apart for prayer, reflection, and church attendance. Christians pray in congregations, small groups or individually. The most important event for most congregations is the Eucharist (the Mass, Communion Service, Lord's Supper), when Christians share bread and wine.
Dying	Christians involved in a disaster will value prayers being said for them, or with them, and short readings from scripture, such as the Lord's Prayer and the 23rd Psalm. Roman Catholics who are injured or distressed may wish to receive Holy Communion and/or the Sacrament of the Sick (which used to be called Extreme Unction). Other Christians may ask for prayer for healing with the laying on of hands.
Death customs	The choice between cremation and burial can either be a matter of personal choice or a denominational requirement. In all cases, the wishes of the deceased's family, or friends, should be sought if possible. If this cannot be done, then Christians should be buried.

Resources (texts, community facilities etc.)	The sacred text is the Bible, which for Christians consists of the Old Testament (or Hebrew Scriptures), and the New Testament, bound as a single book. Of the translations of the Bible, the New Revised Standard Version, the Authorized Version and the Jerusalem Bible are recognized by Catholics, Protestants and Orthodox Christians. Other versions are favored by evangelical Christians. Emergency Planners should discuss with church authorities the possible use of church facilities in a major emergency.
Names	Christians have one or more given names, usually called Christian names because for most Christians these were given historically at the service of baptism, which for most happened when the infant was a few weeks old. These names are followed by the surname or family name, which is constant for men. Many women change to their husband's surname on marriage, though this custom is changing. Individuals may not be known by their first Christian name, so it is always wise to ask, "What should I call you?" or for a funeral "What name should I use?"

Christian Science

Christian Science is a prayer-based system of healing that is fully explained in Mary Baker Eddy's book Science and Health with Key to the Scriptures, currently published in 17 languages. Some people who follow the practices of Christian Science choose to become members of the Church of Christ, Scientist, the organization Eddy established to make these teachings available and accessible, but others do not.

Language	People of diverse cultures and languages practice Christian Science.
Diet	Individuals make their own decisions regarding diet.
Fasting	Individuals make their own decisions regarding fasting.
Dress	No particular requirements.
Physical contact	In the practice of Christian Science, respect for individual choice in questions of healthcare or any other aspect of daily life is paramount. Many Christian Scientists rely on their own prayer for healing of adverse health conditions. Some may also ask for help from a Christian Science practitioner - a professional spiritual healer who employs the Christian Science method of healing. (There is a worldwide directory of practitioners in each issue of The Christian Science Journal, a monthly magazine.) However, individuals are always free to choose conventional medical treatment or other complementary and alternative therapies.
Medical treatment	If a Christian Scientist were taken to a hospital because of an accident, for example, and chose to decline conventional medical treatment, this would ordinarily mean that the individual was choosing instead, as a competent adult, to rely on prayer for healing (individually or with the help of a Christian Science practitioner). Such an individual would cooperate with authorities to take appropriate actions, such as quarantine, which may be considered necessary to protect others.

Hospital stays	Individuals relying on Christian Science may ask to be retested, or to have a pending procedure reevaluated after having had time to pray for healing. If a Christian Scientist entered a hospital voluntarily, the individual would probably accept conventional medical treatment. He/she might ask that drugs/therapy be kept to a minimum.
	Individuals make their own decisions about blood transfusions and organ/tissue donation.
	Doctors, nurses, mental health professionals and chaplains will find that there are many meaningful ways they can show support for patients relying on Christian Science. Where possible, the best way to ascertain what would be most helpful in any circumstance is to ask the individual patient. Some of the following might be requested by a patient, or could be offered by the healthcare worker:
	Providing the patient time and a quiet space to pray, during the various stages of diagnosis and treatment.
	Providing the patient time and a quiet space to pray, during the various stages of diagnosis and treatment.
	Facilitating the patient's contact with a Christian Science practitioner.
	Making sure that the patient has access to the Bible and Science and Health.
	Reading aloud to the patient requested passages from these books (or other Christian Science literature).
Daily acts of faith and major annual events	There are no prescribed holy days. Members would normally attend services and meetings at Church on Sundays and Wednesday evenings. Christian Scientists study a weekly Bible Lesson, a collection of topic-specific passages from the Bible and Science and Health.
Dying Death customs	There are no specified last rites. Such issues are an individual/family decision. Questions relating to care of the body should be answered by the individual's partner/ family. In general, Christian Scientists request that, whenever possible, the body of a female should be prepared for burial by a female. The individual's family should answer questions relating to post mortem examinations.

Church of Jesus Christ of Latter Day Saints (Mormon)	
Language	English
Dress	Those who have been endowed in a Temple of the Church of Jesus Christ of Latter Day Saints wear a special undergarment next to the skin. Mormons are always encouraged to dress modestly.
Physical contact, medical treatment, hospital stays	Necessary medical treatment can be carried out without delay and surgery and blood transfusions may be carried out as necessary. Transplants and organ donation are an individual and family matter. There are no religious objections.
Daily acts of faith and major annual events	Scripture reading is considered an important part of daily life. The Sabbath is observed on Sundays, with services conducted by lay leaders called bishops. Christmas and Easter are important celebrations in the Church.
Diet	Mormons do not smoke, drink alcohol, or use non-medicinal drugs. Food and drinks containing caffeine and other stimulants should be avoided.
Dying	Members may request a priesthood blessing. A quiet private place is appropriate for the blessing
Death customs	The Church takes no position on post mortem examinations. Church or family members will usually arrange for the body to be clothed for burial. Burial rather than cremation is recommended by the Church, but the final decision is left for the family of the deceased.
Resources (texts, community facilities etc.)	The Bible and the Book of Mormon: Another Testament of Jesus Christ – are regarded as the word of God. Although Mormon individuals and families are advised to be prepared spiritually and temporally to meet both problems of everyday life and emergencies that may arise, local Church leaders have the responsibility to organize proper responses to assist individuals and families in an emergency. Church branches are encouraged to prepare detailed Emergency Preparedness and Response Plans, based on principles contained in Providing in the Lord's Way. Branch Welfare Committees are identified as the coordinators if disaster strikes.

Hindu	
Language	In addition to English, Hindus may speak Gujerati (most common), Hindi, Punjabi, Bengali or Tamil.
Diet	Hindus regard the cow as sacred and do not eat beef. Orthodox Hindus are strictly vegetarian, which also excludes fish, eggs and animal fat for cooking. Some may also prefer to refrain from alcohol, and some very orthodox Hindus may refrain from garlic and in extreme cases onion. Salt-free salads, rice, vegetables, yoghurt and milk products and fruit are quite acceptable foods to offer.
Fasting	Fasting is commonplace and frequent but fasts generally last just one day or one day a week (e.g. Lord Shiva's fasting every Monday for 17 weeks, where yoghurt at lunch with water or fruit juice and a normal light meal in the evening is permitted). Hindu women keeping the Karvachauth fast in Autumn cannot even drink water until the moon is seen at night.
Dress	Generally, modesty and decency are considered essential factors in dress code. The sari is a one-piece female garment wound around the lower body in different styles to suit the occasion and the tradition from which the person comes. Women also wear a dress and baggy trousers (shalwar). Men may sometimes wear a loose shirt (Kurta) and baggy trousers but generally they wear Western clothes.
Physical contact Medical treatment	A Hindu would prefer to be comforted by a person of the same sex. There is no stated preference in respect of medical examination and treatment.
Hospital stays	Hindus traditionally live in extended families, so information or requests (e.g. for organ donation) should be made by the authorities to the head of the family to be passed on without delay to the rest of the family unit, where this is practicable. Some groupings within the Hindu community are men only or women-only and the authorities should always appoint a person of the appropriate sex to liaise with such a grouping.
Daily acts of faith and major annual events	Holi: A celebration at the start of spring, with much use of color Rama Navami Janamashtami: There is fasting until midnight Divali: The festival of lights Shivaratri: The night is spent in prayer, fasting and meditation
Dying	Most fatally ill Hindus would prefer to pray with a mala (rosary). A Hindu will appreciate being with someone, preferably of the same sex.

Death customs	It is preferred that all Hindu bodies can be kept together after death. A dead body should be placed with the head facing north and the feet south. Cleanliness is important and the body can be undressed and cleaned, but the family should be consulted where possible. The arms should be placed to the sides and the legs should be straightened. The face should be pointed upward with eyes closed and the whole body must be covered with white cloth. Any detached body parts must be treated with respect as if they were a complete body. Post mortems are permitted, usually with prior agreement of the immediate family. The bereavement in the family lasts a minimum of two weeks during which several rituals are followed. Hindus believe in cremating the body so that the soul is completely free of any attachment to the past physical matter.
Resources (texts, community facilities etc.)	The Hindu ancient scriptures are called the Vedas and contain, amongst other texts, the Upanishads, philosophical works discussing the purpose of life, and the Brahmanas, which contain advice on ritual. The Bhagawad Gita is a prominent holy book with condensed spiritual teachings, and the Ramayana sets the highest ideals.
Names	Members of Hindu families may have three or four names, depending on cultural background and tradition. Suffixes to the first name are used, e.g., 'Bhai' or 'Ji' for males and 'Ben' for females. In some traditions the father's first name is one of the middle names. Other middle names, which may be used as surnames are Kumar, Pal or Paul, Dev, Lal etc. Sometimes the surname is clan based as Patel or in case of Rajputs, Singh. Some Hindu women may adopt 'Devi', 'Kumari' or 'Wati' in place of a family surname. For records, it is advisable to ask the individual's family name and use that as surname. Hindu equivalents to Mr. and Mrs. are Shri and Shrimati, commonly used, but for Miss one can use Sushai/Kumari/Devi but rarely used. In written records and invitations the practice is to say Shrimati and Shri (surname), i.e. Mrs. and Mr. (surname).

Humanists

Humanism is not a faith. It is the belief that people can live good lives without religious or superstitious beliefs. Most humanists would describe their beliefs as either atheist or agnostic, and humanists reject the idea of any god or other supernatural agency and do not believe in an afterlife. However, Humanism is more than a simple rejection of religious beliefs. Humanists believe that moral values are founded on human nature and experience, and base their moral principles on reason, shared human values and respect for others. They believe that people can and will continue to solve problems, and should work together to improve the quality of life and make it more equitable.

Language	English
Diet	There are no particular requirements. Some humanists are vegetarian or vegan, and many who do eat meat would refuse meat that has been slaughtered by methods they consider inhumane (Halal or Kosher meat).
Fasting	There are no particular requirements.
Dress	There are no particular requirements.
Physical contact, medical treatment, hospital stays	There are no specific restrictions on physical contact, or on medical treatments.
Daily acts of faith and major annual events	There are no daily acts of faith or worship, and no annual festivals.
Dying	Many humanists will want to have family or a close friend with them if they are dying, or the support of another caring individual. Some may appreciate the support of a secular counselor or a fellow humanist. Humanists may refuse treatment that they see simply as prolonging suffering. Some may strongly resent prayers being said for them or any reassurances based on belief in god or an afterlife.
Death customs	There are no specific requirements. The choice between cremation and burial is a personal one, although cremation is more common. Most will want a humanist funeral, and crosses and other religious emblems should be avoided. However, since many humanists believe that when someone dies the needs of the bereaved are more important than their own beliefs, some may wish decisions about their funeral and related matters to be left to their closest relatives.
Resources (texts, community facilities etc.)	There are no humanist scriptures or religious texts.
Names	There are no particular traditions. Names may vary according to ethnic or cultural background.

Jain	
Language	Apart from some of the elderly, Jains speak and understand English.
Diet	Jains are pure vegetarians, and do not consume meat, fish, seafood, poultry or eggs. In addition, those Jains who adhere to the stricter code of conduct do not eat any root vegetables, particularly onions and garlic but also potatoes, carrots, beets, etc. Jains do not consume alcohol. Salads, fruits, cooked grain of all types, cooked vegetables, bread or biscuits made without the use of eggs and dairy products are generally acceptable.
Fasting	There are fasts with (a) no meal (b) one meal (c) two meals within 24 hours. Water, if used in a fast, must be boiled. Some Jains observe fasts without any intake of food or water. Abstention from fruit and vegetables is practiced on many days. Fasts are undertaken on various days throughout the lunar month. They are more popular during the festival of Paryushana during August or September, which lasts for 8 or 10 days. Two special 9-day periods called Ayambil are observed during June and December during which only one meal is taken. This meal is prepared using only grain, flour, water, rock salt and pepper. Use of dairy products, fruits, vegetables, nuts, oils and fats, and any raw food is forbidden.
Dress	Jain males have adapted the western dress code for everyday use whereas females may be orthodox or modern. The elderly usually wear Indian dresses such as saris and kurta-pyjama, whilst the younger generation wear all sorts of dresses.
Physical contact	Ideally, same-sex contact are preferred but there is no taboo where medical and/or specialist personnel are involved.
Medical treatment	Blood transfusions and organ transplants are acceptable if these are not obtained at the expense of another life. Medication for the purpose of saving life is usually accepted without question.
Hospital stays	If the toilet and bathroom are separate, a water supply and beaker should be provided in the toilet for cleaning purposes. Diet restrictions should be observed during stays in hospital or rest center.

Daily acts of faith and Major annual events	Paryushana: 8 or 10 days during August or September. The most significant Jain event. Prayers are recited with confession of sins, forgiveness is sought from all living beings and penances are undertaken. Mahavira Jayanti: This is the Birthday of Lord Mahavira, the last Tirthankara, which is celebrated during April. This is a joyous occasion and the experiences of Lord Mahavira's mother before and after his birth are recounted. Mahavira Nirvana: This is the liberation of Lord Mahavira. Most Jains celebrate the eve of the Hindu New Year with Deepavali, the festival of lights. However, some observe this day as the day of liberation of Lord Mahavira followed by the day of enlightenment of his first disciple Gautam Svami around October. Ayambil: Two periods are observed - see the Fasting section.
Dying	If death is certain and there is nothing to benefit by staying in the hospital, the Jain would prefer to spend the last moments at home. Ideally, the subject would wish for mental detachment of all desires and concentrate on the inner self. Family members or others would assist by reciting text or chanting verses from the canon. As much peace and quiet should be maintained as possible.
Death customs	There are no specific rituals in Jain philosophy for this event. Bodies are always cremated and never buried except for infants. Cremation must be performed as soon as practicable, even within hours if possible. Many Jains still pursue Hindu customs as a family preference. All normal practices of undertakers are acceptable if handled with respect. The family normally provide the dress and accessories for the preparation and final placement in the coffin.
Resources (texts, community facilities, etc.)	The Jain scriptures are called Agamas and although the texts vary according to sects, the basic philosophy is the same. The Jains believe that the mission of the human birth is to achieve liberation from mundane life, and the cycle of death and rebirth. This is achieved through the practice of non-violence and equanimity as preached by Lord Mahavira in the Agamas.
Names	All names are made up of 3 or 4 words in a definite sequence: the person's given name comes first. Sometimes this is appended with a gloss such as -Kumar, -ray, -lal, -chandra, -bhai, -kumari, -bhen etc., that is usually written with the given name but sometimes becomes the second name. The following name (usually the middle) is the father's first name for males and the husband's first name for the females. The last name is the surname or family name, which is usually common to all members of the family.

Jehovah's Witnesses	
Language	English
Diet	While Jehovah's Witnesses believe that Christians are required to abstain from blood and the meat of animals from which blood has not been properly drained, there are no religious restrictions on what they can eat. Use of alcohol is a personal matter.
Fasting	There is no religious requirement of fasting.
Dress	There is no special religious dress.
Physical contact, medical treatment, hospital stays	For deeply held reasons of religious faith there are basically only two medical interventions that Jehovah's Witnesses object to: elective termination of pregnancy and allogeneic blood transfusion. Baptized Jehovah's Witnesses usually carry on their person an Advance Medical Directive/Release document directing that no blood transfusions be given under any circumstances, and this document is renewed annually. A more detailed directive form outlining their personal treatment choices may also be carried. Jehovah's Witness are happy to sign hospital forms that direct that no allogeneic blood transfusion or primary blood components be administered under any circumstances, while releasing doctors, medical personnel and hospitals from liability for any damages that might result from such refusal despite otherwise competent care.
Daily acts of faith and major annual events	Daily activities include reading the Bible. Witnesses commemorate the death of Jesus according to the Hebrew calendar (late March/April). They do not celebrate other traditional festivals, nor do they celebrate birthdays.
Dying	There are no special rituals to perform for those who are dying, nor last rites to be administered to those in extremis. Pastoral visits from elders will be welcomed.
Death customs	An appropriate relative can decide if a limited post mortem is acceptable to determine cause of death. The dead may be buried or cremated, depending on personal or family preferences and local circumstances.
Resources (texts, community facilities etc.)	The Bible
Names	There is no particular tradition.

Jewish	
Language	English is generally used although Hebrew or Yiddish are also spoken.
Diet	Observant Jews are required to uphold the Kashrut, a series of dietary laws. Jews do not eat pork in any form. Fish must have both fins and scales: shellfish is not permitted. Red meat and poultry must comply with kosher standards of slaughter. Meat and milk products must not be cooked together, and separate dishes must be kept. Milk products must not be eaten during or after a meat meal, and most observant Jews will wait three to six hours before dairy products are eaten or drunk. A vegetarian meal is often acceptable, since this ensures no doubt over the utensils used for its preparation, with dairy-free dressings or sauces if available.
Fasting	Yom Kippur is a major annual 25-hour fast observed by the majority of Jews. There are other fast days during the year, which are less widely observed. Jews are not permitted to eat or drink on fast days. Additionally, no leavened bread is eaten during the period of Passover, when unleavened bread known as matzah may be consumed instead.
Dress	Devout Jewish men and women will keep their heads covered at all times. Men wear a hat or skull-cap (the yarmulka or kippa). Orthodox women will wear a hat, scarf or wig. Orthodox women and girls are required to keep the body and limbs covered with modest clothing. Strictly Orthodox men are likely to wear black clothes (sometimes 18th century dress) and may have ringlets and beards.
Physical contact	Strictly Orthodox men and women actively avoid physical contact with people of the opposite sex and will not welcome being comforted by someone touching or putting an arm around them.
Medical treatment	All laws normally applying on the Sabbath or festival can be overruled for the purpose of saving life or safeguarding health. Blood transfusion is permitted and is a matter of personal choice. Transplants and organ donation are usually permissible, but may require advice from a Rabbi.
Hospital stays	A quiet area for prayer should be provided if possible.
Daily acts of faith and major annual events	Practicing Jews say prayers three times a day. The Sabbath (Shabbat) is observed from sunset on Friday evening until sunset on Saturday evening. Prayers and a family meal are part of the observance. The observance of festivals is very important. The major ones are: Days of Awe: Rosh Hashanah (New Year) and Yom Kippur (Day of Atonement) The Three Foot Festivals: Sukkot, Pesach and Shavuot Chanukah Purim Tishah B'Av

Death customs	The prompt and accurate identification of the dead is particularly important for the position of a widow in Jewish law. Post mortems are forbidden unless ordered by the civil authorities. Body parts must be treated with respect and remain with the corpse if possible.
	When a person dies, eyes should be closed and the jaws tied; fingers should be straight. The body is washed and wrapped in a plain white sheet, and placed with the feet towards the doorway. If possible it should not be left unattended. For men a prayer shawl, tallit, is placed around the body and the fringes on the four corners cut off.
	The Chevra Kadisha (Holy Brotherhood) should be notified immediately after death. They will arrange the funeral, if possible before sunset on the day of death, but will not move the body on the Sabbath. Coffins are plain and wooden (without a Christian cross). Someone remains with the body constantly until the funeral. It is not usual to have floral tributes. Orthodox Jews require burial but Reform and Liberal Jews permit cremation.
Resources (texts, community facilities etc.)	The Jewish scriptures are known as the Tanakh and include the Torah, the Nevi'im and the Ketuvim.
Names	Individuals usually have one or more Hebrew names, often taken from Biblical sources, followed by the Hebrew names(s) of their father.

Muslim	
Language	Muslims may speak several languages other than English; the most common are Punjabi, Urdu, Gujarati, Arabic and Turkish.
Diet	Muslims do not eat pork in any form, and foods and utensils that have come into contact with pork should not touch any food to be eaten by a Muslim. Consumption of alcohol in any form (e.g. desserts) is strictly forbidden. Muslims may eat fish, they can eat poultry, mutton and beef, providing the meat is halal, i.e. killed and prepared according to Islamic law. Halal food and drink should be clearly labeled where other food is being served. Vegetarian meals and fresh fruit/vegetables are acceptable. Food is eaten with the right hand only.
Fasting	Muslims fast from dawn to sunset to mark the month of Ramadan, and some will fast at other times during the year. Fasting during Ramadan is compulsory for all except menstruating, pregnant or lactating women, pre-pubescent children and those with medical problems who can be harmed by fasting.
Dress	Observant Muslim women usually have at least a head covering (Hijab), and are often covered from head to toe when in public or in the presence of men who are not family members. Covering the area between the navel and knees is a requirement for Muslim men and some devout male Muslims may prefer to keep their heads covered at all times.
Physical contact	Treatment by medical staff of any religion is permissible, but men and women prefer to be treated by staff of the same sex where possible.
Medical treatment	The views of the family/Imam on whether organ donation, transplants and blood transfusions are acceptable should be sought in each case.
Hospital stays	In hospital, a shower is preferred to a bath. Muslims ritually wash after using the toilet, so a tap or container of water for washing should be provided whenever the toilet area is separate from the bathroom. In a rest center, suitable facilities for pre-prayer washing, time to conduct prayer, and a clean prayer room with a prayer mat and a compass or sign pointing to Makkah (Mecca) are appreciated.
Daily acts of faith and major annual events	Muslims pray five times a day, facing Makkah: before dawn, just after midday, late afternoon, after sunset and late evening. Sunrise and sunset determine the exact timings. Ritual washing (Wudu) is performed before praying. Men and women will not usually pray together, though in emergencies this is acceptable if a temporary partition is erected. Major events in the Muslim 12 month lunar-based calendar are: The First of Muharram: Begins the Islamic New Year Lail-ul-Qadr: A time of fasting and all-night prayer during Ramadan Eid-ul-Fitr: The end of the month of Ramadan. A day of celebration Eid-ul-Adha: The end of the time of the annual Hajj pilgrimage

Dying	If a Muslim is terminally ill or dying, the face should be turned towards Makkah. The patient's head should be above the rest of the body. The dying person will try to say the Shahadah prayer (the testimony of faith).
Death customs	Muslim dead should be placed in body-holding areas or temporary mortuaries, and ideally be kept together in a designated area (with male and female bodies separated). Post mortems are acceptable only where necessary for the issue of a death certificate or if required by the coroner. Ideally only male Muslims should handle a male body, and female Muslims a female body. The body should be laid on a clean surface and covered with a plain cloth, three pieces for a man and five for a woman. The head should be turned on the right shoulder and the face positioned towards Makkah. Detached body parts must be treated with respect. Next of kin or the local Muslim community will make arrangements to prepare the body for burial. Muslims believe in burying their dead and would NEVER cremate a body. Burial takes place quickly, preferably within 72 hours.
Resources (texts, community facilities etc.)	The Qur'an and Hadith (e.g. Hadith Sahih Muslim) are sources of divine guidance for life. The Qur'an, written in Arabic, should not be touched by non-Muslims except with a cloth (translations may be handled by all, with respect), or by menstruating women. Many mosques have private mortuaries, which may be available in an emergency. Clerics and jurists of all denominations classify individual hadith as sahih (authentic), hasan (good) and da'if (weak).
Names	Muslims usually have several personal or religious names. The name of the family into which someone has been born is not necessarily used. Where names are required for record purposes, it is advisable to register the most used personal name as a surname, followed by the lesser used names.

Pagans	
Language	English
Diet	Dietary practice varies but many Pagans are vegetarian and some may be vegan. Dietary choices are, however, a matter for the individual who should be consulted on their preferences.
Fasting	There is no religious requirement of fasting.
Dress	In everyday life, Pagans do not usually wear special forms of dress. Ritual jewelry is however very common and may have deep personal religious significance. In some traditions, the wearing of a ring, which symbolizes the person's adherence to Paganism or a particular Pagan path, is common. The removal of such a ring may cause considerable distress.
Physical contact, medical treatment, hospital stays	There are no specific restraints on types of physical contact and no religious objections to blood transfusion and organ transplants.
Daily acts of faith and major annual events	Private practice: Most Pagans will keep an altar, shrine or a devotional room (often called a temple) in their own homes. Private devotions take place whenever the individual wishes and may include prayer, meditation, chanting, reading of religious texts and ritual. Ritual practice and items used on the Altar in Pagan worship are described below. Group practice: This often occurs on the lunar observance days and on the seasonal festivals celebrated by most Pagans. Many Pagans will celebrate these on the most convenient date rather than on the exact date, although the latter is preferred. Festivals include: Samhain: October 31 Yule (Midwinter): December 21 Imbolc: February 1 Spring Equinox: March 21 Beltane: April 30 Midsummer: June 21 Lammas or Lughnasadh: August 1 Autumn Equinox: September 21

Death customs	Most Pagans believe in reincarnation. The emphasis in funerals is on the joyfulness for the departed in passing on to a new life, but also consolation for relatives and friends that the person will be reborn. Disposal of the body may be by burning (cremation) or burial. Funeral services will take place in crematorium chapels, at the graveside or at the deceased's home. In some traditions, any religious items of significance to the deceased must be buried or burned with the body. Ritual jewelry, personal ritual items such as the Witch's athame, and the person's religious writings (such as the Book of Shadows) are commonly buried with or burned with the body. A wake (mourning ceremony) carried out around the body by friends and relatives is common in some traditions.
Resources (texts, community facilities etc.)	Resources vary by locality.
Names	There are no specific directions as to use of names.

Rastafarians	
Language	The vocabulary is largely that of the Jamaican patois of English.
Diet	Most Rastafarians are vegetarian and avoid stimulants such as alcohol, tea and coffee. Sacred food is called I-TAL (organic vegetarian food). Some Rastafarians will eat fish, but only certain types.
Fasting	Fasting is observed, and can take place at any time. Nothing is consumed from noon until evening.
Dress	Rastafarians wear standard Western dress, except that some Rasta men will wear crowns or tams (hats) and Rasta women, wraps (headscarves). The wearing of headwear can be deemed as part of a Rastafarian's attire, with some Rastafarian men and especially women never uncovering their heads in public.
Physical contact, medical treatment, hospital stays	Cutting of hair is prohibited in any circumstance. Dreadlocks symbolize the 'mane of the Lion of Judah' (reference to the divine title of Emperor Haile Selassie). In a medical emergency this issue would need to be discussed with the patient.
Daily acts of faith and major annual events	Worship takes place at various times depending upon each Rastafarian commune. A service is conducted at least once a week. Rastafarians consider Saturday to be the Sabbath day. Nyahbinghi drumming and chanting is an important part of Rastafarian culture. It is used for spiritual upliftment and can last for many days. At the start of this spiritual time a Firekey also takes place: a fire is lit and must be kept burning until the drumming and chanting have stopped. Festivals include: Ethiopian Constitution Day (July 16) Birthday of Haile Selassie (July 23): One of the holiest days of the Rastafarian year Birthday of Marcus Garvey (August 17) Ethiopian New Year's Day (early September): A four-year cycle, with each year named after a Biblical evangelist. Anniversary of the crowning of Haile Selassie/Ethiopian Christmas: November 2
Dying Death customs	There are no particular rituals observed. The dying person will wish to pray. When a Rastafarian person passes (dies) a gathering takes place where there is drumming, singing, scriptures read and praises given. Usual on 9th and or 40th night of person passing.
Resources (texts, community facilities etc.)	DVD resources include: Time and Judgment (by Ras Menelik); The Journey of the Lion (by Brother Howie). CD resources include: Churchial Chants of the Nyahbinghi; Prince Teban and the Sons of Thunder communication drumming. Information about Rastafarianism can be found at www.encyclopedia.thefreedictionary.com/Rastafarianism
Names	There is no particular tradition. Older men may take the prefix Jah or Ras.

Seventh-day Adventists	
Language	English
Diet	Seventh-day Adventists do not smoke, drink alcohol or use non-medicinal drugs. Some even avoid foods and drinks containing caffeine and other stimulants. Many are vegetarian but those that do eat meat avoid pork or shellfish products. Some are vegan.
Fasting	Some Adventists may have a personal period of fasting in conjunction with special prayer projects.
Dress	There is no special dress.
Physical contact, medical treatment, hospital stays	In a rest center, provision of vegetarian food from outlets not handling meat would be required. Provision of a room for Sabbath worship would be requested, and access to a Bible.
Daily acts of faith and major annual events	The Seventh-day Adventist Sabbath is kept from sunset on Friday to sunset on Saturday. It is a day of rest and worship, when Adventists like to practice fellowship and worship together. During this time most Adventists avoid secular activities such as watching television. Communion, or the Eucharist, is celebrated once every three months. Adventists celebrate Christmas and Easter as commemorative events, usually marking the occasions by a special service on the closest Sabbath day.
Dying	Adventists would prefer to have an Adventist clergyman or woman present when facing death. However they would appreciate general prayers and other spiritual care from clergy of other Christian denominations if Adventist clergy were not available. Adventists do not hold the sacraments as required rituals; hence Sacrament of the Sick would not be necessary.
Death customs	Cremation or burial is a matter of personal or family preference.
Resources (texts, community facilities etc.)	As with other Christians, Adventists accept the Bible as the inspired word of God.
Names	There are no particular traditions.

Shinto	
Shinto is Japan's indigenous religion: a complex of ancient folk belief and rituals which perceive the presence of gods or of the sacred in animals, in plants, and even in things which have no life, such as stones and waterfalls. As well as Shinto, individuals of Japanese origin may adhere to Buddhism.	
Language	Japanese and English
Diet	Rice is a staple in the Japanese diet. Other diet elements vary.
Fasting	There is not a custom of fasting.
Dress	There are no religious requirements for the form of every day dress. For particular annual events such as New Year's Day and the Bon Festival (and for local shrine festivals in Japan) some wear traditional dress (kimono).
Physical contact	When undergoing medical examination and treatment or being comforted by strangers, Japanese people would prefer to be touched by a person of the same sex.
Medical treatment	There are no religious objections to blood transfusions or transplants.
Hospital stays	During hospital stays, baths are considered preferable to showers and the bathroom should be separated from the toilet.
Daily acts of faith and major annual events	Shinto has little theology and no congregational worship. Its unifying concept is Kami, inadequately translated as "god". There are no Shinto prayers as such but many Japanese will follow Buddhist meditative practices. In addition to Buddhist festivals, Shintonists will celebrate: New Year: 1 January Bon Festival: Respect to ancestors (13-16 August)
Dying	Dying Japanese will wish to meditate.
Death customs	Generally Japanese would prefer cremation to burial. Funeral services are administered according to Buddhist rites.
Resources (texts, community facilities etc.)	There are no specific Shinto texts. See Buddhism. Those requiring further information on Shinto should contact the Japanese Embassy or the International Shinto Foundation (www.shinto.org).
Names	It is usual for Japanese people to have two names. The first may be the family name and the second may be the given name. When names are required for record purposes it is advisable to ask for the family name and to use this as the surname.

Sikh	
Language	The Punjabi and English languages are widely spoken and used. Swahili, Urdu and Hindi may be understood.
Diet	Dietary practice varies, but devout Sikhs do not use tobacco, alcohol or drugs and are vegetarians, who will also exclude eggs. Those who do eat meat, fish and eggs will refrain from eating beef, halal and kosher meat. Salads, rice, dahl (lentils), vegetables and fruit are generally acceptable.
Dress	All initiated male Sikhs wear the five K symbols: Kesh (uncut hair); Kangha (a comb to keep the hair neat); Kara (a steel bangle which symbolizes the unity of God); Kirpan (a short dagger which symbolizes the readiness of the Sikh to fight against injustice); and Kachhera (breeches or shorts to symbolize modesty). Women will wear all others except for the Turban, obligatory for men, it is optional for women who may instead wear a chunni (a long Punjabi scarf) to cover the Kesh. The removal of the Turban or the Kachhera will cause great embarrassment to a Sikh and should be avoided.
Physical contact	Treatment by medical staff of any religion is permissible, but men and women prefer to be treated by staff of the same sex where possible.
Medical treatment	There are no specific medical requirements and no religious objections to blood transfusion and organ transplants. The views of the family/ individual concerned should be sought.
Hospital stays	A Sikh in hospital may wish to have all five faith symbols within reach. Kachhera (shorts) should on no account be changed or removed other than by the individual concerned. A shower is preferred to a bath. Sikhs wash after using the toilet, so access to a tap and a container of water for washing should be provided in the toilet area.
Daily acts of faith and ma-jor annual events	Sikhs are required to shower or bathe daily, especially before conducting their dawn prayers. Prayers are said three times a day: at sunrise, sunset and before going to bed. Festivals are normally celebrated with a continuous reading of the Guru Granth Sahib (Holy Scriptures) over a period of 48 hours. Major annual festivals are:Guru Nanak's Birthday: A three-day celebration The Martyrdom of Guru Tegh Bahadur Guru Gobind Singh's Birthday The Martyrdom of Guru Arjan Dev Baisakhi Divali
Dying	The dying person will want to have access to the Sikh scriptures where possible.

Death customs	The five Ks should be left on the dead body, which should, if possible, be cleaned and clothed, in clean garments before being placed in a coffin or on a bier. According to Sikh etiquette, comforting a member of the opposite sex by physical contact should be avoided, unless those involved are closely related. Deliberate expressions of grief or mourning by bereaved relatives are discouraged, though the bereaved will want to seek comfort from the Sikh scriptures. The dead person should always be cremated, with a close relative lighting the funeral pyre or activating the machinery. This may be carried out at any convenient time. The ashes of the deceased may be disposed of through immersion in flowing water or dispersal.
Resources (texts, community facilities etc.)	The Sikh Scriptures (Adi Granth) are treated with the utmost respect and reverence. Additionally, Sikhs may refer to the writings of Guru Gobind Singh (Dasam Granth) and the Sikh Code of Conduct (Rahit Maryada).
Names	Sikhs generally have three names: their given name; a title (Singh (Lion) for all males and Kaur (Princess) for all females); and a family name. Where names are required for records, the family name can tactfully be asked for, bearing in mind that Sikhs generally prefer to use and will usually offer, their first name alone or their first name together with their title (Singh or Kaur).

Zoroastrian (Parsee)	
Language	English, Persian or Farsi.
Diet	Zoroastrians have no particular dietary requirements. They are not vegetarian.
Fasting	On certain days in the year, Zoroastrians may abstain from meat.
Dress	Zoroastrians almost always wear western clothes. Traditional dress is for ceremonial occasions only. As part of their inner garments, most adult Zoroastrians will wear a vest made of fine muslin cloth called a Sudra. They also tie a girdle around the waist and this is called the Kusti. It is important to wear a clean Sudra, to change it daily and to remove it only for medical reasons.
Physical contact, medical treatment, hospital stays	It is believed that many Zoroastrians are prone to Glucose-6-Phosphate Dehydrogenase deficiency, a common human enzyme deficiency. There are no taboos on medical treatment or physical contact.
Daily acts of faith and major annual events	Zoroastrians should untie their girdle and tie it back whilst saying their prayers, at least once a day. They may wish to cover their head whilst praying. Zoroastrians follow two different calendars; some follow the Shenshai calendar and others the Fasli calendar. Main days of observance include: Jamshedi Noruz (Fasli): New Year's Day according to the Fasli calendar used in Iran. Khordad Sal (Fasli) Farvandigan (Fasli) Zartusht-no-Diso (Shenshai) Farvardigan No Ruz (Shenshai): New Year's Day on the Shenshai calendar. Khordad Sal (Shenshai) Fravardin (Shenshai) Zartusht-no-Diso (Fasli)
Dying Death customs	Zoroastrians prefer to die quietly and without being disturbed. Zoroastrians may be either cremated or buried. It is important to dispose of the body as soon as possible after required paperwork and prayers for the dead have been performed. At least one priest should perform these prayers, which can last for about one hour, prior to the funeral.
Resources (texts, community facilities etc.)	Resources vary by locality.
Names	Each Zoroastrian has one first name. The father's name appears as the second name. The family name serves as the surname.

FACT SHEET: DEATH CERTIFICATES

ABOUT DEATH CERTIFICATES
- Permanent legal record of fact and cause of death.
- Identifies deceased individual.
- Includes demographic information of the deceased.
- Specifies final disposition of the decedent.
- Specifies the cause of death of the deceased.
- Provides information about the funeral director and medical certifier completing the record.
- Used for both administrative and public health analytical needs.
- Necessary for the family to handle the business matters of the decedent.
- Source of mortality statistics at national and jurisdictional levels.
- Data used to:
    - o Allocate research and development funding.
    - o Establish goals related to public health.
    - o Impact policy.
    - o Measure health status.

FACTS ABOUT SIGNING THE DEATH CERTIFICATE
- Physicians must complete the medical portion of the death certificate within 15 hours of the death event.
- The causes of death are the physician's opinion regarding the death.
- The physician is legally responsible to complete the medical portion of the death certificate.
- The causes of death on the death certificate are not legally binding in and of themselves; the entire death certificate is the legal document.
- The physician is not obligated to sign the death certificate if he/she determines that there was possibly something unnatural about the cause of death – these should be referred to the Coroner.

WEBSITES
Death certificate information for Long Beach, Pasadena, and Los Angeles County
- http://www.publichealth.lacounty.gov/dca/dcadeath.htm
- http://www.longbeach.gov/health/records.asp
- http://www.ci.pasadena.ca.us/PublicHealth/Vitalrecords/

Instructions for Completing the Cause-of-Death Section of the Death Certificate, CDC
National Center for Health Statistics
- http://www.cdc.gov/nchs/data/dvs/blue_form.pdf

SAMPLE CA-EDRS DEATH CERTIFICATE

CERTIFICATE OF DEATH
STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV 1/94)

3200719000334

STATE FILE NUMBER	LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT — FIRST (Given)	2. MIDDLE	3. LAST (Family)
SEVEN BUMBLE	FLOWER	BEE

AKA, ALSO KNOWN AS — Include full AKA (FIRST, MIDDLE, LAST)	4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs.	IF UNDER ONE YEAR Months / Days	IF UNDER 24 HOURS Hours / Minutes	6. SEX
LUCKY	05/05/1925	82			F

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS (at Time of Death)	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 Hours)
CA	451-28-9657	YES [X] NO UNK	WIDOWED	06/21/2007	0421

13. EDUCATION — Highest Level Degree (see worksheet on back)	14/15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet on back)	16. DECEDENT'S RACE — Up to 3 races may be listed (see worksheet on back)
BACHELOR	YES [X] NO	WHITE

17. USUAL OCCUPATION — Type of work for most of life. DO NOT USE RETIRED	18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	19. YEARS IN OCCUPATION
ACTRESS	MOVIE INDUSTRY	80

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number or location)
7 LUCKY LN

21. CITY	22. COUNTY/PROVINCE	23. ZIP CODE	24. YEARS IN COUNTY	25. STATE/FOREIGN COUNTRY
LUCKY CITY	LOS ANGELES	45789	80	CA

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP)
FLOWER ROSE, FRIEND	56 DAISY DR, FLOWER CITY, CA 45789

SPOUSE AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE — FIRST	29. MIDDLE	30. LAST (Maiden Name)
-	-	-

31. NAME OF FATHER — FIRST	32. MIDDLE	33. LAST	34. BIRTH STATE
SEVEN	BUMBLE	BEE	CA

35. NAME OF MOTHER — FIRST	36. MIDDLE	37. LAST (Maiden)	38. BIRTH STATE
WHITE	YELLOW	DAISY	CA

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION
06/30/2007	BEE CEMETERY 1 CEMETERY LN, CEMETERY CITY, CA 45789

41. TYPE OF DISPOSITION(S)	42. SIGNATURE OF EMBALMER	43. LICENSE NUMBER
BURIAL	▶ NOT EMBALMED	-

44. NAME OF FUNERAL ESTABLISHMENT	45. LICENSE NUMBER	46. SIGNATURE OF LOCAL REGISTRAR	47. DATE mm/dd/ccyy
BEE FUNERAL HOME	4578	▶ JONATHAN FIELDING, MD	06/29/2007

PLACE OF DEATH

101. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
LAC/USC MEDICAL CENTER	IP [X] ER/OP DOA	Hospice / Nursing Home/LTC / Decedent's Home / Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location)	106. CITY
LOS ANGELES	1200 N. STATE ST.	LOS ANGELES

CAUSE OF DEATH

107. CAUSE OF DEATH	Enter the chain of events — diseases, injuries, or complications — that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.	Time Interval Between Onset and Death	108. DEATH REPORTED TO CORONER?
IMMEDIATE CAUSE (Final disease or condition resulting in death) → (A) GUNSHOT TO THE HEAD		(A) RAPID	[X] YES / NO — FEDERAL NUMBER 2007-00909
Sequentially list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST → (B)		(BT)	109. BIOPSY PERFORMED? YES [X] NO
(C)		(CT)	110. AUTOPSY PERFORMED? [X] YES NO
(D)		(DT)	111. USED IN DETERMINING CAUSE? [X] YES NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107
NONE

PHYSICIAN'S CERTIFICATION

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)	113A. IF FEMALE, PREGNANT IN LAST YEAR?
NO	[X] YES / NO / UNK

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. Decedent Attended Since (A) mm/dd/ccyy / Decedent Last Seen Alive (B) mm/dd/ccyy	115. SIGNATURE AND TITLE OF CERTIFIER ▶	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
	118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE		

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED FROM THE CAUSES STATED. MANNER OF DEATH: Natural / Accident / [X] Homicide / Suicide / Pending Investigation / Could not be determined	120. INJURED AT WORK? YES [X] NO UNK	121. INJURY DATE mm/dd/ccyy	122. HOUR (24 Hours)
		06/24/2007	1234

123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)
HOME

124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)
SHOT BY ANOTHER

125. LOCATION OF INJURY (Street and number, or location, and city, and ZIP)
1234 MAIN ST., LOS ANGELES, CA 90001

126. SIGNATURE OF CORONER / DEPUTY CORONER ▶ MARIA CAMPOS	127. DATE mm/dd/ccyy 06/25/2007	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER MARIA CAMPOS

STATE REGISTRAR	A	B	C	D	E		FAX AUTH. #	CENSUS TRACT

012007000010495

FACT SHEET: CA-EDRS

CA-EDRS FEATURES

- Electronic filing of death certificates
- On-line collaboration among multiple death registration system users (funeral directors, medical facilities, local registrar, state registrar, etc.)
- User-friendly death record data entry screens
- Electronic signatures for embalmer, physician, coroner staff, and local registrar.
- Built-in instructions and on-line help
- Internet accessibility
- Electronic authentication (User IDs/passwords)

CA-EDRS BENEFITS

- Improved efficiency and timeliness in processing of the death certificate
- Document tracking – records are transferred electronically with unique record number
- Higher quality of data (internal data checks)
- Electronic signatures (coroner, physicians, funeral directors, medical facility staff, local registrar)
- Internet accessibility
- Disposition/burial permits printed at funeral homes, thereby expediting services for families
- Reduced number of amendments and duplicates due to error checks

USING CA-EDRS DURING A MASS FATALITY INCIDENT/EVENT

- Death certificate processing does not change during a mass fatality incident; if all electronic systems are rendered unavailable, paper process will be used.
- Using CA-EDRS will expedite death certificate processing; mutual aid from surrounding counties and the State is likely during a mass fatality incident.
- Hospitals that have staff trained to use CA-EDRS will be able to process death certificates more expediently.
- NOTE: CA-EDRS accounts require training – no accounts will be issued on an emergency basis. For information on CA-EDRS training classes, please call the Los Angeles County Department of Public Health's Data Collection & Analysis Unit at (213) 240-7785.
- Once the hospital has completed the decedent's name, date of death, hour of death, causes of death, and has obtained the physician signature, the hospital can then forward the record to a mortuary or the Coroner.

WEBSITES

- CA-EDRS Training modules (for reference only): http://www.edrs.us/training.jsp
- CA-EDRS login page: https://ca.edrs.us
- CA-EDRS homepage/general information: http://www.edrs.us
- Los Angeles County Vital Records Office: http://www.ph.lacounty.gov/dca/edrs.htm

EDRS Policy Sheet
Los Angeles/Long Beach/Pasadena Jurisdictions

EDRS Filing Hours, Monday-Friday
Los Angeles: 8:30 AM - 4:00 PM
Long Beach: 8:00 AM - 4:00 PM
Pasadena: 8:00 AM - 4:30 PM (Health Dept closed every other Friday)

Emergency/Weekend Filing
Los Angeles: Saturday-Sunday, 8:30 AM-12:30 PM at Headquarters (313 N. Figueroa St.)
Long Beach: Saturday-Sunday, certain holidays, 8-4 PM. Please call (562) 435-6711.
Pasadena: Staff will be available on call, every other Friday, weekends and holiday.

Processing Time
Please allow up to 2 **business** hours for Medical Information Review (MI Review) and Local Registration (SUBM LR) after submission.

Funeral Home Responsibilities
① Social Security Verification - EDRS requires that SSV be attempted at least ONCE before submitting for registration whether SSN is known or unknown.
② Medical Review - VS11e, 101-117 must be submitted for medical review prior to physician attestation or coroner attestation. If a document has not been submitted for MI Review, it will not be registered.
③ Disposition permit - Funeral home is responsible for completing an EDRS Disposition Permit (DP) and Death Certificate (DC) for registration. Once the DC is registered and the DP is issued, the Funeral Home must print all four (4) copies of the DP. The funeral director must then submit a signed Copy #4 with payment to the appropriate jurisdiction's Vital Records Office. This payment must be placed in the mail within 24 hrs of the issuance, or received within 72 hrs (mail or walk-in).

EDRS Record Correction/Notification
If you are requesting record correction for any of the following reasons, you must **FAX** a completed EDRS Fax Communication sheet to the appropriate jurisdiction:
- Abandon EDRS record
- Unlock PI, MI, or Both on EDRS record
- Multiple disposition EDRS filing
- EDRS file/Permit with drop to paper certificate
- Ship out/International Disposition

Fax numbers:
- Los Angeles: 323-722-9851
- Long Beach: 562-570-4374
- Pasadena: 626-744-6095

Amendments
If a record has been registered by the Local Registrar (EDRS status = SUBM SR), an amendment must be filed to correct the record.

Re-file Permit
If a DC has been registered and a re-file is needed to change the disposition, the funeral home can create a re-file Permit/Amendments in EDRS. Please notify the Vital Records Office via the EDRS Fax Communication sheet.

ME/Coroner Protocol
Please refer to LAC ME/Coroner Workflow that is in the EDRS training packet. The workflow is also available at the Los Angeles County Dept of Public Health's website: www.lapublichealth.org/dca/edrs.htm

Certified Copies
Certified copies will be requested in the same manner as they were prior to EDRS. An application for a certified copy of a Death Certificate must be submitted with appropriate fees to the Health Department. Payment for the Disposition Permit must be made before certified copies are issued.

Time Interval Abbreviations
Second(s) - SEC or SECS
Minutes(s) - MIN or MINS
Hour(s) - HR or HRS

Day(s) - DAY or DAYS
Weeks - WK or WKS
Year(s) - YR or YRS

Month(s) - MO or MOS
Immediate - IMMED

All non-EDRS death certificate filings must take place in person at the respective Vital Records Office's headquarters. These certificates will be processed on a first come, first serve basis. Fax filing and Cross Filing will be discontinued.

CA-EDRS Help Desk (State): (916) 552-8123
CA-EDRS website: www.edrs.us
LA Dept of Public Health's EDRS website: www.lapublichealth.org/dca/edrs.htm

Note: All policies subject to revision. Last updated 09/28/2011

FACT SHEET: COUNTY PUBLIC ADMINISTRATOR

The Public Administrator for the County of Los Angeles has a staff of deputies to provide administration of the estates of decedents who were residents of Los Angeles County. The powers of the Public Administrator are mandated by the Probate Code of the State of California.

The Public Administrator should be notified by anyone (mortuary, convalescent facility, hospital or private citizen) who has knowledge of an estate of a decedent under the following circumstances:

1. Where there are no known heirs.
2. When no executor or administrator has been appointed and the estate is being wasted, uncared for or lost.
3. When the named executor of a Will fails to act and the court appoints the Public Administrator.
4. When the Will names the Public Administrator as the estate administrator.

When an heir, or heirs, wish to have the Public Administrator administer the estate for them.

To report such an estate you may call the Investigation Unit of the Public Administrator's Office at 213-974-0460 or TTY: 213-628-4010. An investigator will be available to provide assistance in determining the need for the Public Administrator to administer the estate.

http://ttc.lacounty.gov/Proptax/PA_openning.htm

FACT SHEET: HEALTH RISKS

Victims of natural disasters, accidents, or WMD events usually die from trauma and are unlikely to have acute or 'epidemic-causing' infections. In the event of an intentional release of a biological agent or natural pandemic resulting in mass casualties, the risk is greater from live victims rather than the deceased. The microorganisms responsible for these diseases have limited ability to survive in a body that is cooling after death.

BASIC INFECTION CONTROL FOR STAFF HANDLING HUMAN REMAINS

The safety of personnel performing these functions is paramount.
Measures should be taken to reduce the risk of infection or exposure associated with handling decedents
- Standard precautions are essential for those handling decedents; avoid exposure to potential pathogens and via wounds/punctures or mucus membranes. Follow standard precautions for blood and body fluids.
- Other PPE such as eyewear, gowns, and masks, may be required where large quantities or splashes of blood or body fluids are anticipated.
- Appropriately dispose of used protective equipment such as gloves or other garments
- Avoid cross-contamination: personal items should not be handled while wearing soiled gloves. Hand washing is essential.
- In HazMat or WMD events, the appropriate level of PPE is required depending on the agent.
- Vehicles used for transportation should be washed carefully with a disinfectant or decontaminated if appropriate.
- Human remains pouches will further reduce the risk of infection and are useful for the transport of decedents that have been badly damaged. Wrapping with plastic and a sheet may be an economical and practical containment solution.

FACT SHEET: RECOMMENDATIONS

All delays between the death and autopsy hinder the medicolegal processes. 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, and next of kin notification.

WHY REFRIGERATION IS HIGHLY RECOMMENDED

- Most hospital morgues' refrigeration capacity will be exceeded during a disaster, especially if there are many unidentified decedents or remains recovered in the first hours of the event.
- Refrigeration between 38° and 42° Fahrenheit is the best option.
- Large refrigerated transport containers used by commercial shipping companies can be used to store up to 30 bodies. (Laying flat on the floor with walkway between).
    - o Enough containers are seldom available at the disaster site.
    - o Consider lightweight temporary racking systems. These can increase each container or room's capacity by 3 times.
- Refrigeration does not halt decomposition, it only delays it.
    - o Will preserve a decedent for 1-3 months.
    - o Humidity also plays a role in decomposition. Refrigeration units should be maintained at low humidity.
    - o Mold can become a problem on refrigerated bodies making visual identification impossible and interfering with medicolegal processes.

WHY DRY ICE IS AN ACCEPTABLE RECOMMENDATION

Dry ice (carbon dioxide (CO_2) frozen at –78.5° Celsius) may be suitable for short-term storage.
- Use by building a low wall of dry ice around groups of about 20 decedents and then covering with a plastic sheet.
- About 22 lbs of dry ice per remains, per day is needed, depending on the outside temperature.
- Dry ice should not be placed on top of remains, even when wrapped, because it damages the decedent.
- 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. The area needs good ventilation.

FACT SHEET: NOT RECOMMENDED

WHY STACKING IS NOT RECOMMENDED

- Demonstrates a lack of respect for individuals.
- The placement of one body on top of another in cold or freezing temperatures can distort the faces of the victims, a condition which is difficult to reverse and impedes visual identification.
- Decedents are difficult to manage if stacked. Individual tags are difficult to read and decedents on the bottom can not be easily removed.

WHY FREEZING IS NOT RECOMMENDED

- Freezing causes tissues to dehydrate, which changes their color; this can have a negative impact on the interpretation of injuries, as well as on attempts at visual recognition by family members.
- Rapid freezing of bodies can cause post-mortem injury, including cranial fracture.
- Handling decedents when they are frozen can also cause fracture, which will negatively influence the investigation and make the medicolegal interpretation of the examination results difficult.
- The process of freezing and thawing will accelerate decomposition of the remains.

WHY ICE RINKS ARE NOT RECOMMENDED

- Ice rinks are frequently brought up as possible storage sites. As previously mentioned, freezing has several undesirable consequences.
- A body laid on ice is only partially frozen. It eventually will stick to the ice making movement of the decedent difficult.
- Management and movement of decedents on solid ground is challenging in good circumstances. Workers having to negotiate ice walkways would pose an unacceptable safely risk.

WHY PACKING IN ICE IS NOT RECOMMENDED

- Difficult to manage due to ice weight and transport issues.
- Large amounts are necessary to preserve a decedent even for a short time.
- Difficult to resource or obtain during an emergency.
- Ice is often a priority for emergency medical units.
- Results in large areas of run off water.

FACT SHEET: CONSIDERATIONS

PACKING WITH CHEMICALS

- Some substances may be used to pack a decedent for a short period. These chemicals have strong odors and can be irritating to workers.
- Powdered formaldehyde and powdered calcium hydroxide may be useful for preserving fragmented remains. After these substances are applied, the decedent or fragments are wrapped in several nylon or plastic bags and sealed completely.

EMBALMING AND TEMPORARY BURIAL

Embalming is:
- the most common preservation method.
- not possible when the integrity of a corpse is compromised, i.e., it is decomposed or in fragments.
- to be performed by a licensed professional with knowledge of anatomy and chemistry.
- expensive; considerable time involved for each case.
- used to preserve a body for more than 72 hours after death.
- required for the repatriation or transfer of a corpse out of a country.

Temporary burial is:
- not a mass grave.
- a good option for immediate storage where no other method is available, or where longer-term temporary storage is needed.
- an option that might be considered when there will be a great delay in final disposition.
- Temperature underground is lower than at the surface, thereby providing natural refrigeration.

Additional temporary burial information:
- Temporary burial sites should be constructed in the following way to help ensure future location and recover of bodies. Trench burial for larger numbers.
- Burial should be 5 feet deep and at least 600 feet from drinking water sources.
- Leave 1 foot between decedents. Lay decedents in one layer only. Do not stack. Clearly mark each decedent and mark their positions at ground level.
- Each decedent must be labeled with a metal or plastic identification tag.
- The Coroner is the only entity that can authorize temporary burial.

FACT SHEET: DECOMPOSITION

DEFINITION

Definition

Decomposition is the disintegration of body tissues after death, and begins at the moment of death.

CAUSE OF DECOMPOSITION

The following processes release gases that are the chief source of the characteristic odor of decdents as well as cause the decedent to swell:
- Autolysis: self dissolution by body enzymes released from disintegrating cells
- Putrefaction: action of bacteria and other microorganisms
- Anthropophagy: insects and animals

FACTORS THAT AFFECT DECOMPOSITION

- Temperature
- Humidity or dryness
- The surface where the body lies
- Burial
- Wrapping
- Insect and scavenger activity
- Indoors vs outdoors
- Water
- Fire
- Condition of the person prior to death

GLOSSARY

After-Action Report – Principal post-exercise document that provides a historical record of findings and forms the basis for refinements to plans, policies, procedures, training, equipment, and overall preparedness of an entity. After-Action Reports describe preliminary observations, major issues, and recommendations for improvements.

Autopsy – Medical examination of a corpse, by which a specialist determines the cause and manner of death.

Biohazard – Biological agent or condition (e.g., an infectious organism or insecure laboratory procedures) that constitutes a hazard to humans, animals and/or the environment.

Body recovery – Measures taken to locate bodies, remove them from a disaster site, and identify them.

Casket or coffin – General terms for the box used to bury a body.

Corpse removal or recovery – Complex procedure that consists of the survey and examination of bodies at a disaster site, and the transfer of the bodies and body parts.

Cremation – Process that reduces a corpse and its coffin to ashes and small bone fragments with the use of intense heat. The heat evaporates the water, burning the soft tissues, and reduces the bones to 4-8 pounds of ash and fragments.

Critical Incident Stress Debriefing – "Mitchell model" (Mitchell and Everly, 1996), a 7-phase, structured group discussion, usually provided 1 to 10 days post-crisis. It is designed to mitigate acute symptoms, assess the need for follow-up, and if possible, provide a sense of post-crisis psychological closure for responders.

Critical Incident Stress Management – Integrated system of interventions designed to prevent and/or mitigate the adverse psychological reactions that often accompany emergency services, public safety, and disaster response functions.

Death certificate – Documented proof of the death of someone; a legal instrument which includes the victim's name, age, sex, the cause and manner of death, the hour and date of death, and the name of the professional who confirms the death. In theory, no one can be considered dead until the respective death certificate is issued.

Death – Legal definition of death is the complete loss of function of the cerebral neo-cortex and brain stem.

Dental chart – Record of teeth used for the purpose of identification.

Department Operations Center – The location from which department management supervise and coordinate field response.

Disaster – A serious disruption of the functioning of society, causing widespread human, material or environmental losses, which exceed the ability of affected society to cope using only its own resources. Disasters are often classified according to their cause (natural or man-made).

Early warning (for disease surveillance) – System established to report, in a timely fashion, whether an affected area presents a complex of symptoms of illnesses. Data collected form

the basis for a more thorough investigation, and, if necessary, specific control measures are implemented.

Embalming – Procedure using chemicals and disinfectants to preserve a body for more than 72 hours after death.

Emergency Operations Center – Site from which civil government officials (municipal, county, state, and Federal) or senior private sector administrators (e.g. Clinic Emergency Operations Center) exercise direction and control in an emergency.

Endemic – Characteristic of a place or region. In epidemiology it is the usual number of cases of a disease that occur in given population in a given time.

Epidemic – Disproportionate increase in the number of cases of a disease in a locality or region.

Epidemiologic surveillance – A notification system that makes it possible to identify outbreaks and to rapidly implement necessary control measures. In disaster situations a local surveillance system is based on the recognition of disease symptoms and should be faster and more flexible than the surveillance used in normal conditions.

Exhumation – Removal of a body from its grave; usually done to carry out examination or to bury it in another place.

Family Assistance Center – Established collection point of family members of victims resulting from a mass fatality or mass casualty incident/event. The Family Assistance Center seeks to provide a private place for families to grieve;

protect families from the media and curiosity seekers; facilitate information exchange between key government agencies and families so that families are kept informed and information can be obtained that will assist in identifying the victims.

Family Information Center – A healthcare entity Family Information Center is a place where decedent and victim family members can go, within the healthcare facility, to obtain additional information and services regarding the incident, such as incident updates, counseling and faith/spiritual support.

Field – Slang term for pre-hospital care area, e.g. used in the field.

Funeral – Rite of passage that has two connotations: for the deceased it is the transition between life and death (conceived as "heaven," "spiritual world," or "afterlife"), and for the survivor it implies the loss of the deceased and corresponding roles and status, as well as the assumption of new roles.

Hospital Command Center – Location of the command staff as defined by HICS.

Incident Action Plan – A planning tool used in major incident management. Can be referred to as an Event Action Plan for planned events.

Interment – Burial and lay or religious ceremonies that accompany it.

Joint Information Center – Location from where local, state, and federal public information officers gather to produce and release information regarding an incident to the media and the public.

Joint Information System – Integrates incident information and public affairs into a cohesive organization designed to provide consistent, coordinated, accurate, accessible, timely, and complete information during crisis or incident operations. The mission of the Joint Information System is to provide a structure and system for developing and delivering coordinated inter-agency messages; developing, recommending, and executing public information plans and strategies.

Mass Casualty Incident – The Los Angeles County EMS Agency (Department of Health Services) defines an Mass Casualty Incident as the combination of numbers of ill/injured patients and the type of injuries going beyond the capability of an entity's normal first response.

Mass Fatality Incident – A Mass Fatality Incident is a surge of deaths above what is normally managed by normal medicolegal systems.

Mass grave – Indiscriminate burial of more than two bodies in the same hole. No identification is made of the bodies buried.

Medical Alert Center (MAC) – Assists provider agencies and basehospitals with patient destination decisions and multiple casualty incidents. It serves as the controlpoint for VMED28 and ReddiNet systems.

Morgue – Place where bodies are temporarily deposited until final disposal is decided on.

Post-traumatic stress – Psychological syndrome that appears as a delayed reaction to exceptionally threatening or catastrophic events.

ReddiNet – ReddiNet is a dedicated emergency medical communications network. It facilitates information exchange among hospitals, EMS agencies, paramedics, dispatch centers, public health officials and other health care system professionals in local and regional communities.

Religion – Set of formally established doctrines of faith.

Rite/ritual – Symbolic use of movements and body gestures to express and ascribe meaning to a social situation.

Sacred ground – Area where it is impossible to remove the human remains following a disaster (burial by landslides, building collapse or other similar circumstances), and declared by authorities to be sacrosanct. This also refers in general terms to cemeteries.

Temporary interment – A site for the purpose of the interment of the remains if the circumstances permit; or the reburial of remains exhumed from an emergency interment.

Transitory preservation – Process that attempts to preserve the condition of a corpse during the first 24 to 72 hours after death.

Vigil/wake – Practice of accompanying, or "watching" the body before its burial, either in its home or at a funeral establishment. Its aim is to make a difficult situation more bearable, and when the coffin is open, to see a person's body for the last time.

Vulnerability – The conditions determined by physical, social, economic, and environmental factors or processes, which increase the susceptibility of a community to the impact of hazards.

ACRONYMS

AQMD
Air Quality Management District

CA-EDRS
California Electronic Death Registration System

CAL EMA
California Emergency Management Agency

CCC
Coordinated Communications Center

CDC
U.S. Centers for Disease Control and Prevention

CDPH
California Department of Public Health

CFR
Code of Federal Regulations

CO2
Carbon Dioxide

CWIRS
County-wide Integrated Radio System

DHS
Department of Health Services

DHHS
U.S. Department of Health and Human Services

DMAT
Disaster Medical Assistance Teams

DMORT
Disaster Mortuary Operational Response Teams

DOB
Date of Birth

DOC
Department Operations Center

DOE
Date of Expiration

DPH
Department of Public Health

DRC
Disaster Resource Center

ED
Emergency Department

EMS
Emergency Medical Services

ENLA
Emergency Network Los Angeles

EOC
Emergency Operations Center

FAC
Family Assistance Center

FEMA
U.S. Federal Emergency Management Agency

FIC
Family Information Center

FY
Fiscal Year

HCC
Hospital Command Center

HIPAA
Health Insurance Portability and Accountability Act

HICS
Hospital Incident Command System

HPP
Hospital Preparedness Program

HSEEP
Homeland Security Exercise and Evaluation Program

ICS
Incident Command System

JEOC
Joint Emergency Operations Center

JIC
Joint Information Center

JIS
Joint Information System

JIT
Just in Time

LAC
Los Angeles County

MAC
Medical Alert Center

MCI
Mass Casualty Incident

MFI
Mass Fatality Incident

MSCC
Medical Surge Capacity and Capability

NHICS
Nursing Home Incident Command System

NIMS
National Incident Management System

NOK
Next of Kin

OSHA
Occupational Safety and Health Administration

PHEP
Public Health Emergency Preparedness

PIO
Public Information Officer

PPE
Personal Protective Equipment

PsySTART
Psychological Simple Triage and Rapid Treatment

RDMHC
Regional Disaster Medical Health Coordinator

REPEAT
Readiness for Events with Psychological Emergencies Assessment Tool

RIMS
Regional Information Management System

SCAQMD
South Coast Air Quality Management District

SEMS
Standardized Emergency Management System

SNF
Skilled Nursing Facility

WHO
World Health Organization

WMD
Weapon of Mass Destruction

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