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Appendix 3.5.1.3 cmhpc mass fatality plan

##

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The Mass Fatality Plan outlines the role of the Central Minnesota Health Care Preparedness Coalition (CMHPC) in response to a mass fatality incident (MFI) and provides guidance to CMHPC members for their facility planning. This is an Appendix to the CMHPC Response plan – it is not designed to supersede the local healthcare and community plans however it is meant to support plan development and utilization at the local level.

**Fatality Planning Assumptions**

The following assumptions apply to this fatality management plan.

* Local Emergency Management is responsible for Fatality Management Operations.
* Fatality Management Operations will occur in accordance with local Emergency Operations Plans (EOPs) and contracts with the local Medical Examiners and/or Coroners. Refer to local EOPs for details.
* The Coroner or Medical Examiner must be notified of any death where the cause of death is other than natural (i.e. accident, homicide, and suicide). Minnesota state statutes list additional circumstances when the county coroner or medical examiner must be notified (See *Minnesota Statutes Section 390.11, Subdivision 1. Reports of death.* *“All sudden or unexpected deaths and all deaths that may be due entirely or in part to any factor other than natural disease processes must be promptly reported to the coroner or medical examiner for evaluation. Sufficient information must be provided to the coroner or medical examiner.”*)
* Mass Fatality Incident (MFI) is an emergency management term used to identify an incident involving more dead bodies and/or body parts than can be located, identified, and processed for final disposition by available response resources.
* The Central Region HMAC may be activated to assist with the response.

**Role of the Regional Healthcare Preparedness Coordinator (RHPC) in Fatality Management**

* Assist CMHPC members in Fatality Management Operations
* Anticipate storage needs for a surge of human remains
* Guide development of hospital mass fatality plans.
* Support local Emergency Management and local Public Health in response efforts.
* An Family Assistant Center (FAC) may be setup to provide for the support of family members. Local Public Health and local Emergency Management are the lead agencies for an FAC.
* The RHPC or the Central Region Healthcare Multi-Agency Coordination (HMAC) may assist with the FAC by providing situational awareness, communications, or other support.
* Mental Health and Behavioral Health are available to the CMHPC members. The RHPC can assist with requesting these resources.

**CMHPC Fatality Management Plan Components**

**Process for Identification of Remains**

* To the extent possible, remains and associated personal effects should be identified.
* When identification is not possible, a good augmentation plan ensures a unique designation is assigned to each body and/or body part. This system of designation should also be used for personal effects; effects and remains are given the same number only when it is absolutely certain the remains and effects are associated with each other.
* When multiple remains are involved, articles of identification are not to be removed from the body until an alternative method (toe tag, etc.) has been attached to that body.

In some circumstances, the augmentation plan may need to provide a place for next of kin to identify the remains. This space should not have multiple bodies in it during the identification; it should provide privacy for family members to view the remains.

**Security**

* The remains and the personal effects must be kept secure while in the custody of the medical facility. Existing morgues may be adequate. If not, plans should reflect alternative locations and methods of providing security.
* Plans must clearly spell out when and to whom remains and personal effects can be released. When the death is not a coroner’s case, it will probably be appropriate to release the personal property of the deceased to the next of kin. For coroner’s cases, all personal property must be given to the coroner/medical examiner, who will arrange for its return to appropriate members of the family.
* Logs and other forms will be helpful in keeping track of which remains are in custody, where the remains are located, and when remains have been released to the custody of another.

**Coordination**

During a mass fatality incident, coordination could be required among several agencies, organizations and individuals. Examples include:

* Office of the coroner/medical examiner.
* Law enforcement agencies.
* Emergency medical services.
* Physicians who have cared for the deceased in the past.
* Government representatives (city, county, state, federal).
* Members of the family of the deceased.
* Mortuaries.
* Media.
* Volunteer organizations.

Mass fatality incident plans must ensure accurate, appropriate, consistent information is provided to each group in a timely way.

**Storage**

* Remains and personal effects must be kept in ways that provide security, dignity, and safety. Remains should be stored in ways that do not have an adverse effect on identification, post-mortem examination, or rituals and religious services for the deceased.
* Vinyl or plastic pouches provide a barrier between the body and hospital / mortuary personnel and are recommended when the cause of death is an infectious disease. In traumatic or disfiguring deaths, pouches facilitate storage and transfer. When several bodies are present in one location, pouches offer a degree of privacy and a sense of dignity.
* Temperature controls are an important consideration when choosing a storage facility. Ideally human remains should be stored between 38-42 degrees Fahrenheit. This slows changes to the body that affect the outcomes of medico-legal investigations, post mortem examinations, and embalming/restoration (if this option is selected by family members).
* Freezing distorts the physical appearance of the body, requires a thawing period before certain examinations and procedures can be completed, and causes inter-cellular damage and changes to tissue color. These may compromise subsequent exams, interpretations of injuries, and embalming/restorative efforts. In limited circumstances, freezing may be required to stop post-mortem changes and allow certain procedures to be performed (e.g. jaw bone removal to assist in identification). Freezing may be considered when bodies have been dead for a considerable time and extensive decomposition (without mummification) has taken place, such as if a body has been submerged in water for several days.
* Stacking of bodies must be avoided. Stacking shows a lack of respect for the people who have died, it can cause distortion of features (which make identification and restoration more difficult), and it is harder to access and move bodies that have been stacked. Shelves or racks increase the number of bodies that can be stored per square foot of floor space in a temperature-controlled room or container.

Minnesota Department of Health (MDH) helps maintain a disaster portable morgue unit that was purchased with Federal Emergency Management Agency (FEMA) program funds and supports a Disaster Mortuary Emergency Response Team that could be activated during a mass fatality incident.