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Appendix 3.5.1.3 wcmhpc mass fatality and family reunification center planning

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##  Purpose

The purpose of this document is to outline the role of the West Central Minnesota Healthcare Preparedness Coalition (WCMHPC) in response to a mass fatality incident (MFI) as well as to discuss the Family Reunification Center. This chapter also provides guidance to the WCMHPC members and partners for their planning purposes.

A key point in this Appendix is the need to collaborate with local partners. Emergency Management have plans in place to support these instances. Healthcare needs to work with their local Emergency Manager to ensure that facility plans align with local/county plans.

## Fatality Management Operations

* + 1. Local Emergency Management is responsible for Fatality Management Operations.
		2. 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.
		3. 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.”*)
		4. 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.
		5. The West Central Region may be activated to assist with the response. See Chapter 1: WCMHPC Regional Coordination Plan for more information.

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

1. Assist WCMHPC members in Fatality Management Operations
	* + 1. Anticipate storage needs for a surge of human remains
			2. Guide development of hospital mass fatality plans. Refer to Attachment A: Fatality Plan Components for information related to hospital-based fatality management operations.
			3. Procure mortuary storage equipment
2. Family Assistance Center (FAC)
3. An FAC may be setup to provide for the support of family members. Local Emergency Management are the lead agencies for a FAC which may include working with other partners such as Local Public Health and/or Health and Human Services.
4. The RHPC (or the West Central Healthcare Multi-Agency Coordination (HMAC)) may assist with the FAC by providing situational awareness, communications, or other support. See: WCMHPC Regional Coordination Plan.
5. Mental and Behavioral Health Support
6. Mental Health and Behavioral Health are available to the WCMHPC members. The RHPC can assist with requesting these resources.
	* + - 1. For resources – refer to: [Mental Health and Well-being - MN Dept. of Health (state.mn.us)](https://www.health.state.mn.us/people/mentalhealth.html)

## WCMHPC Fatality Plan Components

1. Process for Identification of Remains
2. To the extent possible, remains and associated personal effects should be identified.
3. 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 certain the remains and effects are associated with each other.
4. 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.
5. 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.
6. Security
7. 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.
8. 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.
9. 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.
10. Coordination
11. During a mass fatality incident, coordination could be required among several agencies, organizations and individuals. Example include:
	1. Office of the coroner/medical examiner.
	2. Law enforcement agencies.
	3. Emergency medical services.
	4. Physicians who have cared for the deceased in the past.
	5. Government representatives (city, county, state, federal).
	6. Members of the family of the deceased.
	7. Mortuaries.
	8. Media.
	9. Volunteer organizations.
12. Mass fatality incident plans must ensure accurate, appropriate, consistent information is provided to each group in a timely way.
13. Storage

1. **Respect**: 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.
2. **Body bags or pouches**: 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.
3. **Climate**: Temperature controls are an important consideration when choosing a storage facility. Ideally human remains should be stored between 38 and 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).
4. **Freezing**. 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.
5. **Stacking**: 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.

## Special Considerations in managing fatalities

Religious and cultural practices that follow death should be considered when possible. Working with subject matter experts is very important. Some examples to consider:

* For practicing Muslims – burials must occur within 24 hours of death. When this is not possible due to the chaos of the situation an increase of anxiety and stressors to the families are expected.
* Some cultures view cremation as taboo – there are some instances – for example highly infectious diseases that require the bodies to be cremated. Working with religious leaders will help decrease the angst in the community.
* The practice of family members dying alone occurred during the Covid-19 response due to isolation and quarantine practices. To some dying alone is considered a “bad” death.”

## Family reunification center (FRC)

It is recommended that all hospitals have a plan in place to manage a surge of concerned family members, guardians, and friends that may present following a disaster, especially if large numbers of unaccompanied pediatric patients could be involved in the event. The number of family members presenting to the hospital can overwhelm hospital lobbies and other care areas and as a result adversely affect clinical operations.

Family Reunification Centers provide a location for families and others to gather while awaiting news. Hospitals/healthcare should work with their local emergency managers to establish the Reunification Center. A Reunification Center may work in conjunction with a Family Assistance Center (FAC).

The FRC is meant to:

* Provide a private and secure place for families to gather, receive, and provide information regarding children and other loved ones who may have been involved in the incident.
* Provide a secure area for these families away from the media and curiosity seekers.
* Facilitate efficient information sharing among hospitals and other response partners to support family reunification.
* Identify and support the psychosocial, spiritual, informational, medical, and logistical needs of family members to the best of the hospital’s ability.
* Coordinate death notifications, when necessary.

Considerations in FRC locations:

* Locate the HFRC away from the hospital Emergency Department and media staging location.
* Ensure there is sufficient space to accommodate many individuals.
* Adequate space facilitates communication between designated hospital personnel and family members.
* Provide nearby access to smaller rooms that may be used for confidential discussions, notifications, and provision of other support.
* Distraught family members may need additional space; alcoves or additional rooms may help both psychologically and with security.
* Ensure the space has an area for food and beverage.
* Ensure restrooms are easily accessible.
* Ensure the space is accessible to patients and family members with considerations for access and functional needs.
* Access to the FRC can be controlled and security can be assured within the site.

Equipment, Supplies, and Resources for the FRC include:

* Multiple computers with Internet access. (Paper backups of digital forms should, of course, be available as well.) Templates should permit families to input as much detail as possible regarding their loved ones, including information that would be used for parent/child verification.\*
* A mechanism to upload photos of the loved ones to assist with the reunification process.\*
* Sign-in–sign-out sheets for those presenting at the HFRC, with name, contact number, and time of sign-in–sign-out for tracking purposes.
* Access to appropriate support assistance and resources (eg, psychological or spiritual support).
* Phone chargers with multiple kinds of plugs.
* Posted contact information for any available community disaster resources and information.
* Toileting and sanitation, including diaper-changing area.
* The ability to acquire food and drink.
* Chairs and tables.
* Writing utensils/paper/clipboards.
* Language interpreters.

\*Privacy rules, including the Health Insurance Portability and Accountability Act of 1996, apply to information collected; consult the hospital’s Privacy Office or legal counsel regarding collection and storage of this information.

# Approvals and Revisions

This plan is reviewed annually and updated as necessary. All changes will be voted upon by the Advisory Committee. Any revisions will be noted within this table.

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| **Purpose/Changes** | **Date** |
| Created Mass Fatality Plan  | May 2016 |
| Updated to include Patient Tracking | May 2022 |
| Update to include Special considerations – Page 4 | May 2023 |
| Updated to include Family Reunification language – page 4 | June 2023 |
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