State of Delaware
Department of Health and Social Services
Division of Public Health

MASS FATALITY MANAGEMENT PLAN (MFMP)

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1.0 Purpose

1.1 To describe the response and management of the investigation and mortuary process of the deceased in a mass fatality event in Delaware. The Mass Fatality Management Plan (MFTP) defines:

1.1.1 Agencies roles and responsibilities

1.1.2 The process of the Central Processing Unit (CPU) to handle surge

1.1.3 The storage for the remains of the deceased

1.1.4 The mortuary capacities of funeral homes and hospitals

1.2 This plan should be used in conjunction with existing emergency operations and response plans.

1.3 This plan is intended to be used as a *guide* and does not replace sound judgment nor anticipates all situations and contingencies.

2.0 Planning Assumptions

2.1 The definition of a mass fatality event is any situation, i.e. natural disaster or public health emergency such as a pandemic influenza, which there are more deaths than can be handled by local resources and may effect normal operations.

2.1.1 Effects on operations may include:

2.1.1.1 Investigation of the death

2.1.1.2 Morgue capacity

2.1.1.3 Funeral home capacity

2.1.1.4 Cemetery capacity

2.1.1.5 Transportation of deceased

2.2 For the Mass Fatality Management Plan (MFTP), the definition of mortuary process is the processing of the deceased to include investigation, identification and notification of families, storage, paperwork, and funeral services.

2.3 In a pandemic influenza, locations of bodies are not restricted to a geographical or jurisdictional area. Deaths, in a pandemic influenza, occur outside of a hospital, 50% to 75%, and may place additional stress on all community responders in the field such as Emergency Medical Service (EMS).

2.4 The state of Delaware addresses and considers religious and cultural issues and sensitivity in handling the deceased during a mass fatality event. The appropriate and respectful treatment of deceased is a moral obligation and can be of significant psychological assurance and comfort to both the family of the deceased and the larger community.

2.5 Traditional burials and funeral services within several days of the death of the deceased may not be possible due to extended time needed to process remains.

2.6 Supplies for caring for the remains of the deceased, such as embalming fluid, coffins, body bags, and areas of storage, may be in short supply due to staffing and manufacturing shortages during the pandemic period as multiple waves occur in the country simultaneously.

2.7 Events may require the activation of a Central Processing Unit (CPU). CPUs serve as a means of processing deceased for hospitals, funeral homes, or the Office of Chief Medical Examiner (OCME) in a Mass Fatality Event.

2.8 Hospitals may run out of space to store the deceased, in which the CPU may be activated for storage purposes only.

2.9 Decisions to store bodies long-term may be required.

2.10 Non-traditional temporary interments may be required.

2.11 Funeral Directors may need guidance on risks of handling bodies that may be contaminated.

2.12 In the State of Delaware, there are a total of 14 cremation chambers. Only one body at a time can be cremated, and each cremation process takes up to 4 hours to complete.

2.13 A Mass Fatality Task Force (MFTF), compiled of members from the Division of Public Health (DPH) partnering agencies (See Section 5.0) will be created to discuss the development of resources, future planning options, and for response and recovery in a mass fatality event.

2.14 Delaware's standard level of fatalities averages 145 deaths weekly and 7,600 annually.

2.15 On average funeral homes in Delaware can accommodate a total of 40 deaths per day and normally average a 140 weekly.

2.16 In a mass fatality event, funeral homes in Delaware could accommodate 280 deaths per week. However, they could not sustain operations without additional supplies and personnel.

2.17 Most funeral homes could not sustain event mass fatality capacity for more than two weeks without needing assistance due to supplies and staff shortages.

2.18 OCME investigated 3,567 deaths in 2006 and 3,613 deaths in 2007.

3.0 Conception of Operations

3.1 General

3.1.1 As defined by the *Mass Fatality Management Plan* (MFMP), the Division of Public (DPH), in conjunction with the OCME and partner agencies (*see section 5.0*) is responsible for coordination and management of a mass fatality event that overburdens local resources.

3.1.2 The State Health Operations Center (SHOC) provides command, control, and management for planning and response.

3.1.3 The SHOC, with partnering agencies, coordinates the recovery, transport, identification, preparation, investigation, notification, death certification, storage, and final disposition of bodies.

3.1.4 The Mass Fatality Task Force (MFTF) activates and provides assistance on scene and/or at the Central Processing Unit (CPU).

3.1.5 A CPU may be necessary to handle surge and can serve as a temporary morgue.

3.1.6 The OCME and/or the MFTF, in coordination with the Delaware Funeral Directors Association and the Office of Vital Statistics, activate and manage the CPU.

3.1.7 The SHOC and the MFTF utilize the Mass Fatality Module (MFM) for tracking of the deceased.

3.1.8 SHOC notifies and may request additional resources through the Delaware Emergency Management Agency (DEMA).

3.1.9 The SHOC may request a federal Disaster Mortuary Operational Response Team (DMORT) to assist with the response and additional resources to execute the MFMP, which are based similar in its operations.

3.1.10 See *Figure 1 Mass Fatality Process Flow.*

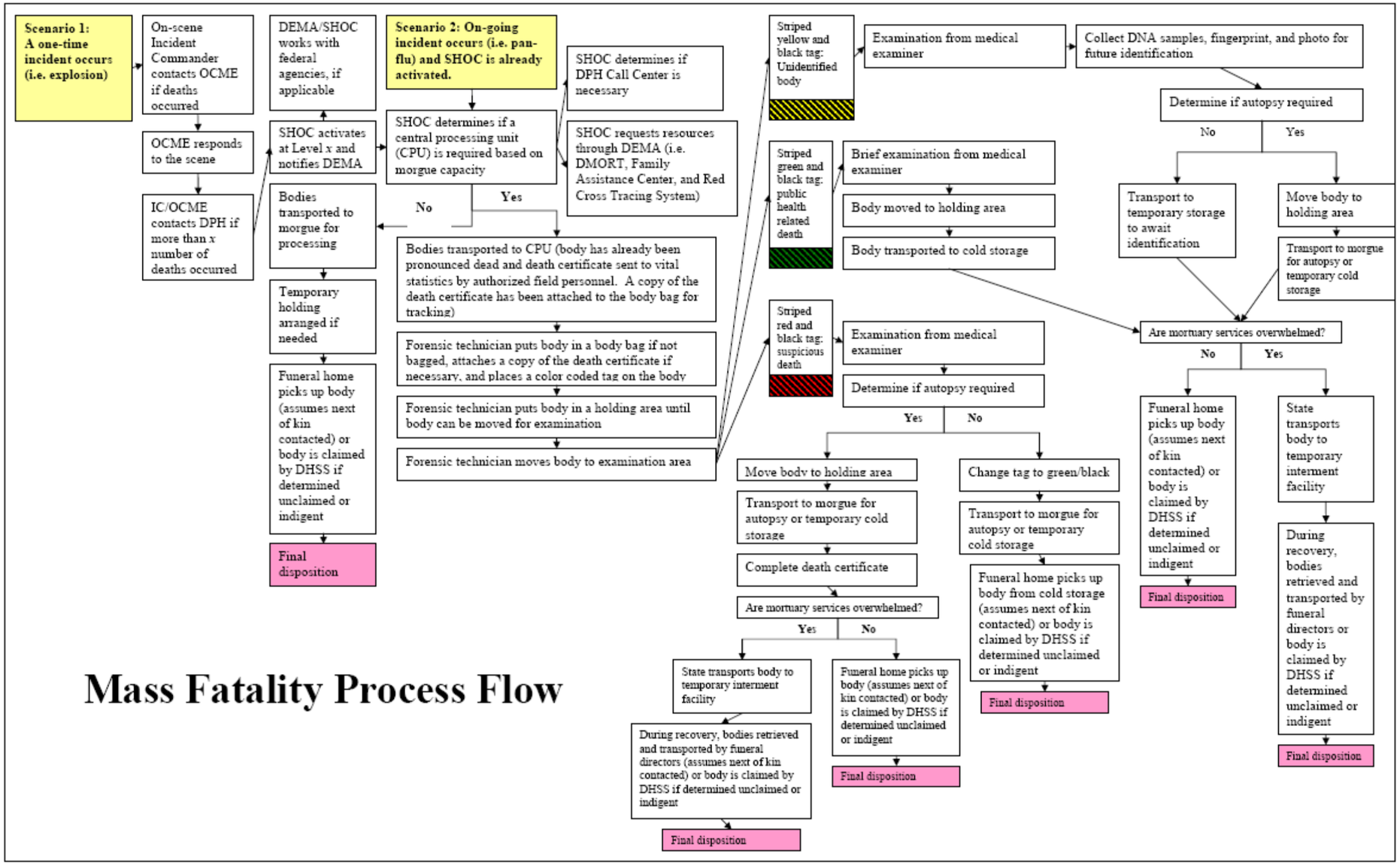


Figure 1 Mass Fatality Process Flow

3.2 Activation

3.2.1 The State Health Operations Center (SHOC) Incident Commander (IC) based upon the information and data from the Office of Chief Medical Examiner (OCME) and/or other state and local emergency management agencies determines the need to activate resources and perform operations associated with the MFMP.

3.2.2 A state of emergency must be declared to activate the MFMP and resources.

3.2.3 The following may initiate or "**trigger**" the activation of the *Mass Fatality Management Plan* (MFMP):

3.2.3.1 One-time local mass fatality event that results in a death rate exceeding 75.

- The Division of Public Health (DPH) should activate the plan, the Mass Fatality Task Force (MFTF), request DMORT, and consider activating the CPU. At a death rate of 75, the morgue capacity would be near capacity at the Hospital/Healthcare facilities and the Office of Chief Medical Examiner (OCME).

3.2.3.2 On a statewide mass fatality event that results in a death rate exceeding 150 to 200.

- DPH should activate the CPU and all components of the plan.

3.2.3.3 On-going mass fatality events that result in a weekly death rate exceeding 300.

- DPH should activate the CPU and all components of the plan.

3.2.4 See *Figure 2 Delaware Morgue Capacity and Activation "Triggers"*.

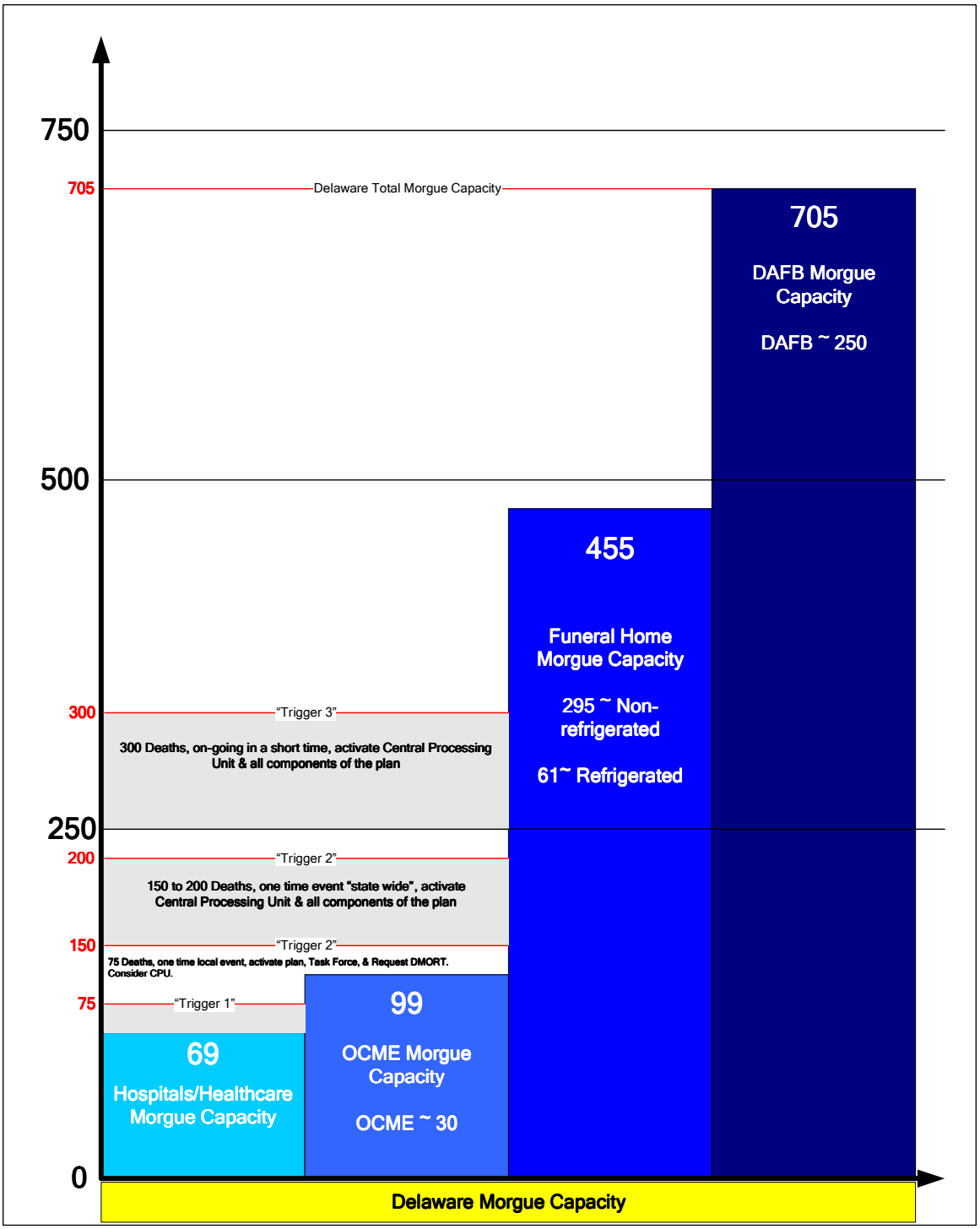


Figure 2 Delaware Morgue Capacity and Activation "Triggers"

4.0 Command and Control

4.1 The Division of Public Health is responsible for overall coordination in a mass fatality event, as defined by the processes in the Mass Fatality Management Plan (MFMP), through the State Health Operations Center (SHOC) and partnering agencies.

4.2 If the State Emergency Operations Center (EOC) is operational, the Delaware Emergency Management Agency (DEMA) acts as lead state agency for disasters and/or public health emergencies including a mass fatality event and provides supporting resources, when requested.

4.3 A unified command may be established at the State EOC or at the event to enhance command and control efforts and outgoing public information.

5.0 Agencies Roles and Responsibilities

5.1 Department of Health and Social Services (DHSS)

5.1.1 Division of Public Health (DPH)

5.1.1.1 Provides oversight for the Mass Fatality Management Plan (MFMP).

5.1.1.2 Coordinates with other state agencies and partner on mass fatality planning.

5.1.1.3 Coordinates the development of the Mass Fatality Task Force (MFTF).

5.1.1.4 Procures and stores a Portable Central Processing Unit Cache (PCPUC) of supplies to support the mass fatality event.

5.1.1.5 Activates the State Health Operations Center (SHOC) to provide command and control during the event.

5.1.1.6 Provides information to healthcare providers on infection control procedures.

5.1.1.7 Provide training or Just-In-Time training, in conjunction with OCME, to law enforcement to assist OCME with death investigations during a mass fatality event.

5.1.1.8 Notifies funeral home directors about the need to implement disease containment refresher training for their staff.

5.1.2 Office of Vital Statistics

5.1.2.1 Issues and files death certificate for the deceased in a Mass Fatality Event.

5.1.2.2 Create a secured web-based electronic death certificate process.

5.1.3 **Division of Social Services (DSS)**

5.1.3.1 Coordinates burying unclaimed bodies or remains of indigent persons.

5.1.4 **Office of Chief Medical Examiner (OCME)**

5.1.4.1 Provides support for mass fatalities and fulfils the role of the Mass Fatality Group Supervisor in the SHOC.

5.1.4.2 Manages and supports the Central Processing Unit.

5.1.4.3 Assists in the development of the Mass Fatality Management Plan (MFMP).

5.1.5 **Division of Substance Abuse and Mental Health**

5.1.5.1 Provides counselors at Family Assistance Center (FAC).

5.1.5.2 Assists in education and communication with Public Affairs Officer (PAO) with deaths at home and messages to address stress management to the community.

5.2 **Department of Safety and Homeland Security (DSHS)**

5.2.1 **Delaware Emergency Management Agency (DEMA)**

5.2.1.1 Acts as the lead state agency for coordination of response to a mass fatality.

5.2.1.2 Coordinates and provides equipment, supplies, transportation, personnel, and other support, as needed.

5.2.1.3 Coordinates with surrounding states and jurisdictions for available resource sharing through the use of Emergency Management Assistance Compacts (EMAC).

5.2.2 **Delaware State Police (DSP)**

5.2.2.1 Acts as lead law enforcement agency

5.2.2.2 Provides security at the event and Central Processing Unit (CPU).

5.2.2.3 Provides personnel and support with investigations for OCME.

5.3 **Local Law Enforcement**

5.3.1 Assists Delaware State Police (DSP) in security measures in a mass fatality event and the Central Processing Unit (CPU).

5.3.2 Provides personnel and support with investigations for OCME.

5.4 **Delaware National Guard (DNG)**

5.4.1 Provides transportation needs as requested.

5.5 **Attorney General (AG)**

5.5.1 Provides legal counsel and support in a mass fatality event.

5.6 **Funeral Directors Association**

5.6.1 Coordinates with the State Health Operations Center (SHOC) on mortuary services and provides representative, if requested.

5.6.2 Assists in the transportation of deceased remains in a mass fatality event.

5.6.3 Manages the Family Assistance Center (FAC) and notifies families.

5.6.4 Assists in the development of the Mass Fatality Task Force (MFTF).

5.7 **Federal Agencies**

5.7.1 **Federal Bureau of Investigation (FBI)**

5.7.1.1 Conducts criminal investigations in a mass fatality event including terrorism.

5.7.2 **US Department of Health and Human Services (HHS)**

5.7.2.1 Deploys the Disaster Mortuary Operational Response Team (DMORT) to assist Delaware in a mass fatality event.

5.7.2.2 Deploys additional resources when requested.

6.0 Mass Fatality Task Force (MFTF)

6.1 The work of assembling and directing a multidisciplinary team in a mass fatality event can be complex regardless of the physical conditions or the material resources available.

6.2 To assist in response and recovery and to provide command and control at the event and the Central Processing Unit (CPU), the Division of Public Health and partnering agencies will coordinate the development of a Mass Fatality Task Force (MFTF).

6.3 MFTF may include but not limited to the following:

6.3.1 Forensic anthropologist

6.3.2 Forensic dentist

6.3.3 Forensic pathologist

6.3.4 Medical investigator

6.3.5 Funeral Home Directors or licensed/trained funeral home personnel

6.3.6 Trained law enforcement officers

6.3.7 Other qualified experts as necessary and dependent on the incident.

7.0 Catastrophic Event Recovery

7.1 A mass fatality event can be separated into two categories a "catastrophic event such as a building or stadium collapse or act of terrorism, i.e. 9-11, or a "biological disease outbreak" such as a pandemic influenza.

7.2 The removal of human remains from a catastrophic event is one of the most important aspects in the investigation of a presumably criminal act. In several incidents, suspicion of a criminal act is not adequately considered at the outset of the response, which can hinder the investigation in many cases.

7.3 Collaboration and following procedures among agencies is important, and as a result of, the Division of Public Health (DPH), State Health Operations Center (SHOC), is required to partner and work with law enforcement officials and OCME during a mass fatality event.

7.4 If the event has numerous fatalities, a Central Processing Unit (CPU) should be opened to assist the Mass Fatality Task Force (MFTF) in the identification and recovery of deceased bodies. (See *Section 10.0 Central Processing Unit (CPU)*).

7.5 Presumed security at the scene of mass fatality disasters is critical to the success of all operations. The scene must be clearly delineated and rules of access must be established and strictly enforced in order to perform appropriate missions.

7.6 Search and rescue team may be necessary in a one-time (e.g. building collapse) incident.

7.7 **Recovery Process**

7.7.1 The locating, collecting, and recovering of remains and other pertinent materials from the event sites requires a standardized approach to ensure that the location and condition of materials within the scene are documented.

7.7.2 MFTF can conduct and/or assist in the numbering and protection of remains and additional scene activities that could impact CPU operations

7.7.3 No remains shall be moved or touched by workers until direction and approval have been given by the OCME, unless necessary for officer safety or to prevent further damage to the remains.

7.7.4 The appropriate forms/documentation and/or systems must be completed and utilized for appropriate tracking and identification in all mass fatality events. (*See Tab G Mass Fatality Forms and Module*).

7.7.5 **Field Safety**

7.7.5.1 Working at a mass fatality site is hazardous and site workers must be briefed to understand the hazards and take steps to take care of their health and safety. Local HAZMAT teams may be involved in this briefing.

7.7.5.2 If requested, specialized DMORT teams such as DMORT-WMD may be available to respond.

7.7.5.3 For Infectious Control Measures see *Section 12.0*.

7.7.6 **Documentation of Bodies at the Scene**

7.7.6.1 MFTF will:

- Photograph
- Fix markers at the site
- Number and tag bodies, body parts, and property
- Inventory property, including documentation and securing
- Prepare (wrap/bag) body for removal

7.7.6.2 A numbered body tag with the words "EVIDENCE-PHOTOGRAPH" are attached to each body

7.7.6.3 Each body will be photographed at the scene. The identification number should be visible.

7.7.6.4 After photographs are taken, the Forensic Investigator or designee are initial the body tag next to the word "PHOTOGRAPH".

7.7.6.5 If a body bag is used for removal, a tag fixed to the zipper of the body bag should have the same number as that affixed to the body.

7.7.6.6 When it is obvious that parts of a body belong to a particular torso, the recovery team may place that part with the body to which it belongs.

7.7.6.7 If it cannot be ascertained to which body a body part belongs, a tag may be used with the word "PARTS" imprinted on it.

7.7.7 **Documentation of Property**

7.7.7.1 All property items that are on the body should remain on the body (i.e., watches, rings, etc.). A tag with the word "PROPERTY" printed on it is attached to all property of effects not attached to a body such as (purses, briefcases, etc).

7.7.7.2 When it is evident that the property belongs to a body, include the body tag number on the property tag.

7.7.7.3 When it is not apparent to which body the property belongs, number the property tag with reference location of the most proximate bodies.

7.7.8 Documentation of Scene

7.7.8.1 At each location where a body, body part, or item of property is located must be marked. Depending upon the terrain, surface, weather condition, etc. different types of markers may be used. Each marker will have a colored ribbon attached to it. The ribbon color is determined by the item found at that location.

7.7.8.2 Follow these steps for major body parts or entire bodies:

- Attach the proper color coded plastic ribbon to the marker and write the body number on the marker with black water resistant pen.
- At the location of each body part attach the proper color coded ribbon to the marker. Write the body part number on the marker.
- At the location of each item of property/evidence attach the proper color coded plastic ribbon to the marker.
- Photograph each body, body part, and item of property while in place at the scene along with the corresponding markers.

7.7.9 Decontamination of Remains

7.7.9.1 Human remains in a WMD environment need to be handled in a safe and consistent manner. WMD contaminated remains need to be decontaminated before removal from the event site to avoid cross contamination of other areas and people.

7.7.9.2 If the threat of contaminated remains, personal effects, and other items exists, the on scene Incident Commander (IC) will assess the nature of the hazardous material and the options for timely, safe, and effective decontamination. If necessary, a DMORT-WMD may be activated and deployed to clean and decontaminate human remains, in accordance with the DMORT-WMD Manual of Operations.

7.7.9.3 During the initial planning phase, the IC will address the sequence of operations for the decontamination process. Considerations may include:

- Determining whether decontamination of remains is necessary.
- Determination of the level of personal protective equipment (PPE) necessary.
- Verification that all participating personnel have been trained to minimum HAZMAT operation levels.
- Determination of the most suitable cleaning compounds for the particular agent.
- Monitoring of remains to determine whether they are "clean."
- Storage and transportation of the decontaminated remains to the incident morgue.

7.7.9.4 When tagging, treat body parts as individual bodies.

7.7.9.5 Do not separate personal belongings when recovering the body unless the body is recovered from home.

7.7.9.6 Provide PPE to body recovery workforce.

7.7.10 **Temporary Morgue at Incident**

7.7.10.1 In some incidents, an area must be designated as the temporary or holding Morgue. Some preliminary examination and inventory of remains may take place at this morgue.

7.7.10.2 When the remains are collected from the incident site, they will be placed in body bags or a similar appropriate container/bag. This container/bag will be marked according to set standards in *Section 7.7.6*.

8.0 Biological Disease Outbreak Recovery

8.1 Home Recovery Process

8.1.1 Due to the need of an investigation by the Office of Chief Medical Examiner (OCME), unattended deaths in the home will have the greatest impact in a mass fatality event and the recovery process.

8.1.2 All deaths that occur within the home should be treated through normal OCME procedures and state law, when applicable.

8.1.3 Infection control procedures should be utilized when handling the deceased during a pandemic influenza or disease outbreak.

8.1.4 Bodies should be toe tagged and bagged prior to removal from the room or medical facility, and before transporting to the Central Processing Unit (CPU).

8.1.5 Telephone calls may be made into 911 or the State Health Operations Center (SHOC) Call Center notifying them that deaths have occurred as a result of the outbreak.

8.1.6 The MFTF can assist in handling the deceased at home in the event that a Central Processing Unit is set up, if OCME is unable to respond to the death at home and medical facilities.

8.1.7 The MFTF should be trained on the process of collecting bodies from home or medical facilities so that they may respond in the absence of the OCME.

8.1.8 Bodies recovered from the home are sent to the CPU to be processed.

8.1.9 Non-event specific deaths may also be processed at the CPU, but need to be labeled accordingly.

8.1.10 Deaths that may occur in the home that may not be event specific (e.g. gun shot wound, strangulation, or other criminal activity) will need to be investigated.

8.1.11 All non-event specific death investigations will have to be carried out by the OCME.

8.1.12 Deceased should be transported to the designated mortuary storage area (refrigerated room) until released to the appropriate agency.

8.2 **Hospital Recovery Process**

8.2.1 During a pandemic, hospitals are expected to utilize existing morgue space to capacity.

8.2.2 Hospitals should plan for increased use of mortuary supplies (morgue packs, body bags, identification toe tags, PPE specific for care of deceased , etc.) for pandemic planning.

8.2.3 Hospitals will send bodies to Central Processing Unit (CPU) to be stored and processed.

8.2.4 Hospitals should coordinate and schedule delivery of the deceased to the CPU through the State Health Operations Center (SHOC) and the CPU Logistics staff.

8.2.5 Appropriate forms will need to be filled out for transport to the CPU (see Tab F).

8.2.6 Bodies that arrive at the CPU from the hospital are taken to a designated mortuary storage area (refrigerated room) until transport is arranged.

9.0 Transportation

9.1 Transportation of remains to or from the Central Processing Unit (CPU) or other designated facility will be professional and dignified.

9.2 Care should be taken to ensure that all remains are properly bagged, tagged, inventoried, and placed in a refrigeration trailer or other appropriate vehicle for transportation to the CPU or designated facility.

9.3 Enclosed professional funeral vehicles or refrigerated trailers should be used.

9.3.1 Vehicles are placed in a secure area near incident site with easy access for loading remains.

9.3.2 The following protocols for refrigerated transportation vehicles should institute:

9.3.2.1 Refrigerated trailers can generally hold 25-30 bodies without additional shelving.

9.3.2.2 Exterior markings should be obscured or covered.

9.3.2.3 All bodies should be transported in body bags.

9.3.2.4 Bodies should not be stacked or haphazardly loaded.

9.3.2.5 Bodies may be transported on metal or plastic shelving systems, if properly secured. Use of wood shelving should not be allowed.

9.3.2.6 Trailer doors are locked and remain locked while human remains are inside.

9.3.3 Emergency Medical Services and funeral homes may be tasked in transporting the deceased.

9.3.4 To assist in transportation funeral homes may recruit and train individuals to assist in transporting remains.

9.3.5 The Delaware National Guard may provide additional support in transporting the deceased.

9.4 A log sheet will be maintained indicating the following:

9.4.1 Assigned body number of remains being transported.

9.4.2 Number of remains being transported in vehicle.

9.4.3 License number of the transporting vehicle.

9.4.4 Name of the driver of the vehicle.

9.4.5 Signature of the driver accepting responsibility for remains.

9.4.6 Date and time vehicle leaves incident site for morgue.

9.5 If possible, the deceased should come into the CPU with death certificates which is needed for transport. *If not possible, the CPU Incident Commander or designee will issue the death certificate once certification of death is made.*

9.6 At the CPU, the driver must deliver the door key to Morgue Refrigerator Storage Unit Leader.

9.7 The vehicle driver provides the route and proceeds directly to the CPU with no deviations.

9.8 Police escort may be arranged with the local or state law enforcement.

9.9 **Transportation of Contagious Bodies**

9.9.1 Contaminated remains are unsafe to process in the incident morgue and must be decontaminated before removal from the event site to avoid cross contamination of other areas and people.

9.9.2 The body is placed in a suitable container or body bag. .

9.9.3 Body must be labeled as "This body is infected with a designated highly-contagious disease specified by the Division of Public Health and must be handled and transported in accordance with precautions required by these regulations".

9.9.4 Transport out of state is prohibited unless approved by the SHOC IC and the receiving jurisdiction.

9.9.5 Body can be removed from container for temporary or final disposition and the container can be reused following disinfection.

10.0 Central Processing Unit (CPU)

10.1 Based on the number of deaths in an event or biological or disease outbreak as defined in the planning assumption and "triggers", a Central Processing Unit (CPU) should be established.

10.2 The CPU may be used to store bodies prior to transport, serve as a facility for visual identification, or serve as a substitute location for the routine processing, autopsy, and related activities which normally would occur at the Office of the Chief Medical Examiner facility. A CPU may serve all or a combination of these functions.

10.3 Considering hospitals, funeral homes, and OCME morgue capacities may quickly reach capacity, additional bodies that are event specific or biological deaths that occur at home will be sent to the CPU.

10.4 The CPU should only be set up once capacities have been reached and it is requested.

10.5 A Portable Central Processing Unit Cache (PCPUC) should be established that contains containing forensic equipment, instrumentation, support equipment, and

administrative supplies required to operate an incident morgue facility under field conditions and/or support the CPU.

10.6 A PCPUC also carries computers and related equipment to support the Family Assistance Center (FAC), Information Resource Center (IRC), and morgue operations in the management of postmortem and ante mortem information. (See *Family Assistance Center (FAC) Plan*)

10.7 **Central Processing Unit Site Selection**

10.7.1 Location of the CPU will be incident dependent with priority given to existing structures.

10.7.2 Minimal conditions, as defined in *Tab C Central Process Unit (CPU) Site Requirements*, must be in place to carry out the examination and temporary deposit of the bodies. Control of access and availability of water and lighting are some of the basic requirements that should be taken into account for temporary working areas in disaster situations outside of a mortuary.

10.7.3 The CPU must meet certain requirements for size, layout, and support infrastructure. These requirements are listed below. In general, places such as airplane hangars and abandoned warehouses have served well as incident morgues. Facilities such as school gymnasiums, public auditoriums, or similar facilities used by the general public will not be used. The facility should not have adjacent occupied office or work space. If needed, a large banquet style tent may be used, but it will require configuration for sufficient flooring, HVAC, electrical, and water requirements.

10.7.4 See *Tab C Central Processing Unit (CPU) Site Requirements*.

10.8 **CPU Command Structure**

10.8.1 The CPU utilizes the following incident command system (ICS) and reports to the State Health Operations Center and the Mass Fatality Group Supervisor. See *Figure 3 CPU Command Structure*.

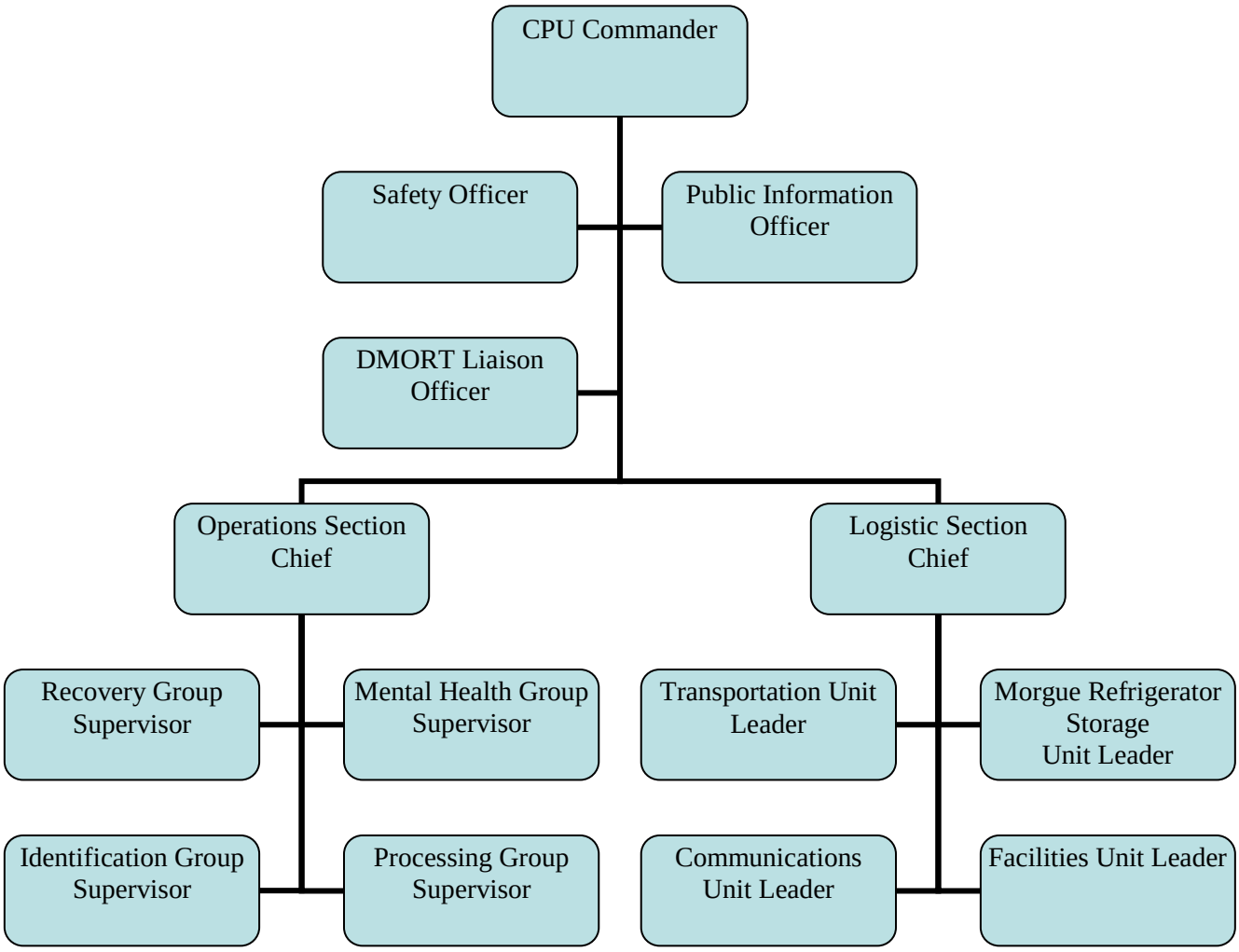


Figure 3 CPU Command Structure

11.0 Identification of Bodies

11.1 Identification methods at the Central Processing Unit (CPU) will depend on body condition and availability of ante mortem records.

11.2 For means of positive identification, documentation such as fingerprints, dental charts and x-rays, or skeletal x-rays, are maintained as a permanent record by the Office of the Chief Medical Examiner.

11.3 Visual recognition is used to identify the great majority of those killed as the result of a disaster, as well as survivors who, because of their condition, cannot provide information.

11.4 Additionally, government issued identification cards should be utilized to complete the information on color coded tags.

11.5 The tags should, at a minimum, provide space for the following information:

- 11.5.1 Name
- 11.5.2 Probable Cause of Death
- 11.5.3 Age
- 11.5.4 Address
- 11.5.5 Social Security Number or Resident Identification Number
- 11.5.6 Date of Death
- 11.5.7 Date of Birth
- 11.5.8 Place of Birth
- 11.5.9 Race
- 11.5.10 Religious Affiliation
- 11.5.11 Sex
- 11.5.12 Mother's Maiden Name
- 11.5.13 Next of Kin
- 11.5.14 Remains can be placed in groups or subgroups according to individual identification criteria in a level area or courtyard that is divided into sections, or inside a refrigerated container or vehicle.

11.6 **Tracking**

- 11.6.1 All deceased in a mass fatality event and entering the CPU are tracked through the State Health Operations Center Incident Command System, Mass Fatality Module and/or Victims Identification Profile System (VIPS) through DMORT.
- 11.6.2 Mark body bag with a color coded tag indicating likely cause of death.

- Green- Death related to public health emergency or other known/likely causes
- Red- Death from suspicious causes requiring autopsy
- Yellow-Unidentified remains

11.6.3 Bodies leaving the CPU are tracked by CPU personnel and the Mass Fatality Module.

11.6.4 Storage locations are assigned by the Morgue Refrigerator Storage Unit Leader.

11.6.5 Storage locations are clearly marked on the body bag by CPU personnel.

11.6.6 Standard procedures for dealing with the deceased will likely be modified, suspended, or expedited if the numbers of decedents becomes unmanageable. Healthcare facilities should maintain a comprehensive record keeping system of fatalities per day, with identification information and location of bodies, in-hospital, in transport, at morgue/funeral home. Identification and documentation of deceased patients via toe tagging, bagging of decedent, and issuance of a death certificate for every person that is pronounced dead on hospital facility premises must continue to occur.

11.6.7 Records accompany each movement of the deceased to temporary cold storage, as well as the movement to any interment site.

12.0 Infection Control Procedures

12.1.1 In general, the Center for Disease Control (CDC) standard precautions calls for hand hygiene before and after all contact with bodies or items potentially contaminated with secretions.

12.1.2 Isolate and secure, as quickly as possible, the scene of the event. Biological evidence should be the first evidence collected unless circumstances prohibit it.

12.1.3 The use of gloves and gowns are recommended, as is eye protection.

12.1.4 Individuals using respirators must be fit-tested. (See *Personal Protective Equipment & Respiratory Protection Program Standard Operating Guideline*)

12.1.5 Personnel removing bodies from storage bags or conducting examination should use respiratory protection.

12.1.6 Family members identifying bodies should be issued disposable gloves and gowns.

12.2 Universal Precautions

12.2.1 Universal precautions apply to blood, tissue, and body fluids containing visible blood, vaginal secretions, cerebrospinal fluid, amniotic fluid, pleural fluid, synovial fluid, pericardial fluid, and peritoneal fluids.

12.2.2 The assumption behind the universal precautions for infectious disease control is that every direct contact with body fluids is infectious. Therefore, every person exposed to direct contact must take precautions.

12.2.3 At a mass fatalities incident, this would include all workers involved in search, recovery, transportation, body identification, and disposition.

12.2.4 Universal precautions include:

12.2.4.1 Prevent, at all times, direct contact by the worker with the sample.

12.2.4.2 Prohibit the consumption of food, drink, and tobacco products while handling the sample.

12.2.4.3 Needles and sharps should never be reheated, bent, broken, cut or removed from disposable syringes. They should be placed in a rigid puncture resistant disposable container with a lid and a prominent biohazard label.

12.2.4.4 Hand washing needs to be done for at least 15 seconds after contact with victims.

12.2.4.5 Double gloving- use heavy-duty gloves and replace latex gloves if working long periods and washing frequently.

12.2.4.6 Facial barriers, respirator full face shield, or goggles with a plastic seal over mouth and nose.

12.2.4.7 Disposable protective apparel kits are mandated by OSHA for funeral directors when embalming infectious disease victims. Gowns, aprons, and lab coats should have long sleeves with a closed or full button front.

12.2.5 Body should be fully sealed in an impermeable body bag prior to the removal.

12.2.6 Clean the exterior of the body bag prior to the removal of body if the exterior is soiled.

12.2.7 Remove PPE, perform hand hygiene, replace PPE and transfer body to appropriate location through appropriate passageways (designated hallways/elevators if strategy applied).

12.2.8 Transfer to pathology or mortuary should occur as soon as possible after death.

12.2.9 If the family of the patient wishes to view the body after removal from the morgue and the patient died in the infectious period, the family should wear gloves and gowns and perform hang hygiene.

12.2.10 Cultural customs should be practiced when able.

12.2.11 Perform thorough environmental cleaning of area after body removal.

13.0 Disposition and Storage

13.1 Final disposal of the deceased can be done by burial (interment), which is almost universally practiced.

13.2 It might be necessary to preserve the body until it can be taken to a vigil or public viewing and laid to rest in accordance with cultural or religious customs.

13.3 DPH should establish a Memorandum of Understanding (MOU) with cold storage facilities, to provide sufficient amounts of space to store remains.

13.4 **Burial**

13.4.1 Under normal standards, 75% of bodies are buried and the remaining cremated.

13.4.2 Burial is preferred because it allows for future forensic investigations, if necessary

13.4.3 Use individual burials for small number of bodies and trench burials for large numbers: burial should be 1.5m deep and at least 200m from drinking water sources; leave 0.4m between bodies; lay bodies in one layer, not on top of each other; clearly mark each body and mark position at ground level.

13.4.4 Decide on location of burial sites if necessary-public cemeteries, private cemeteries, veterans, private property, potters field.

13.4.5 Temporary burial may be used when no others option are available. This is a last resort due to cultural issues and sensitivity to the family.

13.4.6 Located in each county, the State of Delaware has land reserved for indigent bodies (potter's field) and/or individuals that reside in the State prisons.

13.5 **Cremation**

13.5.1 Cremation is a personal and a family decision.

13.5.2 Cremation is not preferred because it is difficult for a large number of dead bodies.

13.6 **Storage**

13.6.1 Embalming may be considered as a means of preservation of human remains in instances where extended storage time is deemed necessary.

13.6.1.1 Embalming should take place at funeral homes whenever possible.

13.6.2 If the body has been embalmed, refrigeration is not necessary. If the body has not been embalmed, refrigeration is necessary.

13.6.3 Refrigeration between 2 degrees Celsius (35F) and 4 degrees Celsius (39F).

13.6.4 Refrigerated trailers can generally hold 25-30 bodies without additional shelving.

13.6.5 When storing bodies, basic conditions ranging from privacy, to a place out of the sun where corpses can be placed thereby slowing decomposition need to take place.

14.0 Legal Authority

This section summarizes the state's legal authority and responsibilities as it relates to a Mass Fatality Event. During such an event the declaration of Executive Orders may be necessary to temporarily modify existing laws during a state of emergency. *See Tab E Executive Order*.

Title 16, Health and Safety, Chapter 31 Registration of Births, Deaths, Marriages, Divorces, Annulments and Adoptions, Vital Statistics and Title 29, Chapter 47 Medical Examiner refers to the states legal authority and responsibilities for such an event. (*Reference Delaware Code*).

14.1 **Death Certificate**

14.1.1 According Title 16, Death Certificates should be filed within 3 days of death and prior to final disposition.

14.1.2 Hospitals or institutions may assist in the preparation of certificates by filling out certain information on the certificate (Vital Statistics Regulation).

14.1.3 Only an attending physician can pronounce death.

14.1.4 Medical certification should be completed and returned to the funeral director within 48 hours, except when an official death investigation is required by the Office of Chief Medical Examiner (OCME).

14.1.5 The attending physician, attending physician's designated physician, or the chief medical officer may complete and sign the medical certification.

14.1.6 If the body is in the possession of a medical examiner, the medical examiner determines the manner and cause of death and completes and signs death certification.

14.1.7 If there is not a qualified person to pronounce death at the scene, the death can be certified by an attending physician and/or emergency room department physician.

14.1.8 If cause cannot be determined within 48 hours, physicians or Medical Examiner (ME) must file a pending certificate of death. Once determined a revised death certificate can be issued.

14.1.9 A death certificate must be completed before transport for final disposition of the body can occur. Death Certificate is necessary to get burial-transit permit.

14.1.10 Funeral director files death certificate and obtains personal data from source available.

14.2 Medical Examiner

14.2.1 According to Title 29, any person that dies in this state, from a undiagnosed cause which may be related to a disease constituting a threat to public health death, or in any suspicious or unusual manner, or when unattended by a physician, i.e. death in the home, will be examined, investigated, and removed by the Office of the Chief Medical (OCME).

14.2.2 The Medical Examiner has 30 days to provide a written report after investigation of such a death.

14.2.3 For disposition of unclaimed deceased of indigent person, OCME representative will notify the Division of Social Services (DSS) to arrange for the burial.

14.2.3.1 In the State Health Operations Center (SHOC), representatives from DSS are present to expedite services as well as a representative from OCME.

15.0 Risk Communications

15.1 Public Affairs

15.1.1 Information regarding event and announcements of time and location of press conferences will be coordinated through the SHOC Public Affairs Officer (PAO) and/or the Joint Information Center (JIC) if the State EOC is activated. *See Crisis and Risk Communication Plan.*

15.1.2 The PAO or JIC should communicate the State's position and be sensitive to accommodate the publics need (i.e. timely funerals and burials). In a mass fatality event, these processes may be prolonged due to the nature of the event and modified to meet the needs of the community.

15.1.3 The PAO or JIC in conjunction and approval from mental health professionals should educate community on deaths at home. *See Mental Health Response Plan.*

15.2 Death Notification

15.2.1 All families should be counseled with regard to their wishes for final disposition of the deceased and sensitivity to their wishes.

15.2.2 SHOC will utilize trained counselors to notify family members.

15.2.3 After positive identification has been established by OCME and/or the MFTF, a release authorization form should be completed.

15.2.4 Associated personal effects not deemed to be evidence should be released with the body and documented.

16.0 Plan Development and Maintenance

16.1 DPH is responsible for the Mass Fatality Management Plan (MFMP) development and maintenance.

16.2 The MFTF advises DPH in the development and maintenance of the MFMP.

16.3 Participants are to review the plan annually and submit suggested changes to DPH.

16.4 Contact numbers are updated quarterly by DPH.

16.5 Memorandums of Agreement are reviewed annually.

17.0 Training and Exercises

17.1 The Public Health Preparedness Section (PHPS) is responsible for providing education and training on the Mass Fatality Management Plan (MFMP) to DPH employees and DPH's partner organizations.

17.2 Required training will be offered after the plan has been revised.

17.3 The MFMP will be exercised annually. This may be accomplished through a tabletop, functional, or full-scale exercise.

17.4 Just-In-Time Training

17.4.1 Definition – Just-in-Time Training is a concise, specific training provided just prior to people performing their duties when the plan is operational.

17.4.2 Situation – JIT is most typically used to orient new staff to their role. Pro-longed events, events that cause workforce shortages, changes in procedures, new staff, are some reasons why JIT may be needed.

17.4.3 Delivery - JIT will most likely be delivered on site by management personnel who have received Train-the –Trainer classes. The SHOC Logistics may deploy the JIT Team to the site. JIT may also be available via videoconference, pre-deployed materials, and distance learning (DETRAIN).

17.4.4 Content – JIT Content for the MFMP includes

17.4.4.1 Incident Command Structure

17.4.4.2 Sequence of Events

17.4.4.3 Description of MFMP Operations and Facility Orientation

17.4.4.4 Review Responsibilities

17.4.4.5 MFMP Forms

17.4.4.6 Safety

18.0 Evaluation and Quality Improvement

18.1 PHPS will require After Action Reports (AARs) for each exercise conducted.

18.2 PHPS will review AAR and consider recommendations for improvement.

Quality assurance and improvement activities including reviews of policy, procedures, protocols and processes are incorporated as part of the annual plan review.

19.0 Tabs

Tab A References

1.0 ***Disaster Mortuary Operational Response Team (DMORT) Standard Operating Procedures*, 2008.**

2.0 ***Management of Dead Bodies in Disaster Situations, Disaster Manual and Guidelines Series, Numbering 5,*** **Pan American Health Organization, Washington , D.C., 2004.**

3.0 ***National Association of Medical Examiners Mass Fatality Plan***

Tab B Glossary

A

AAR: After Action Reports

B

C

CACHE: A predetermined compliment of tools, equipment, and/or supplies stored in a designated location, available for incident use.

D

DEMA: Delaware Emergency Management Agency

DHSS: Delaware Health and Social Services

DMORT: Disaster Mortuary Operational Response Team

DMORT -WMD: Disaster Mortuary Operational Response Team – Weapons of Mass Destruction

E

EOC: Emergency Operations Center

EMS: Emergency Medical Services

F

FAMILY ASSISTANCE CENTER (FAC): Gathers ante-mortem information about disaster victims through interviews with the victims' next of kin and assist in notifications with the next of kin.

G

H

I

IC: Incident Commander

J

JIC (Joint Information Center): A central point of contact for all news media when a large-scale or multi-agency disaster response occurs. Public information official who represent all participating federal, state, and local agencies provide information to the media in a coordinated and consistent manner.

K

L

M

MASS FATALITY: An incident with multiple fatalities, which overwhelm the capabilities or have a significant impact on the Office of Chief Medical Examiner, funeral home, and/or cemetery to include resources.

MFM: Mass Fatality Module

MFTF: Mass Fatality Task Force

ME: Medical Examiner

N

NDMS (National Disaster Medical System): A federal program that dispatches out-of-state medical teams to an area that has suffered from a disaster.

O

OCME: Office of Chief Medical Examiner within the Department of Health and Social Services.

OEMS: Office of Emergency Medical Services within the Division of Public Health

P

PAO: Public Affairs Officer; Similar Terms: PIO (Public Information Officer)

PCPUC: Portable Central Processing Unit Cache

PHPS: Public Health Preparedness Section within the Division of Public Health

PIO: Public Information Officer: Similar Terms: PAO (Public Affairs Officer)

Q

R

S

SEOC: State Emergency Operations Center at the Delaware Emergency Management Agency

SHOC (State Health Operations Center): The physical location for the DPH's command center.

T

U

V

W

X

Y

Z

Tab C Central Processing Unit (CPU) Site Requirements

1.0 Site Requirements

1.1 Structure

- 1.1.1 Hard, weather-tight roofed structure
- 1.1.2 Separate accessible office space for IRC
- 1.1.3 Separate space for administrative needs/personnel
- 1.1.4 A minimum of 5,000 square feet for the PCPUC re-supply and staging area
- 1.1.5 Non-porous floors, preferably concrete

1.2 Size of CPU

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

1.3 Accessibility

- 1.3.1 Tractor trailer accessible
- 1.3.2 10-foot by 10-foot door (loading dock access (preferable) or ground level entry).

1.4 Electrical

- 1.4.1 Standard household current (110-120 volts)
- 1.4.2 Accessible on-site distribution panel (200-amp service)
- 1.4.3 Electrical connections to distribution panels made by local licensed electricians
- 1.4.4 Two diesel generators carried in PCPUC cache
- 1.4.5 PCPUC may need 125k generator and a separate 70k generator for Administrative and IR sections.

1.5 Water

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

1.6 Communications Access

- 1.6.1 Existing telephone lines with fax capabilities
- 1.6.2 Expansion of telephone lines may occur as the mission dictates
- 1.6.3 Broadband internet connectivity

1.6.4 If additional telephone lines are needed, authorized personnel will complete any expansion and/or connections.

1.7 **Sanitation/Drainage**

1.7.1 Pre-existing rest rooms within the facility are preferable

1.7.2 Gray water (wastewater) will be disposed of utilizing existing drainage.

1.7.3 Biological hazardous waste, liquid or dry, produced as a result of morgue operations, will be disposed of according to federal, state, and local requirements.

1.8 **Special Equipment Needs**

1.8.1 A forklift must be provided that is capable of lifting 8,000 pounds with six foot forks, or fork extensions and possibly all terrain capability to safely off-load the PCPUC pallets.

1.8.2 A smaller forklift, of 2,000 or 4,000 pound lifting capacity is needed to move heavy equipment within the morgue during set up.

1.9 **Miscellaneous Requirements**

1.9.1 53’ refrigerated trailers for storing the deceased and can be accessed by morgue personnel.

1.9.2 Number of descendants will dictate the number of refrigerated trailers needed.

1.9.3 Refrigerated trailers will be designated for processed and unprocessed remains.

2.0 Layout of CPU

2.1 Exact placement of the CPU within the facility is determine by electrical source location, water source location, accessibility by personnel, placement of refrigerated trailers, the flow plan, and security concerns. The CPU Incident Commander determines morgue placement within the CPU.

2.2 The flow plan and specific needs of the event will determine the basic floor plan of the CPU. Sections, or workstations, may include:

2.2.1 Admitting

2.2.2 Personal effects

2.2.3 Photography

2.2.4 Pathology

2.2.5 Anthropology

2.2.6 Dental

2.2.7 Fingerprints

2.2.8 DNA

2.2.9 Radiology

2.2.10 Casketing and Release

2.2.11 PPE gown and disposal

2.3 Proximity to electrical and water sources reduces the hose and power cord size. Flexibility allows for variably sized work stations/areas. The floor plan can be modified to support the specific needs of the workstation.

2.4 Floor space can be added or deleted, as the needs of the mission change, or the specific needs or requirements of the event. Consideration must be given to the additional floor space required for the radiology (x-ray) section.

Figure 4 Central Processing Unit Example Site Layout

3.0 Floor Preparation

3.1 The PCPUC carries 6 ml plastic sheeting (20' x 100') in sufficient quantity to initially protect all floors used for the morgue. A basic floor plan will require two rolls of 6 ml plastic secured to each other side by side with duct tape. Care must be taken to minimize the overlap of the two pieces to eliminate plastic on plastic "slippage." All leading edges of the plastic will also be taped to prevent tripping and maintain integrity of the floor. This provides an approximate 40' x 100' footprint (4.000 square feet). Additional floor covering may extend beyond this basic floor plan to accommodate radiology.

4.0 Basic Layout

4.1 Once the floor is covered and secured, the basic lay out of the morgue commences. Assisting members may break out and assemble the partitioning poles and bases. All of the PVC poles, with attached threaded tailpieces, are of the same size and length to facilitate the layout.

4.2 Once the bases and poles are placed appropriately creating the basic layout, the horizontal top rail is assembled from one starting point utilizing PVC poles and appropriate connector pieces (90 degree elbows, tees, straight connectors, etc.), and attached to the upright poles and bases. This will create the sectioning of the individual workstations, ad the basic structure to which the partitioning drop curtains will be attached.

4.3 The drop curtains are not attached at this time in order to facilitate the movement of equipment from the staged pallets into the individual workstations.

5.0 Water Distribution System

5.1 After water sources have been determined, appropriate water hose and power cords are laid out. The water distribution system includes sinks & hot water heaters. It is preferred to have all water hose and power cords to run on the outside perimeter of the morgue

6.0 Electrical Distribution System

6.1 The electrical distribution system includes power distribution boxes, quad boxes, extension cords and lighting in sufficient quantity to supply each workstation. If crossing the morgue floor with power cords, cable protectors, which are carried by the DPMU, will be used.

7.0 Drainage & Liquid Waste

7.1 Prior to the commencement of CPU operations, the disposal of liquid waste generated by the CPU needs to be determined in accordance with federal, state, and local regulations.

8.0 Work-Station Set-Up

8.1 Once equipment is placed into a workstation, and prior to CPU operations commencing, each Section Chief will be given an inventory list of the equipment

in their section. They need to inventory their equipment and supplies, making sure that all is in good working order. Once completed, the CPU Logistics Chief will ensure that the Hand Receipt Form is signed, acknowledging that the Section Leader has taken possession of and is now responsible for the equipment and supplies in their area. The section chief will have the opportunity to arrange his or her assigned workstation for specific needs.

Tab D Equipment/Supply Cache

1.0 The Division of Public Health will work with partnering agencies to support and/or supply the necessary resources for a Mass Fatality Event. DPH has increased the state's number of body bags on hand by over 5,000.

2.0 Suggested Resources Equipment List for PCPUC

2.1 Administrative Support Boxes

2.1.1 IRC has 7 Boxes

2.1.2 FAC has 2 Boxes

2.2 2 Copy machines

2.3 2 Panafax UF880 (Hi-Resolution)

2.4 2 LaserJet Printers

2.5 2 Desktops

2.6 8 Dell Latitude Computers (with CD-R, external keyboard and mice)

2.7 Complete Wireless LAN

2.8 2 100 MB Zip Drives

2.9 1HP-2000 Inkjet Printer

2.10 2 Scanners

2.11 2 HP 340 Color Inkjet Printers

2.12 Copies of all forms

2.13 On-Site Facilities acquired on a mission (multiple phone lines- main line, back line, fax line, modem line)

2.14 Digital Photography Equipment

2.15 Digital Full Body Radiography

2.16 Digital Dental Radiography

Tab E Executive Orders (Under Development)

1.0 The following executive orders for execution of the Mass Fatality Management Plan (MFMP) will be developed and approved the Governor's Office for utilization during a state of emergency.

1.1 Death Certificate Time Processing

1.2 Medical Examiner Processing Time and Report

1.3 Utilization of the Central Processing Unit (CPU)

1.4 Storage of Remains

1.5 Supplemental Staff for OCME

1.6 Others identified by the Mass Fatality Task Force (MFTF)

Tab F Capacity

F1 Morgue Capacity

Name	Capacity
A.I DuPont Children's Hospital	3
Atlantic General Hospital (located in Berlin, MD but serves Selbyville, De and area	4
Beebe Medical Center	3
*Christiana Hospital Newark	23/43
*Christiana/Wilmington	12/18
Dover Air Force Base (urgent to know that their first obligation is to the military and Fed. Govt. and during a pandemic probably would have NO CAPACITY to serve the State of Delaware)	250
Delaware Medical Examiner Office/Millsboro	10
Delaware Medical Examiner Office/Selbyville	20
Kent General Hospital, Dover (Bay Health)	6
Milford Memorial Hospital (Bay Health)	3
Nanticoke Hospital, Seaford	5
Saint Francis Hospital, Wilmington	6
Smyrna Hospital for the Chronically Ill	2
Veteran's Administration Hospital, Elsmere	6

* Christiana Hospital- Includes (23 refrigerated, 20 non-refrigerated) Wilmington Hospital- Includes (12 refrigerated, 6 non-refrigerated). If necessary, Christiana Hospital can increase numbers to (31 refrigerated, 40 non-refrigerated) by stacking remains in a dignified manner (bodies will only be stacked if there will be no viewing).

F2 Funeral Home and Crematory Capacity

Name, Address, Phone #	Morgue Capacity	Refrigerator Capacity	Crematory
Arcaro Funeral Home 2309 Lancaster Ave Wilmington, De 19805 (302) 658-9095	4		
Beeson Memorial Services of Christiana-Elkton 2053 Pulaski Hwy Newark, De 19702 (302) 453-1900	15		
Beeson Memorial Services of North Wilmington 412 Philadelphia Pike Wilmington, De 19809 (302) 764-2900			
Bell Funeral Home 909 Clifford Brown Walk Wilmington, De 19801 (302) 658-1555			
Bell Memorial Chapel 4201 N Washington St Wilmington, De 19802 (302) 764-6789			

Berry-Short Funeral Home Inc Main St Felton, De 19943 (302) 284-4548	See other location		
Berry-Short Funeral Home Inc 119 Nw Front St Milford, De 19963 (302) 422-8091	See other location		
Chandler Funeral Homes & Crematory 7230 Lancaster Pike Hockessin, De 19707 (302) 478-7100	14	3	Yes
Chandler Funeral Homes & Crematory 2506 Concord Pike Wilmington, De 19803 (302) 478-7100	See other location		
Congo Funeral Home 201 N Gray Ave Wilmington, De 19805 (302) 652-8887	20		
Corleto-Latina Funeral Home Inc 808 N Union St Wilmington, De 19805 (302) 652-6642	2		

Cranston Funeral Home 300 Shipley St Seaford, De 19973 (302) 629-9237			
Daniels & Hutchison Funeral Homes Main St Townsend, De 19734 (302) 378-3410	See other location		
Daniels & Hutchson Funeral Homes 212 N Broad St Middletown, De 19709 (302) 378-3410	6	3	
Doherty Funeral Homes Inc 3200 Limestone Rd Wilmington, De 19808 (302) 999-8277	See other location		
Doherty Funeral Homes Inc. 1900 Delaware Ave Wilmington, De 19806 (302) 652- 6811	5	6	
Faries Funeral Directors Inc 1250 S Governors Ave Dover, De 19904 (302) 736-6226	12		Yes
Faries Funeral Directors Inc 29 S Main St Smyrna, De 19977 (302) 653-8816	See other location		

Fleischauer Funeral Home 48 W Market St Greenwood, De 19950 (302) 349-4568	2		
Gebhart Funeral Homes Inc 3401 Philadelphia Pike Claymont, De 19703 (302) 798-7726	10		
Gebhart Funeral Homes Inc 531 Delaware St New Castle, De 19720 (302) 328-2312	10		
Hastings Funeral Home Inc 19 S Main St Selbyville, De 19975 (302) 436-8421	5		
House of Wright Mortuary Inc 48 E Commerce St Smyrna, De 19977 (302) 659-5517	28		
House of Wright Mortuary Inc 208 E 35th St Wilmington, De 19802 (302) 762-8448	See other location		
John F Yasik Inc 607 S Harrison St Wilmington, De 19805 (302) 652-5114	1		

Krienen –Griffith Funeral Home 34 W 6th St New Castle, De 19720 (302) 328-9300	See other location		
Krienen-Griffith Funeral Home 1400 Kirkwood Hwy Elsmere, De 19805 (302) 994-6914	8		
Lofland Funeral Home 102 Lakeview Ave Milford, De 19963 (302) 422-5416	(Same as McKnatt)		
Matthews-Bryson Funeral Home Inc 123 W Commerce St Smyrna, De 19977 (302) 653-2900			
McCrery Funeral Homes Inc. 3924 Concord Pike Wilmington, De 19803 (302) 478-2204	12		
McCrery Memorial Chapel 3710 Kirkwood Hwy Wilmington, De 19808 (302) 478-2204			
McKnatt Funeral Home 50 Commerce St Harrington, De 19952 (302) 398-3228	3		

Mealey Funeral Home 703 N Broom St Wilmington, De 19805 (302) 654-3005	7	4	YES
Mealey Funeral Home Limestone & Milltown Rds Wilmington, De 19808 (302) 652-5913	See other location		
Melson Funeral Services Ltd 41 Thatcher St Frankford, De 19945 (302) 732-9000	8	3	Yes (2)
Melson Funeral Services Ltd Long Neck Rd Millsboro, De 19966 (302) 945-9000	See other location		
Melson Funeral Services Ltd West Ave Ocean View, De 19970 (302) 537-2441	See other location		
Melvin, Thomas E, & Son Funeral Home Inc 15522 S Dupont Hwy Harrington, De 19952 (302) 398-3228	5		

Michael J Ambruso Funeral Directors Inc. 1175 S State St Dover, De 19901 (302) 734-2281	5	4	
Miller Funeral Home 274 N Rehoboth Blvd Milford, De 19963 (302) 424-1400			
Minus Funeral Home 222 N Queen St Dover, De 19904 (302) 674-4343			
Nichols-Gilmore Funeral Home 212 E Justis St Newport, De 19804 (302) 998-8013			
Parsell Funeral Home & Cremation Inc/ Clarkesville Chapel Rt 26 & 17 Bethany Beach, De 19970 (302) 539-1600	18	5	Yes
Parsell Funeral Home & Cremation Inc/ Hardesty Chapel 202 S Laws St Bridgeville, De 19933 (302) 337-8594	See other location		See other location

Parsell Funeral Home & Crematory 307 N Bedford St Georgetown, De 19947 (302) 856-2880	See other location		
Parsell Funeral Home Inc/ Atkins-Lodge Chapel 1449 Kings Hwy Lewes, De 19958 (302) 645-9520	See other location		
Pippin Funeral Home 119 W Camden Wyoming Ave. Camden Wyoming, De 19934 (302) 697-7002	4	3	Yes
Price Funeral Home 6 Dorman St Harrington, De 19952 (302) 398-4587			
R T Foard & Jones Inc 122 W Main St Newark, De 19711 (302) 731-4627	3	3	
Rogers Funeral Home 301 Lakeview Ave Milford, De 19963 (302) 422-4025			

Rostoki Funeral Home 500 S Van Buren St Wilmington, De 19805 (302) 655-2219			
Ryland Funeral Home 9 W 30th St Wilmington, De 19802 (302) 764-7711			
Schoenberg Memorial Chapel Inc 519 Philadelphia Pike Wilmington, De 19809 (302) 762-0334	8	6	
Short Funeral Homes Inc 700 West St Laurel, De 19956 (302) 875-3637	See other location		
Short Funeral Homes Inc. 13 E Grove St Delmar, De 19940 (302) 846-2525	10	2	
Short Funeral Services Inc 609 E Market St Georgetown, De 19947 (302) 856-6884	See other location		

Short Funeral Services Inc 416 Federal St Milton, De 19968 (302) 684-8521	See other location		
Smith, Bennie, Funeral Home Inc 717 W Division St Dover, De 19904 (302) 678-8747	8	3	Yes-(Being Built)
Smith, Bennie, Funeral Home Inc 274 N Rehoboth Blvd Milford, De 19963 (302) 422-5955	See other location		
Smith, Bennie, Funeral Home Inc 427 N Front St Seaford, De 19973 (302) 628-8280	See other location		
Smith, Bennie, Funeral Home Inc. 219 S Washington St Millsboro, De 19966 (302) 934-9019	See other location		
Spicer-Mullikin Funeral Homes Inc 214 Clinton St Delaware City, De19706 (302) 328-2213	12	3	Yes
Spicer-Mullikin Funeral Homes Inc 1000 N DuPont Hwy New Castle, De 19720 (302) 328-2213	See other location		

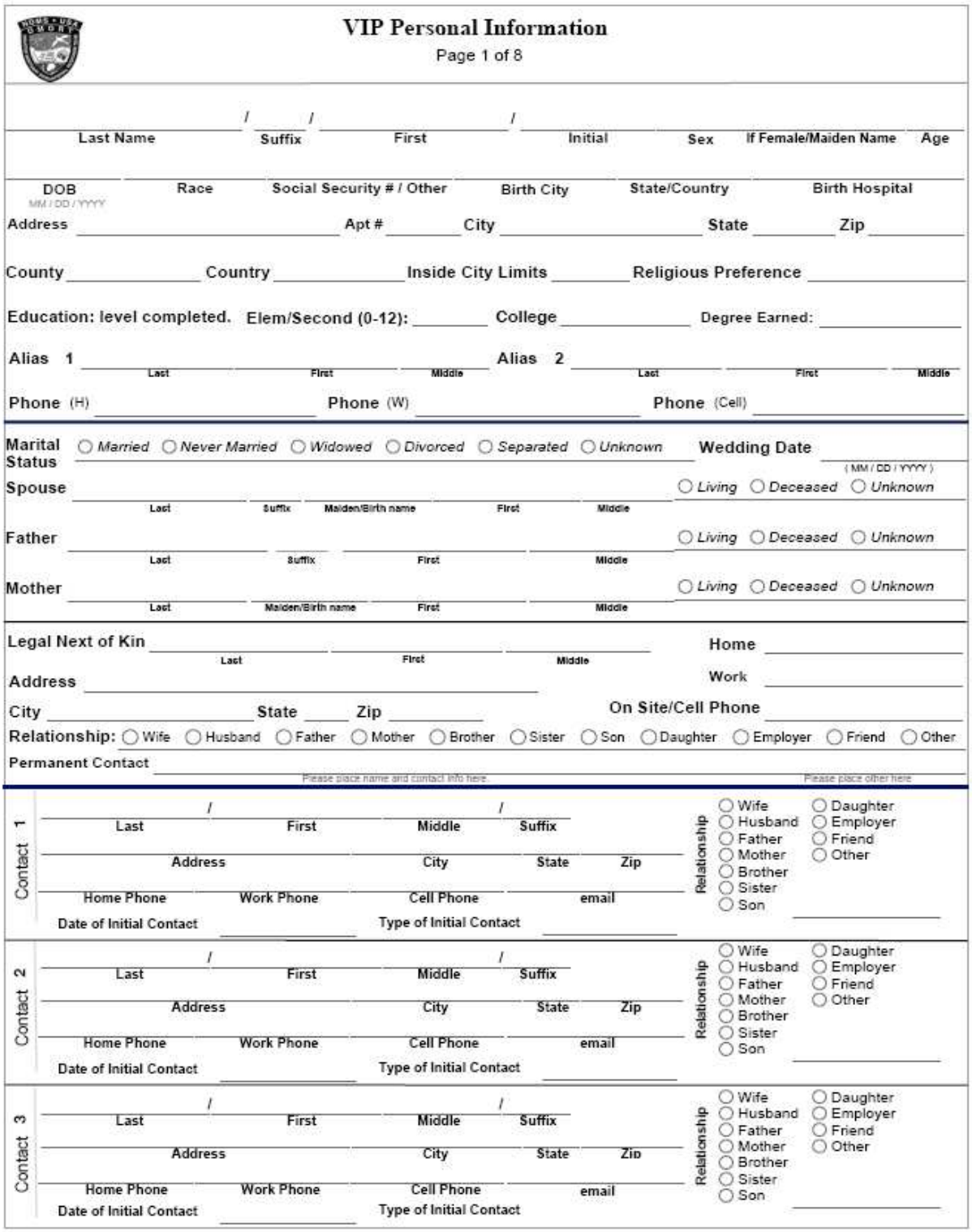
Spicer-Mullikin Funeral Homes Inc 121 W Park Pl Newark, De 19711 (302) 328-2213	See other location		
Stanley S Yasik Funeral Home 801 Kirkwood Hwy Newark, De 197111 (302) 737-4444			
Strano & Feeley Funeral Home 635 Churchmans Rd Newark, De 19702 (302) 731-5459	10		YES
Torbert Funeral Chapels & Crematory 61 S Bradford St Dover, De 19904 (302) 734-3341	17	3	Yes (2)
Trader Funeral Home Inc 12 Lotus St Dover, De 19901 (302) 734-4620	8	4	
Watson Funeral Home Inc. 211 Washington St Millsboro, De 19966 (302) 934-7842	7	6	

Watson-Yates Funeral Home Inc Front & King Sts Seaford, De 19973 (302) 629-8561			
Young Funeral Home 309 North St Milford, De 19963 (302) 422-9441	See other location		
Young Funeral Home 308 N Front St Seaford, De 19973 (302) 629-9283	8		
Total	295	61	14

F3 Burial Plot Capacity (Under Development)

Tab G Mass Fatality Forms and Module

G1 Victim Information Profile (VIP) Information Form



VIP Personal Information

Page 1 of 8

Last Name / Suffix / First / Initial / Sex / If Female/Maiden Name / Age

DOB (MM / DD / YYYY) / Race / Social Security # / Other / Birth City / State/Country / Birth Hospital

Address / Apt # / City / State / Zip

County / Country / Inside City Limits / Religious Preference

Education: level completed. Elem/Second (0-12): / College / Degree Earned:

Alias 1 (Last / First / Middle) Alias 2 (Last / First / Middle)

Phone (H) / Phone (W) / Phone (Cell)

Marital Status ○ Married ○ Never Married ○ Widowed ○ Divorced ○ Separated ○ Unknown Wedding Date (MM / DD / YYYY)

Spouse (Last / Suffix / Maiden/Birth name / First / Middle) ○ Living ○ Deceased ○ Unknown

Father (Last / Suffix / First / Middle) ○ Living ○ Deceased ○ Unknown

Mother (Last / Maiden/Birth name / First / Middle) ○ Living ○ Deceased ○ Unknown

Legal Next of Kin (Last / First / Middle) Home

Address Work

City / State / Zip On Site/Cell Phone

Relationship: ○ Wife ○ Husband ○ Father ○ Mother ○ Brother ○ Sister ○ Son ○ Daughter ○ Employer ○ Friend ○ Other

Permanent Contact (Please place name and contact info here) (Please place other here)

Contact 1

Last / First / Middle / Suffix

Address / City / State / Zip

Home Phone / Work Phone / Cell Phone / email

Date of Initial Contact / Type of Initial Contact

Relationship: ○ Wife ○ Husband ○ Father ○ Mother ○ Brother ○ Sister ○ Son ○ Daughter ○ Employer ○ Friend ○ Other

Contact 2

Last / First / Middle / Suffix

Address / City / State / Zip

Home Phone / Work Phone / Cell Phone / email

Date of Initial Contact / Type of Initial Contact

Relationship: ○ Wife ○ Husband ○ Father ○ Mother ○ Brother ○ Sister ○ Son ○ Daughter ○ Employer ○ Friend ○ Other

Contact 3

Last / First / Middle / Suffix

Address / City / State / Zip

Home Phone / Work Phone / Cell Phone / email

Date of Initial Contact / Type of Initial Contact

Relationship: ○ Wife ○ Husband ○ Father ○ Mother ○ Brother ○ Sister ○ Son ○ Daughter ○ Employer ○ Friend ○ Other

VIP Personal Information

Page 2 of 8

Name _____ / ____ / _____ / _____ ____
Last Suffix First Initial Age

Height: _____ **Approx. Weight (Pounds):** _____

Hair Information

Hair Color ☐ Auburn ☐ Brown ☐ Gray ☐ Salt & Pepper ☐ Other ☐ Blonde ☐ Black ☐ Red ☐ White _____ Please place other here

Hair Length ○ Bald ○ Shaved ○ Short < 3" ○ Medium ○ Male Patern Baldness: ○ Long

Hair Accessory ☐ Extensions ☐ Hair Piece ☐ Hair Transplant ☐ Wig

Hair Description ○ Curly ○ Wavy ○ Straight ○ N/A ○ Other: ○

Facial Hair Type ○ Clean Shaven ○ Beard & Moustache ○ Goatee ○ Sideburns ○ N/A ○ Moustache ○ Beard ○ Stubble ○ Lower Lip

Facial Hair Color ○ Blonde ○ Black ○ Red ○ White ○ Brown ○ Gray ○ Salt & Pepper **Facial Hair Notes** _____

Eye Info

Eye Color ○ Blue ○ Green ○ Gray ○ Other ○ Brown ○ Hazel ○ Black **Color/Descrip:** _____

Optical Lens ☐ Contacts ☐ Glasses ☐ Implants ☐ None **Desc.** _____

Eye Status ☐ Missing R ☐ Missing L ☐ Glass R ☐ Glass L ☐ Cataract ☐ N/A

NAIL Info

Fingernail Type ○ Natural ○ Artificial ○ Unknown **Length** ○ Extremely Long ○ Long ○ Medium ○ Short

Fingernail Color _____ **Description** _____

Characteristics ☐ Bitten ☐ Decorated ☐ Misshapen ☐ Yellowed/Fungus ☐ N/A

Toenail Color _____ **Toenail description** _____

Characteristics ☐ Bitten ☐ Decorated ☐ Misshapen ☐ Yellowed/Fungus ☐ N/A

Body Piercing(s)? ○ Yes ○ No **Photos?** ○ Yes ○ No **Photo Location** _____

#	Location	Side	Quantity	Description (include evidence of old piercings)	Photo
1					
2					
3					

Tattoo(s) ○ Yes ○ No **Photos?** ○ Yes ○ No **Photo Location** _____

#	Location	Side	Description
1			
2			
3			

VIP Personal Information

Page 3 of 8

Name _____ / ____ / _____ / _____ ____
Last Suffix First Initial Age

Dental Info

Dentist _____ _____ ○ Unknown ○ Never Went ☐ Dental Work ☐ Partials
Last First ☐ Dentures ☐ Tooth Jewelry
Address _____ Phone 1 _____ ☐ Both
☐ Braces
City _____ State ____ Zip _____

Additional Dental Information/2nd Dentist: _____

Physician Info

Physician _____ _____ Practice Name _____
Last First
Address _____ Physician Type _____
Address 2 _____ Seen for _____
City _____ State ____ Zip _____ Records Requested ○ Yes ○ No
Phone 1 _____ Phone 2 _____ Records Obtained ○ Yes ○ No
Email _____

Medical Radiographs? Physician(s) _____

○ Yes ○ No ○ Unknown Address _____

Medical Radiographs Location	Potential Type of Radiographs - and dates taken if known

Old Fractures: ○ Yes ○ No
Description: _____

Objects in Body: ☐ Pacemaker ☐ Bullets ☐ Implants ☐ Needles ☐ Shrapnel ☐ Other _____
Please place other objects here

Surgery ☐ Gall Bladder ☐ Tracheotomy ☐ Caesarean ☐ Reconstructive ☐ Other _____
☐ Appendectomy ☐ Laparotomy ☐ Mastectomy ☐ Open heart
Please place other surgery here

Diabetic? ☐ Yes ☐ No ☐ Unknown If Female / pregnancy in the past 12 months ? ☐ Yes ☐ No ☐ Unknown

Unique Characteristics
Description of: Scars, Operations, birthmarks, burns, missing organs, amputations, other special characteristics
○ Yes ○ No _____

Prosthetic Location/Description

Prosthetic(s) _____
○ Yes ○ No _____

Additional Information

VIP Personal Information

Page 4 of 8

Name _____ / _____ / _____ / _____ _____
Last Suffix First Initial Age

Group Status: ○ Alone ○ Group Group Type: _____ Fam/Grp Name: _____
Family, Church Group, Sports,Military — If Family Group, list names here

Last seen with _____

Last location victim was seen _____

Military Service ○ Yes ○ No ○ Unknown Military DNA Taken: ○ Yes ○ No ○ Unknown

Country _____ Service #: _____

Approximate Service Date _____ Military Branch _____

Ever Finger Printed: ○ Yes ○ No Immigration Status _____ Resident Alien Card (Green Card) ○ Yes ○ No

☐ Fingerprints ☐ Footprints Ever been Arrested _____ Arrested By: _____

Print located _____

Usual Occupation: _____ Type of Business _____

Employer _____ Phone _____

Employer Address _____

Please list last employer if retired. Additional employers enter in additional data section

List memberships: Clubs, Fraternities, etc.

Additional Data

VIP Personal Information

Page 5 of 8

Name _____ / _____ / _____ / _____ _____
Last Suffix First Initial Age

WATCH:

#	Type/ Make	Band Material/ Color	Description	Inscription Photo Available
1				○ Yes ○ No
2				○ Yes ○ No

Gold color is denoted by yellow, silver color is denoted by white

JEWELRY:

#	Jewelry/ Type/style	Material Color/ Stone Color	Size / Where Worn/ Frequently Worn?	Description	Inscription Photo Available
1			○ Yes ○ No		○ Yes ○ No
2			○ Yes ○ No		○ Yes ○ No
3			○ Yes ○ No		○ Yes ○ No
4			○ Yes ○ No		○ Yes ○ No
5			○ Yes ○ No		○ Yes ○ No
6			○ Yes ○ No		○ Yes ○ No
7			○ Yes ○ No		○ Yes ○ No
8			○ Yes ○ No		○ Yes ○ No
9			○ Yes ○ No		○ Yes ○ No

Other Commonly Carried Personal Effects _____

Cell phone ○ *Yes* ○ *No* ○ *Unknown* Cell phone type: _____ Service provider: _____

Cell phone number _____ Cell phone description _____

VIP Personal Information

Page 6 of 8

Name _____ / ____ / _____ / _____ ____
Last Suffix First Initial Age

CLOTHING:

#	Clothing Items	Color	Description	Size
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Wallet: Description _____

Contents _____

Purse: Description _____

Contents _____

Pockets: _____

Contents Left _____

Contents Right _____

VIP Personal Information

Page 7 of 8

Name _____ / _____ / _____ / _____

Last | Suffix | First | Initial | Sex

Potential Living Biological Donors

All Biololgical Relatives of Missing Individual----Mother/Father/Spouse/Sister/Brother/Children/Uncle/Aunt/Cousin

1	Last Name	First Name	Middle Name	Email		DOB	Sex	
	Relationship	Address	City	State	Zip	Phone 1	Phone 2	Phone 3
2	Last Name	First Name	Middle Name	Email		DOB	Sex	
	Relationship	Address	City	State	Zip	Phone 1	Phone 2	Phone 3
3	Last Name	First Name	Middle Name	Email		DOB	Sex	
	Relationship	Address	City	State	Zip	Phone 1	Phone 2	Phone 3
4	Last Name	First Name	Middle Name	Email		DOB	Sex	
	Relationship	Address	City	State	Zip	Phone 1	Phone 2	Phone 3
5	Last Name	First Name	Middle Name	Email		DOB	Sex	
	Relationship	Address	City	State	Zip	Phone 1	Phone 2	Phone 3
6	Last Name	First Name	Middle Name	Email		DOB	Sex	
	Relationship	Address	City	State	Zip	Phone 1	Phone 2	Phone 3
7	Last Name	First Name	Middle Name	Email		DOB	Sex	
	Relationship	Address	City	State	Zip	Phone 1	Phone 2	Phone 3
8	Last Name	First Name	Middle Name	Email		DOB	Sex	
	Relationship	Address	City	State	Zip	Phone 1	Phone 2	Phone 3

Primary donor for Nuclear DNA Analysis

An "appropriate family member" for **nuclear DNA Analysis** is someone that is biologically related to and only one generation removed from the deceased. The following are the family members who are appropriate donors to provide reference specimens, and in the order of preference (family members highlighted in bold print are the most desirable):

1. Natural (Biological) **Mother and Father**, AND 2. **Spouse** and Natural (Biological) **Children**, AND
3. A Natural (Biological) Mother or Father and victim's biological children, OR
4. Multiple Full Siblings of the Victim (i.e., children from the same Mother and Father

VIP Personal Information

Page 8 of 8

Name _____ / _____ / _____
Last First Middle

Interview_Location _____ Interview_Date _____ Interview_Time _____
(MM/DD/YYYY)

Interviewer Info:

Interviewer Name _____ _____
First Last

Interviewing_Organization _____

Interviewer Home Information

Interviewer Address: _____
Street, City State, Zip

Interviewer home phone: _____

Interviewer cell phone: _____

Interviewer work phone: _____

Interviewer On-Site Information

Interviewer on-site address _____
Street, Hotel, Room #

Interviewer on-site phone: _____

Interviewer on-site cell: _____

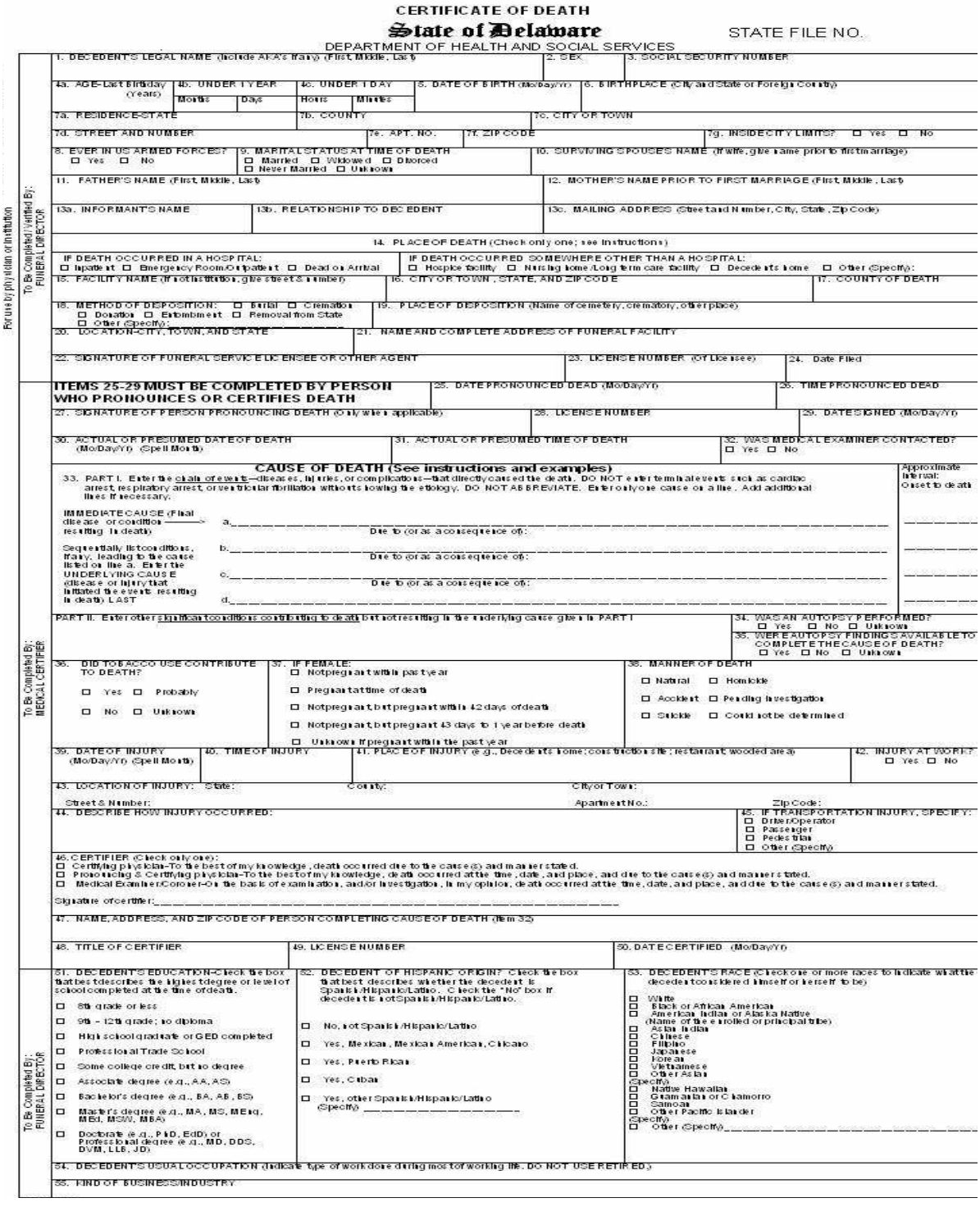
Reviewer Info:

Reviewer Name _____

Reviewer Signature _____

Reviewing agency _____

G2 Delaware Example Certificate of Death



CERTIFICATE OF DEATH

State of Delaware

STATE FILE NO.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

For use by physician or institution — To Be Completed/Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) | 2. SEX | 3. SOCIAL SECURITY NUMBER

4a. AGE-Last Birthday (Years) | 4b. UNDER 1 YEAR: Months, Days | 4c. UNDER 1 DAY: Hours, Minutes | 5. DATE OF BIRTH (Mo/Day/Yr) | 6. BIRTHPLACE (City and State or Foreign Country)

7a. RESIDENCE-STATE | 7b. COUNTY | 7c. CITY OR TOWN

7d. STREET AND NUMBER | 7e. APT. NO. | 7f. ZIP CODE | 7g. INSIDE CITY LIMITS? ☐ Yes ☐ No

8. EVER IN US ARMED FORCES? ☐ Yes ☐ No | 9. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown | 10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)

11. FATHER'S NAME (First, Middle, Last) | 12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

13a. INFORMANT'S NAME | 13b. RELATIONSHIP TO DECEDENT | 13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

14. PLACE OF DEATH (Check only one; see instructions)

IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):

15. FACILITY NAME (If not institution, give street & number) | 16. CITY OR TOWN, STATE, AND ZIP CODE | 17. COUNTY OF DEATH

18. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify): | 19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)

20. LOCATION-CITY, TOWN, AND STATE | 21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT | 23. LICENSE NUMBER (Of Licensee) | 24. Date Filed

To Be Completed By: MEDICAL CERTIFIER

ITEMS 25-29 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

25. DATE PRONOUNCED DEAD (Mo/Day/Yr) | 26. TIME PRONOUNCED DEAD

27. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable) | 28. LICENSE NUMBER | 29. DATE SIGNED (Mo/Day/Yr)

30. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month) | 31. ACTUAL OR PRESUMED TIME OF DEATH | 32. WAS MEDICAL EXAMINER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

33. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

Approximate Interval: Onset to death

IMMEDIATE CAUSE (Final disease or condition ——> resulting in death) a. _____ Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

34. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No ☐ Unknown

35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No ☐ Unknown

36. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

37. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year

38. MANNER OF DEATH ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

39. DATE OF INJURY (Mo/Day/Yr) (Spell Month) | 40. TIME OF INJURY | 41. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area) | 42. INJURY AT WORK? ☐ Yes ☐ No

43. LOCATION OF INJURY: State: | County: | City or Town: | Street & Number: | Apartment No.: | Zip Code:

44. DESCRIBE HOW INJURY OCCURRED:

45. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

46. CERTIFIER (Check only one):
☐ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Medical Examiner/Coroner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.

Signature of certifier: _____

47. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 33)

48. TITLE OF CERTIFIER | 49. LICENSE NUMBER | 50. DATE CERTIFIED (Mo/Day/Yr)

To Be Completed By: FUNERAL DIRECTOR

51. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death.
☐ 8th grade or less
☐ 9th - 12th grade; no diploma
☐ High school graduate or GED completed
☐ Professional Trade School
☐ Some college credit, but no degree
☐ Associate degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, AB, BS)
☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

52. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino (Specify) _____

53. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
☐ White
☐ Black or African American
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify)
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify)
☐ Other (Specify) _____

54. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED)

55. KIND OF BUSINESS/INDUSTRY

New M.E. Case

DELAWARE HEALTH
AND SOCIAL SERVICES

OFFICE OF CHIEF MEDICAL EXAMINER
FORENSIC SCIENCES LABORATORY

Richard T. Callery, M.D., F.C.A.P.
Chief Medical Examiner
Director, Forensic Sciences Laboratory

Death Investigator Report

County: New Castle **Type:** Full Report

CASE INFORMATION FOR: ,
Case No: 2008-- **Case type:**
Date of Death: 02/12/2008 **Time of Death:**

Notifying Agency: **Agency Phone No.:**
Date Notified: 02/12/2008 **Time Notified:**

DECEASED INFORMATION:
Race: **Sex:** **Marital Status:**
DOB: **SSN:**
Residence: ,
Telephone: (302) phone number

EMPLOYMENT INFORMATION: ☐ Incident happened at work

NEXT OF KIN:
Next of Kin: **Relationship:**
☐ Lived with Decedent
Address: ,
Notified by:
Date Notified: **Time Notified:**

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INVESTIGATION INFORMATION:

County: **Police Agency:**
Complaint No.: **Investigating Officer:**
Depth of Investigator's Investigation: **Companion cases:**

Last Seen:	**Date:**	**Time:**	**By:**
	Location:		**Address:**
Found:	**Date:**	**Time:**	**By:**
	Location:		**Address:**
Illness/Injury:	**Date:**	**Time:**	
	Location:		**Address:**
Pronounced:	**Date:**	**Time:**	**By:**
	Location:		**Address:**

Manner of death: Undetermined ☐ **Death Witnessed**

EVIDENCE SEIZED

Evidence Seized:
☐ **Medications**

EXAMINATION INFORMATION:

Pathologist: **Depth of Path. Investigation:**
Location of exam: Office of the Chief Medical Examiner **Date of Path. exam:**
☐ **X-Rays requested**
☐ **Toxicology requested** ☐ **Photographs of exam** ☐ **ME visit scene**
Death Cert. signer: **Address:**

REMAINS INFORMATION:

How Remains Identified: ☐ **Identified by Next of Kin**
Person Identifying: **Relation:**

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New M.E. Case

Telephone:
Address: ,

Disposition of Remains: **Date released:**

☐ **Records Requested**

Investigative Report

Decedent:	,	**Case No:**	2008--
Manner of Death:	Undetermined	**Investigator:**	John Ingle

Narrative report:

_____

Investigator Signature

G4 Mass Fatality Module (Under Development)

Tab H Family Assistance Center (Under Development)

1.0 *Reference Family Assistance Center (FAC) Plan (Under Development)*

2.0 The establishment of a family assistance center is necessary to facilitate the exchange of information and to address the families' needs. The family assistance center provides the families with accurate information in an appropriate manner and setting.

2.1 The family assistance center addresses the basic physical needs, including food, shelter, transportation, telephones, and emergency services, that these families often will have.

2.2 It is essential that county and state victim assistance and staff collaborate to ensure that the family assistance center has information about community resources such as mental health support, spiritual counseling, grief support, and childcare.

2.3 Many organizations and individuals working together as a team, the establishment of a chain of command, and the selection of a site that is acceptable to all the individuals and agencies that will be working there.

3.0 Site Selection Factors

3.1 A family assistance center should be located close enough to the site of the disaster to allow the medical examiner and others to travel easily among the site, morgue, and center but far enough from the site that families are not continually exposed to the scene.

3.2 If available, a neutral, nonreligious site such as a hotel or school is often an ideal choice for a family assistance center because some families may be uncomfortable coming to a religious structure.

3.3 A hotel or school often can provide flexible, long-term accommodations.

3.4 The family assistance center should be established and opened as soon as possible after the incident.

4.0 Infrastructure

4.1 The infrastructure of the site under consideration for the family assistance center must meet several requirements.

4.2 An estimate of the number of family members and friends who may visit the center to determine whether the center's infrastructure is adequate to handle that number of people.

4.2.1 Electrical power,

4.2.2 Telephone service,

4.2.3 Toilets,

4.2.4 Controlled heat and air conditioning,

4.2.5 Water,

4.2.6 Sewage.

4.3 A determination must be made about whether the site can accommodate people with disabilities.

5.0 Space and Floor Plan

5.1 The family assistance center needs to have a floor plan that will accommodate the simultaneous and effective performance of many functions for and delivery of services to the families and friends of the victims.

6.0 Operations center and administrative offices

6.1 An operations center is necessary to allow the different service groups and organizations to meet.

6.2 Administrative offices should be available for all of the different service groups including mental health professionals, clergy, and medical examiners.

6.3 The family assistance center should have a separate entrance for its staff so they can check in, be briefed, and receive their assignments before they interact with the families.

7.0 Death notification rooms

7.1 Several rooms should be set aside for families to receive the information that their loved ones have been identified.

7.2 It is preferable for death notification teams to be sent to the families' homes rather than requiring families to come to the family assistance center.

8.0 Counseling rooms

8.1 Several small rooms should be available to provide a private space where information such as ante mortem data can be gathered from families and where families can receive counseling

8.2 These rooms can be used for family members to spend time together and to use the telephone to contact other relatives and friends.

8.3 The number of rooms necessary will vary depending on the number of fatalities.

8.3.1 100 or fewer fatalities will require 3–5 rooms

8.3.2 101–200 fatalities will require 10–12 rooms

8.3.3 More than 200 fatalities will require 15–25 rooms.

8.4 The family assistance center should provide a space where the victims' families and friends can quietly reflect, meditate, pray, seek spiritual guidance, or observe religious practices.

9.0 Reception and registration for families

9.1 Staff should greet family members and gather information about who will be visiting the family assistance center upon their arrival.

9.2 Staff will assign them an escort who will take them to a designated area where they may be more comfortable and can be located if necessary.

9.3 When families and friends leave the family assistance center, they should check out and leave their address so that they can be contacted with additional information and support and notification of their loved ones' deaths.

10.0 Procedural Considerations

10.1 Personnel at the family assistance center will be assigned to collect accurate and detailed ante mortem information from the families and friends of the victims.

10.2 This information may be gathered by experienced death investigators or funeral directors who have been well briefed on the information they need to collect from the families

10.3 Death certificate information can be collected at the initial interview to save the families from going through another interview at the funeral home.

11.0 Conduct death notifications

11.1 Whenever possible, death notification should be made by a team rather than an individual.

11.1.1 The team may consist of a representative of the medical examiner

11.1.2 member of the clergy,

11.1.3 Mental Health Professional,

11.1.4 Medical Professional.

11.2 The notification team should be well briefed on the information being provided to the families so they can answer as many questions as possible.

11.3 The team should be given a fact sheet that contains relevant information that they can leave with the family for later reference.

11.4 Death notification teams also should be available to travel to meet with families who do not want to or are not physically able to come to the family assistance center.

11.5 Next of kin who are out of town should always be notified in person.

11.6 Staff conducting a death notification for a victim whose body is not intact must ask the family at the time of notification if they want to be informed about later identification.

12.0 Establish victims' suffering

12.1 During the recovery of bodies, information to families must be sensitively conveyed.

13.0 Implement security measures

13.1 Access to the family assistance center must be controlled so families and friends of the victims have privacy and are not overwhelmed by the press, photographers, and the public.

13.2 Checkpoints may need to be established at entrances to the family assistance center and its parking lot.

13.3 A badging system can be implemented that gives family members and authorized workers easy access to the family assistance center.