



Mass Casualty / Mass Fatality Plan

Ohio Homeland Security Region 7

Released 2023

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**OHIO HOMELAND SECURITY REGION 7
MASS CASUALTY /
MASS FATALITY PLAN**



**RELEASED 2023
FOR OHS REGION 7, AND ALL MUNICIPALITIES THEREIN**

OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN ADMINISTRATIVE HANDLING PROCEDURES

FOR OFFICIAL USE ONLY

This Mass Casualty / Mass Fatality Plan contains information regarding the region's response to Mass Casualty Incidents (MCI) and Mass Fatality Incidents (MFI). This plan identifies critical response assets and key resources throughout the region.

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OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN

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OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN APPROVAL AND IMPLEMENTATION

Preface

Ohio Homeland Security (OHS) Region 7 is susceptible to a number of emergencies, all of which could result in casualties and fatalities. Some of these emergencies have the potential to result in a significant number of injuries or deaths, the number of which could overwhelm regional resources. If an incident incapacitates health care workers, damages facilities, or destroys supplies, the capacity of the health care and death care system to respond to a surge in demand for its services may be severely compromised. If other communities are faced with similar demands, the arrival of additional resources would likely be significantly delayed.

In these types of scenarios, generally referred to as “mass casualty / mass fatality incidents”, it would be necessary to allocate scarce resources in a manner that is different from normal circumstances but appropriate for the situation. Making optimal decisions concerning the distribution of these scarce resources could make a big difference in the degree to which health care and death care systems continue to function, and could ultimately save many lives.

This plan describes the health care and death care capability of OHS Region 7 and forms the baseline of a regional response to an incident resulting in a significant number of casualties and/or fatalities. It is not meant to supplant the general operation of existing functions, nor is it meant as a Standard Operating Guideline (SOG) for the regional health care or death care agencies. This plan reaffirms the elements of the normal protocol that would be applicable during a mass casualty / mass fatality incident and indicates where officials have identified limitations in the regional capability. It states where external resources would likely be necessary and outlines, generally, how to access those resources.

This plan provides OHS Region 7 the basis for a systematic approach to the solution of problems created by the threat or occurrence of a MCI/MFI event. It identifies the responsibilities, functions, and working relationships between and within governmental entities throughout the region, and their various departments, and private support groups.

This document was prepared under a grant from the U.S. Department of Homeland Security (U.S. DHS). Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. DHS.

Implementation

This plan was developed utilizing a regional planning committee which included Emergency Management Agency (EMA) Directors from each county that comprises OHS Region 7, and subcommittees comprised of various health and death care agencies throughout the region with responsibilities during mass casualty / mass fatality incidents. A consultant was utilized to assist in the development of this plan. The consultant provided objective, third-party analysis and encouraged and guided continued participation by all organizations involved throughout the planning process.

The regional planning committee is responsible for the maintenance of this document and are authorized to suggest and/or make changes to it as necessary. Regular review of this plan as well as emergency exercises and actual emergencies will serve to refine and clarify emergency responsibilities and contribute to the ongoing planning process.

Approval

This document was approved by the regional planning committee as part of the planning process. It was further “officially” adopted by each participating county of OHS Region 7. The signatures on the next page verifies that this is the current version of the document (dated 2023) and confirms the agencies commitment to supporting its implementation.

Athens County Emergency Management Agency, Director	Date
Gallia County Emergency Management Agency, Director	Date
Hocking County Emergency Management Agency, Director	Date
Jackson County Emergency Management Agency, Director	Date
Lawrence County Emergency Management Agency, Director	Date
Meigs County Emergency Management Agency, Director	Date
Perry County Emergency Management Agency, Director	Date
Pike County Emergency Management Agency, Director	Date
Ross County Emergency Management Agency, Director	Date
Scioto County Emergency Management Agency, Director	Date
Vinton County Emergency Management Agency, Director	Date

OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN RECORD OF DISTRIBUTION

This section serves as documentation of the agencies to which this plan has been distributed. It can also be used as the plan is updated to ensure that all authorized copies are kept current. The Emergency Management Agency's (EMAs) of the 11 counties that make up Ohio Homeland Security (OHS) Region 7 received an electronic copy of the plan. The EMA Director of each county is responsible to distribute the plan to the various agencies with responsibilities in the plan throughout their respected county. The following is a list of example agencies and organizations that should receive a copy of the plan.

- Coroners / Medical Examiners
- Hospital Systems
- Emergency Medical Services Providers
- Health Departments
- Law Enforcement Agencies
- Search & Rescue/Recovery Teams
- Death Care Industry (i.e., Funeral Homes, Crematories)
- Morgues
- Medical Reserve Corps
- Mental Health Boards / Mental Health Providers
- American Red Cross Chapters
- Faith Based Organizations

Copy Number	Recipient Agency	Date Delivered
Athens County		
1		
Gallia County		
2		
Hocking County		
3		
Jackson County		
4		
Lawrence County		
5		
Meigs County		
6		
Perry County		
7		
Pike County		
8		
Ross County		
9		
Scioto County		
10		
Vinton County		
11		

OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN RECORD OF CHANGES

In order for any plan document to remain viable and effective, frequent revisions and updates are needed. This document serves as a record of the changes made to the *OHS Region 7 Mass Casualty / Mass Fatality Plan*. All significant revisions should be logged in this section.

Date	Description of Change(s)	Initials
2023	<ul style="list-style-type: none">Original plan development.	Planning Committee, JH Consulting, LLC

OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN

BASIC PLAN

<i>Related Federal ESFs</i>	<ul style="list-style-type: none"> • ESF #6: Mass Care, Emergency Assistance, Temporary Housing & Human Services • ESF #8: Public Health and Medical Services • Catastrophic Incident Annex
<i>Related State ESFs</i>	<ul style="list-style-type: none"> • ESF #6 – Mass Care <ul style="list-style-type: none"> ➢ Tab C – Volunteer Management Support Plan • ESF #8 – Public Health and Medical Services <ul style="list-style-type: none"> ➢ Tab D – Acute Mass Fatalities Incident Response Plan ➢ Tab E – Non-Acute Mass Fatalities Incident Response Plan ➢ Tab F – Mass Casualties and Medical Surge Plan • Catastrophic Incident Response Annex
<i>Local / Regional Agencies</i>	<ul style="list-style-type: none"> • Emergency Medical Service Providers • Air Medical Resources • Hospitals / Veteran Affairs Medical Center (VAMC) • Local Health Departments • Search & Recovery Teams • COTS • Medical Reserve Corps (MRC) • Coroners/Medical Examiners (C/MEs) • Death Care Industry (funeral homes, cemeteries, crematories, etc.) • Morgues / Mortuary Services • Emergency Communications Centers / 911 Dispatch • Emergency Management Agencies • Law Enforcement Providers • Mental Health Boards / Mental Health Providers • Municipal/County Level governmental leadership • American Red Cross (ARC) Chapters
<i>State Agencies</i>	<ul style="list-style-type: none"> • Ohio Department of Health (ODH) • Ohio Mortuary Operational Response Team (OMORT) • Ohio Hospital Association (OHA) • Ohio Division of Emergency Medical Services (OEMS) • Ohio State Coroners/Medical Examiners Association (OSCA) • Ohio Board of Embalmers and Funeral Directors (OBEFD) • Adjutant General's Department, Ohio National Guard (OHNG) • Ohio Department of Mental Health and Addiction Services (ODMH/AS) • Ohio Emergency Management Agency (OEMA) • Ohio State Highway Patrol (OSHP) • Ohio Fire Chief's Association (OFCA) • Ohio Volunteer Organizations Active in Disaster (Ohio VOAD) • Salvation Army

Federal Agencies	<ul style="list-style-type: none"> • US Department of Health & Human Services (US HHS) • Disaster Mortuary Operational Response Team (DMORT) Region V • U.S. Department of Homeland Security (US DHS) • Federal Emergency Management Agency (FEMA) • US Department of Justice (US DOJ) / Federal Bureau of Investigation (FBI) • US Department of Defense (DOD) • American Red Cross (ARC) • National Voluntary Organizations Active in Disaster (National VOAD) • Center for Disease Control & Prevention (CDC)
Authorities	<ul style="list-style-type: none"> • Local <ul style="list-style-type: none"> ➢ OHS Region 7 Counties Mass Fatality / Mass Casualty Plans ➢ OHS Region 7 Counties Pandemic Influenza Plans ➢ SCO RPH Mass Fatality Response Appendix ➢ OHS Region 7 Counties Continuity of Operations Plans (COOP) ➢ OHS Region 7 THIRA-SPR, 2021 • State <ul style="list-style-type: none"> ➢ <i>Ohio Emergency Operations Plan</i>, Ohio EMA, as amended. ➢ <i>Ohio Administrative Code</i>; 3701-3-1: Isolation Requirement ➢ Ohio Revised Code <ul style="list-style-type: none"> 313.01-.22 Coroner Responsibilities 3701.13: Department of Health Powers 3701.17 Protected Health Information 3701.28 Powers of Dept. when Local Authorities Fail to Act 3701.56 Enforcement of Rules and Regulations 3707 Board of Health 3707.04 Quarantine Regulations 3707.05 Approval of Dept. of Health in Certain Cases 3707.08 Isolation from Communicable Disease 3707.19 Disposal of Body from Communicable Disease 3707.31 Establishment of Quarantine Hospital 3707.34 Quarantine and Isolation Policies 4717 Embalmers, Funeral Directors, Crematories • Federal <ul style="list-style-type: none"> ➢ <i>Developing and Maintaining Emergency Operations Plans</i>, CPG-101, USDHS, September, 2021. ➢ <i>Mass Fatality Planning and Religious Considerations Act</i>, Bill H.R. 6566, October 6, 2012. ➢ <i>Family Assistance Act</i>, October, 1996 ➢ <i>The Homeland Security Act of 2002</i>, Public Law 107-296, 6 USC 101 et. seq., November 25, 2003. ➢ <i>The Public Health Security and Bioterrorism Preparedness and Response Act of 2002</i>, Public Law 107-188, 42 USC 247d. ➢ <i>The National Emergencies Act</i>, 50 USC §1601-1651, as amended. ➢ <i>Emergencies Involving Chemical or Biological Weapons</i>, 10 USC § 382, as amended.

I. PURPOSE & SCOPE

A. Purpose

This living document serves as the Mass Casualty / Mass Fatality Response Plan for Ohio Homeland Security (OHS) Region 7. The plan provides a framework to facilitate an organized, efficient, standardized response capability for OHS Region 7 during Mass Casualty or Mass Fatality incidents; that treats the injured, deceased, and their loved ones, with dignity and respect. The plan presents a basic command structure to guide a mass casualty / mass fatality response within the framework of the overall incident response. It predetermines, where possible, actions to be taken by the responsible elements of governmental and Non-Governmental Organizations (NGOs) within OHS Region 7.

The plan defines and establishes authority and procedures for notification and activation of the response elements delineated in the plan; outlines resources available throughout OHS Region 7, the State of Ohio, and the federal government to manage an incident involving mass casualties and mass fatalities, or medical/death surge-producing incidents.

B. Scope

The scope of this plan is to provide Ohio Homeland Security (OHS) Region 7 with a Mass Casualty Incident / Mass Fatality Incident (MCI / MFI) management system that ensures the pre-hospital and hospital care of casualties, recovery, identification, and effect final disposition of human remains in a dignified and respectful manner; as well as ensuring the preservation of all scenes, and collection of evidences (as needed); and to provide family assistance to victims' relatives and loved ones.

This plan applies to both acute and non-acute mass fatality incidents, and mass casualty operations within OHS Region 7. This plan is intended to address incidents that cause more casualties or fatalities than can be handled by local resources.

Multiple county-level Emergency Operations Centers (EOCs) within OHS Region 7 will likely be activated when a MCI / MFI occurs. These EOCs will provide overall coordination to the multiple agencies and departments involved in the incident (local, regional, state and federal resources) and that support and work with the lead agencies and organizations. This plan requires the establishment and use of the Incident Command System (ICS) for operational management and coordination, and which is in compliance

with the National Incident Management System (NIMS). This plan will operate alongside other emergency response plans that are activated to respond to either a MCI or MFI, it does not supersede nor supplant existing plans maintained by healthcare entities, local healthcare coalitions or other partner agencies. It is not meant to identify the entire MCI / MFI response. It assumes the basics of emergency response outlined in other emergency response plans and adds specific MCI / MFI elements.

This plan applies to all OHS Region 7 agencies that are assigned tasks in the document. To ensure an understanding of these tasks, these agencies have been involved throughout the planning process. The plan serves as a guideline to enhance the effectiveness of MCI / MFI response throughout OHS Region 7 counties. The document does not direct tasked agencies as to “how” they should fulfill their responsibilities; it functions on the assumption that the agencies tasked herein will individually maintain a capability to fulfill those responsibilities.

Note: Mass Fatality Incidents (MFI) may, or may not be a result of a Mass Casualty Incident (MCI). MCI and MFI may, and oftentimes do, occur simultaneously. MFI differ from MCI in that most, if not all, of the victims of the incident are deceased, a major distinction between MFI and MCI is the difference in resource types needed to manage each.

II. SITUATIONS & ASSUMPTIONS

A. Situations

1. Events that could result in a Mass Casualty Incident (MCI) or Mass Fatality Incident (MFI) in Ohio Homeland Security (OHS) Region 7 may include, (but not be limited to) the following:
 - a. Large-scale natural disasters (i.e., earthquake, flash flood, tornado, wildfire)
 - b. Transportation accident (highway / bridge collapse, railway, or airway)
 - c. Civil disturbance, riot
 - d. Industrial accident / hazmat release / mine collapse
 - e. Active shooter situations at a mass gathering venue
 - f. Building collapse
 - g. Pandemic
 - h. Dam failure
 - i. Radiological incident
 - j. Terrorist act

2. Several Mass Casualty Incidents / Mass Fatality Incidents (MCI / MFI) have occurred in the United States and the state of Ohio in recent years. A few have occurred within OHS Region 7.

MASS CASUALTY / MASS FATALITY INCIDENTS			
National Events	Date	# Injured	# Dead
Active shooter incident – Uvalde, Texas (Robb Elementary School)	5/24/22	17	21
Active shooter incident – Buffalo, New York, Tops Supermarket	5/14/22	3	10
Severe Acute Respiratory Syndrome (SARS) CoV2; Corona Virus pandemic (COVID-19)	12/12/19	N/A	1,009,062
Active shooter incident – Marjory Stoneman Douglas High School, Parkland Florida	2/14/18	17	17
Active shooter incident – Sandy Hook Elementary School in Newtown, Connecticut	12/14/12	2	26
Active shooter incident – Century Movie Theater in Aurora, Colorado	7/20/12	58	12
Active shooter incident – Virginia Tech Massacre, on the campus of Virginia Polytechnic Institute and State University in Blacksburg, Virginia.	4/16/07	17	32
Hurricane Katrina – Louisiana and Mississippi Gulf Coast	8/29/05	Unknown	1,833
Terrorist Attack – New York City, Arlington County Virginia, Shanksville Pennsylvania	9/11/01	6,000+	2,996
Terrorist Attack – Oklahoma City Bombing (Alfred P. Murrah Federal Building)	4/19/95	684	169
Jonestown Massacre – Jonestown, Guyana	11/18/78	0	918
Attack on Pearl Harbor – Oahu Island, Hawaii	12/7/41	1,143	2,467

Ohio Events	Date	# Injured	# Dead
Hampton Inn Hotel – Marysville, Ohio, multiple people fell unconscious in the pool area.	1/29/22	9	0
Severe Acute Respiratory Syndrome (SARS) CoV2; Corona Virus pandemic (COVID-19)	12/12/19	N/A	38,657
Columbus Nightclub Shooting	12/8/04	3	5
1974 Super Tornado Outbreak (Xenia, Ohio)	4/4/74	1,300	32
Ohio Fireworks Derecho	7/4/69	559	40+
1953 Tornado Outbreak	5/21/53	400	17
Ohio Penitentiary Fire, Columbus, Ohio	4/21/30	130	322
1913 Great Ohio Flood (Statewide)	3/23/13	Unknown	428
OHS Region 7 Events	Date	# Injured	# Dead
Severe Acute Respiratory Syndrome (SARS) CoV2; Corona Virus pandemic (COVID-19)	12/12/19	N/A	1,744
Ross County Correctional Institute - Substance exposure	8/29/18	29	0
Pike County Massacre, Ohio Shootings	4/21/16	0	8
Silver Bridge Collapse (Gallipolis, Ohio)	11/15/67	18	46
Millfield Mine Disaster (Athens County, Ohio)	11/5/30	19	82
Ironton Fireworks Fire	7/3/96	20	9
Southern Ohio Correctional Institution – Prison Riot	4/11/93	18	10
Noah's Ark Train Derailment Jackson County	7/28/06	25	0

Table 2.1

- The events listed in the table above demonstrate that the mass casualty and fatality management infrastructure is vulnerable to overwhelming events.
- The need to recognize and strengthen mass casualty and mass fatality management planning and response is critical, to prepare for the possibility of a worst-case scenario influenza pandemic, a hazard from which no community is immune.
- The estimated population of OHS Region 7 is 456,800 (U.S. Census Bureau, QuickFacts; Population Estimates, July 1, 2021), combined with a large tourist population, it is possible that OHS Region 7 could experience a natural or man-made catastrophic incident that could result in a large number of human casualties and/or loss of life and property.
- Local jurisdictions in Ohio have primary responsibility for delivering emergency health, medical, mass casualty, and mass fatality services during emergencies. The local jurisdictions that make up OHS Region 7 may quickly become overwhelmed addressing the health and medical needs of emergency survivors.
- The care and management of the dead is one of the most difficult aspects of disaster response and recovery operations. It is important for Coroners/Medical Examiners (C/MEs), and public health officials to understand that the expectations of family members of mass fatality incident victims, and by extension the general public, politicians, and the media regarding identification, return of victims to family and loved ones, and information will be high.

8. The death care/response industry, comprised of public and private agencies, may not be able to process remains in the traditionally-accepted manner due to the increase number of decedents, and increased employee absenteeism due to illness.
9. Due to cascading impacts, the public utility infrastructure may be temporarily hampered or shut down, causing shortages of water, food, medicine, and gasoline. Without such items all governmental personnel may have a difficult time performing their tasks.
10. Non-acute mass fatality incidents can result in a large number of deaths that will primarily occur in medical facilities and in residences over a period of days, weeks, or months. Human remains may need to be recovered from multiple sites, and processed at central locations, until the event subsides to a point that normal operations may resume.
11. The Region V National Disaster Medical System (NDMS) that includes a Disaster Medical Assistant Team (DMAT) and a Disaster Mortuary Operational Response Team (DMORT) will be activated if an incident that results in mass casualties or mass fatalities and will provide support to the local jurisdictions of OHS Region 7.
12. The physical, mental, emotional, and spiritual demand placed upon mass fatality workers involved in the search and recovery, transportation, morgue services, and family assistance operations, exceeds that of any event typically encountered in daily life and work. Providing appropriate support and care for staff who are involved in a mass fatality is critical.
13. It is important to remember that deaths due to other causes will continue to take place in the jurisdictions of OHS Region 7 during a mass fatality event.
14. Caution should be taken when using food, beverage, or other consumer types of commercial refrigerated vehicles to store and transport human remains. These types of vehicles cannot be returned to their prior service function, and the local jurisdiction is responsible for replacement.

B. Assumptions

1. Prior to activation of this plan, a local, or state-level emergency will have been declared or will be anticipated.
2. The multiple organizations involved with a mass casualty or mass fatality incident will work within the Incident Command System (ICS) and cooperate and collaborate with each other, and with activated Emergency Operations Centers (EOCs), to facilitate effective management of the incident.
3. Under certain circumstances select federal agencies will have critical on-scene responsibilities, thus requiring close and on-going coordination with local, regional, and state agencies.
4. A Mass Casualty Incident (MCI) would overwhelm the regional healthcare systems. For example, hospital Emergency Rooms (ERs) would reach surge capacity within a short period of time, both in terms of casualty numbers and surgical complexity; isolation and quarantine capabilities would be strained; mortuary resources would be quickly expended; etc.
5. Mass casualty-producing incidents may have the potential to generate mass fatalities, medical surge, and medical evacuations (e.g., of patients in facilities as well as in their homes).
6. Every jurisdiction will require the same critical resources, including personnel, equipment and supplies, to manage a surge in the number of decedents. Just-in-time inventories may not be able to respond quickly enough to requests for assistance.
7. Evaluation of mass casualty or mass fatality incident sites may require specialized assistance from local agencies and the state, special chemical and biological detection equipment, and personnel with appropriate Personal Protective Equipment (PPE).
8. The existing standard of care may be adjusted to provide a level of care appropriate for the circumstances given the resources available.
9. Significant aid from state and/or federal sources would not be available for 72 hours.
10. A diverse pool of local public and private resources will be available to assist with mass fatality decedent operations.
11. The ultimate purpose in a mass fatality response is to recover, identify, and effect final disposition in a timely, safe, and respectful manner while reasonably accommodating religious, cultural, and societal expectations. Under certain circumstances, this will be challenging and require support and leadership from all levels of government.

12. Mortuary service resources (e.g., funeral homes, crematories, etc.) located throughout Ohio Homeland Security (OHS) Region 7 will be available for use during emergency situations; however, some of these resources may be adversely impacted by the event and may be quickly overwhelmed.
13. Existing morgue storage capacity in OHS Region 7 will be exceeded during mass fatality events.
14. In the event of pandemic influenza or similarly contagious disease, external resources will not be available and some services will need to be delivered differently to minimize spread of the disease.
15. Transient populations (e.g., tourists, business conventions, etc.) may be present during MCI or MFI events.
16. There will be persistent media requests for interviews with city, state, and/or federal officials, survivors, family members, and rescue workers. A Joint Information Center (JIC) may be established to ensure that information released to the public will be accurate, consistent, and coordinated across the responding agencies.
17. Emergency Public Information (EPI) may be necessary to provide critical information to high-risk populations as well as assess community public service and/or public health needs.
18. In the immediate aftermath of a mass casualty or mass fatality incident, families and friends will frantically seek assistance. They will gravitate to where they believe they will find their loved ones, or where they believe they will find information about them. That translates to the incident scene and to local hospitals.
19. Mass casualty and mass fatality incidents create widespread traumatic stress for responders and families that are impacted, and, at times, the community-at-large. Traumatic stress can lead to physical illness and disease, precipitate mental and psychological disorders, and can destroy relationships and families. Attending to behavioral health needs of victims' and responders is critical.

III. CONCEPT OF OPERATIONS

A. General

1. Government authorities, emergency managers, the medical community, death care industry professionals, public and private sector health professionals, Coroners/Medical Examiners (C/MEs), the faith-based community, mental health professionals, and the law enforcement community of Ohio Homeland Security (OHS) Region 7 will work together to manage resources and create mechanisms to address a surge in casualties, as well as acute and non-acute fatalities while maintaining existing services.
2. As required by the National Response Framework (NRF), all Mass Casualty Incident / Mass Fatality Incident (MCI/MFI) operations will be conducted in compliance with the requirements of the National Incident Management System (NIMS). Management and coordination of all medical resources, death care resources, personnel, equipment, procedures, and communications will take place through the Incident Command System (ICS).
3. During the effective period of any declared local emergency, including a mass casualty, medical surge, or mass fatality incident, local Emergency Operations Centers (EOCs) function as the central point for emergency management operations. Coordination will be through the EOC Section Chiefs and the local Emergency Management Agency (EMA) Director in accordance with local Emergency Operation Plans (EOPs). If the incident results in the declaration of a State emergency, some or all of the local EOC functions may be transferred to the State EOC as provided in the Ohio Revised Code (ORC).
4. Following a State of Emergency declaration, the Governor may also request a Presidential Disaster or Emergency Declaration, in order to seek federal assistance under the Stafford Act. The Ohio Emergency Management Agency (OEMA) will work with FEMA Region V to determine whether the situation warrants a declaration.
5. County Coroner's/Medical Examiner's (C/MEs) have jurisdiction over acute mass fatalities within their jurisdictions. When a C/ME deems that the number of fatalities exceeds local resources and capabilities to effectively handle a Mass Fatality Incident (MFI), they may request that the county EMA Director request state-level assistance or request mutual aid from another jurisdiction. After requesting state assistance, local C/MEs in the impacted areas of the region may contact non-impacted, neighboring

- county C/MEs, to ascertain the availability of their morgue space to fill incident needs until state resources arrive.
6. If a Coroner's/Medical Examiner's (C/MEs) office is incapacitated, then alternate services will be established in accordance with ORC 305.02 and 313.04. Additionally, C/ME services may be accessed via the Intrastate Mutual Assistance Compact (IMAC) or the Emergency Management Assistance Compact (EMAC).
 7. During a large-scale emergency that overwhelms and depletes local, regional, and state health and medical resources and affects large populations in Ohio, the Director of the Ohio Department of Health (ODH) will recommend that the governor request federal medical countermeasure assets, including the Strategic National Stockpile (SNS). The Director of ODH or his/her designee is authorized to directly request the SNS from the Centers for Disease Control and Prevention (CDC).
 8. Initial assistance beyond the capabilities of the local jurisdiction will be requested via local mutual aid agreements. When a local jurisdiction's resources (from within the jurisdiction and through local mutual aid agreements) have been exhausted, they may request that the Emergency Response System (ERS) be activated to provide additional assistance. If EMS resources within the state of Ohio have been exhausted, then additional resources will be requested through Emergency Management Assistance Compact (EMAC) and other means.
 9. Ohio Department of Health (ODH) personnel will work out of the State EOC and work with other ESF organizations to meet the needs of incident survivors or displaced population. These needs may include:
 - a. Providing health assessments of conditions based on emergency site information to determine health needs and priorities.
 - b. Monitoring of the availability and utilization of health and medical systems' resources and treatments.
 - c. Providing logistical support for health and medical personnel in the affected area.
 - d. Coordinating among various health and medical organizations affected by the incident.
 - e. Locating and coordinating local, regional, state and federal health and medical mass casualty or medical surge resources for response.
 - f. Coordination and support for mass casualty and mass fatality incidents.
 - g. Coordination of mass prophylaxis of large populations.
 - h. Coordinating supply and prioritization of health and medical resources.

- i. Coordinating provision of behavioral and mental health assistance to disaster victims and incident responders.
 - j. Coordinating provision of health advisories and related information to the public.
 - k. Coordinating local, regional, state, and federal assets that have been assigned to assist at the site of the emergency.
 - l. Coordinating hospital bed tracking and patient tracking.
10. If an incident is suspected to be an infectious disease outbreak, county Health Departments in coordination with the Ohio Department of Health (ODH) will coordinate with, and provide guidance on, the communicable disease investigation to the medico-legal authority.
11. If an incident requires state-level volunteer management support, the primary and support agencies will form a Volunteer Management Team within the Ohio Emergency Operations Center. As the primary agency, OEMA will facilitate this team. Volunteer Reception Centers (VRCs) will be established to receive, organize and direct volunteers as they respond to an incident. The need to activate a county-level VRC will be determined by local jurisdictions.
12. Federal ESF #8 provides supplemental assistance in the following core functional areas as they relate to MCI/MFIs. This assistance is delivered through surge capabilities that augment public health, medical, and behavioral functions with health professionals and pharmaceuticals. The following assistance may be requested through the Emergency Management Assistance Compact (EMAC), or may be executed under the Stafford Act.
- a. Assessment of public health/medical needs.
 - b. Health surveillance – Monitor disease patterns and potential disease outbreaks. Provides support to laboratory diagnostics and through the Laboratory Response Network (LRN) provides a mechanism for laboratories to access additional resources when capabilities or capacity at the local or state level have been exceeded.
 - c. Medical surge – Provides support for triage, provides clinical public health and medical care specialists from the National Disaster Medical System (NDMS), U.S. Public Health Service, VA, and DOD to fill local and state health professional needs. Provides capability to identify bed capacity for the purposes of bed allocation among healthcare treatment networks.

- d. Health/medical equipment and supplies – arrange for the procurement and transportation of equipment and supplies, diagnostic supplies, radiation detection devices, and medical countermeasures including assets from the Strategic National Stockpile (SNS).
 - e. Patient movement – Provides private vendor ambulance support to assist in the movement of patients through the National Ambulance Contract.
 - f. Patient care – Provides resources to support pre-hospital triage, inpatient hospital care, outpatient services, medical needs sheltering, pharmacy services to victims with acute injury/illnesses. Assists with isolation and quarantine measures as well as with medical countermeasure and vaccine Point of Distribution (POD) operations (e.g., mass prophylaxis).
 - g. Safety and security of drugs, biologics, and medical devices.
 - h. Blood and tissues – monitors blood, blood products, and tissue supplies, shortages and reserves.
 - i. Behavioral healthcare.
 - j. Mass fatality management, victim identification, establishing temporary morgue facilities, and mitigating health hazards from contaminated remains.
13. The *National Response Framework – Catastrophic Incident Annex (NRF-CIA)* establishes protocols to pre-identify and rapidly deploy key essential resources (e.g., medical teams, search and rescue teams, transportable shelters, medical and equipment caches, etc.) that are expected to be urgently needed/required to save lives and contain incidents.
- a. Upon the occurrence of a catastrophic incident, or in advance if determined by the Secretary of Homeland Security, the government will deploy federal resources, organized into incident-specific “packages”, in accordance with the NRF-CIA and in coordination with the affected state and incident command structure.
 - b. The NRF-CIA is primarily designed to address no-notice or short-notice incidents of catastrophic magnitude, where the need for federal assistance is obvious and immediate, where anticipatory planning and resource pre-positioning were precluded, and where the exact nature of needed resources and assets is not known.

B. Initial Evaluation/Assessment of Incident

1. If feasible, the Coroner / Medical Examiner (C/ME) will conduct an initial on-scene evaluation of the scene along with representatives from law enforcement, hazmat response, fire and rescue, search and rescue, etc., to develop a better understanding of the response and recovery needs. Specific issues which need to be addressed in the assessment process include:
 - a. Check required level of Personal Protective Equipment (PPE).
 - b. Determine complicating factors (fragmentation, difficult excavation, hazardous materials, excessive heat, etc.).
 - c. Take initial pictures of site.
 - d. Determine approximate number of remains and their location.
 - e. Identify location of atypical cases.
2. The scene and general environment must be thoroughly checked for life-threatening situation and secondary devices to ensure a safe working environment by law enforcement personnel or Explosive Ordinance Disposal (EOD) teams prior to evaluation teams entering.
3. C/ME representatives will work concurrently with lead investigators to begin the development of an Incident Action Plan (IAP).
4. If the State EOC activates in response to an MCI/MFI incident, the State EOC Executive Group's Mass Casualties Incident Assessment Team will be assembled. The team will be composed of representatives of the following agencies:
 - a. Ohio Emergency Management Agency
 - b. Ohio Department of Health
 - c. Ohio Hospital Association
 - d. Ohio Emergency Medical Services
 - e. Ohio Adjutant General's Office, Ohio National Guard
 - f. Ohio Department of Transportation
 - g. Ohio Homeland Security
 - h. Ohio Fire Chiefs' Association
 - i. Ohio Department of Administrative Services
 - j. Public Information – State EOC/Joint Information Center (JIC)

5. The Assessment Team will assess the incident focusing on the following:
 - a. Type of incident.
 - b. Number and type(s) of casualties and/or fatalities.
 - c. Condition of bodies.
 - d. Response parameters (e.g., treatment, search and rescue, extraction, recovery, documentation, patient tracking, transportation, personnel needs, equipment needs, etc.)
 - e. Incident location(s).
 - f. Incident scene accessibility and setup for emergency medical functions.
 - g. Local response coordination – Incident Commander(s), local law enforcement, local fire response, local health departments, local/regional search and rescue.
 - h. Medical surge needs (e.g., State/Federal resources, EMAC requests, etc.)
 - i. Chemical, radiological, and biological hazards.
 - j. Field communication/liaison needs and coordination.

C. Notification / Plan Activation & Deactivation

1. Notification to, as well as the request for assistance from a C/ME, can be made through a variety of channels depending on the location and scope of the incident. The notification may come from a county 911-center, a regional hospital, a county sheriff's department, a municipal police department, or an on-scene Incident Commander (IC).
2. All Mass Fatality Incident (MFIs) must be reported directly to the local C/ME.
3. Local health departments shall activate this plan when managing a MFI that does not fall under the jurisdiction of the C/ME, (i.e., epidemic/pandemic).
4. An incident resulting in casualties or fatalities that exceed the normal operating capacity of the responding agencies will be designated as a Mass Casualty Incident / Mass Fatality Incident (MCI / MFI), and will initiate the activation of this plan.
5. In all instances, the on-scene IC may request this plan to be activated. The decision to expand to higher levels of activation should come from the IC.
6. Plan Activation Levels
 - a. Activation levels do not correspond to pre-determined thresholds, such as the number of casualties / fatalities, or responders involved. The determination of the appropriate level should be capability based. As such, a variety of factors may affect the determination. For example, one (1) incident may have a fewer number of more severe casualties, the response to which exceeds a set of local capabilities

by virtue of the severity of the injuries. In another instance, a larger number of casualties may be managed by that same agency because the injuries are not as severe. By being capability-based, this plan is applicable in both scenarios.

PLAN ACTIVATION	
Activation Levels	Activation Trigger
Level 1	<ul style="list-style-type: none"> • Small to moderate incident with few casualties and/or fatalities, can be resolved by capabilities of a single department or small number of mutual aid departments. Large-scale resource deployment not necessary. • Family Assistance Center (FAC) may, or may not be needed. • The normal day-to-day C/ME Office response system is functional and requires reinforced response (e.g., additional morgue space and staff). • Human remains are not contaminated by any toxic or hazardous materials and are generally intact. • No criminal or terrorist involvement is suspected. • Coroner Mutual Aid from at least one (1) jurisdiction within the region is required.
Level 2	<ul style="list-style-type: none"> • Large incident will require regional mutual aid resources to resolve, number of casualties and/or fatalities is known to exceed local capabilities. • Family Assistance Center (FAC) will need to be activated. • State agencies will be required to assist with on-scene medical treatment and transportation of the injured. • Multiple on-scene triage areas will be required to be set up. • Regional hospitals will initiate surge considerations use of COTS. • The normal day-to-day C/ME Office response system is functional and a mandatory 12-hour shift is initiated for personnel. • Human remains are fragmented, but do not require decontamination. • Criminal or terrorist involvement is not suspected. • The scope of destruction / level of difficulty in recovery is significant. It is difficult to locate and remove human remains. • Coroner Mutual Aid from several jurisdictions within the region and state OMORT is possibly required.
Level 3	<ul style="list-style-type: none"> • Catastrophic incident, number of casualties and fatalities is a worst-case scenario (i.e., pandemic influenza or infectious disease of similar gravity), number of casualties and/or fatalities is known to exceed regional capabilities. • Multiple Family Assistance Centers (FACs) will need to be activated. • State and federal agencies will be required to assist with on-scene medical treatment and transport of the injured. • Multiple on-scene triage areas will be required to be set up. • Regional hospitals will initiate patient-diversion plans coordination with COTS. • The normal day-to-day C/ME Office response system may not be functional. A mandatory 12-hour shift schedule for Coroner's Office personnel who are able to work is initiated. • Human remains are fragmented or contaminated and require decontamination. • Criminal or terrorist involvement may be suspected. • There is risk of biological, chemical, and/or physical hazards. • Coroner Mutual Aid (regional, state, and federal-DMORT) is required. In the case of a worst-case scenario pandemic, external assistance may be very limited or not available. • Non-traditional death care methods, as coordinated by a Regional Operations Center (ROC), may be required.

Table 3.1

7. Plan Deactivation: The Coroner/Medical Examiner (C/ME) will deactivate the mass fatality portion of this plan once all mass fatality operations have been completed. This deactivation will be coordinated with the deactivation of involved Emergency Operations Centers (EOCs).
8. The C/ME Office will follow procedures for demobilization as required by organizations that have loaned facilities, refrigerated vehicles, equipment, and supplies. In the absence of specific procedures, the C/ME Office will adhere to Disaster Mortuary Operational Response Team (DMORT)-Region V procedures for demobilization.
9. Following a mass fatality event there will likely be long-term issues that will need to be addressed. These may include environmental damage, economic impact, grief counseling for family members and critical incident stress debriefing for staff. The agencies responsible for managing the long-term impacts will depend on the particular issue. It is useful to discuss the anticipated long-term considerations in the After Action Report (AAR) in order to identify the responsible agency.

D. Resource Request Prioritization & Acquisition

1. OHS Region 7 agencies in coordination with state, non-governmental, private-sector, and as needed federal agencies will work together to manage the safe recovery of the deceased with dignity and respect; however, will prioritize providing care to the living.
2. The nature of the incident will dictate priorities. Saving lives is the priority and will take precedence over human remains recovery. In some situations, a full focus on human remains recovery may not begin until rescue operations are terminated.
3. In accordance with the Ohio Catastrophic Incident Response Annex to the State EOP, resource prioritization decisions for Ohio-controlled assets for response to catastrophic incidents will be made by the State EOC's Executive Group.
4. Local jurisdictions and the State of Ohio will employ, to the best of their abilities, all available local resources and implement established mutual aid agreements as needed. Federal assistance will be requested only after it is determined that local- and state-level resources will be inadequate for response or have been exhausted.

5. The COTS Healthcare Incident Liaison (HIL) will coordinate regional request in the event hospitals are in crisis mode and will facilitate information sharing and situational awareness by:
 - a. Requesting EMResource updates and implementing EMTrack for patient tracking.
 - b. Convening a Zone 2 Surge Call with the Zone Lead and regional Clinical Advisors for situational awareness and information sharing for resource needs and clinical expertise.
 - c. Discussing the need to activate the Surge Operations Call Center (SOCC) which includes the four large health systems in Franklin County, and can be requested to be activated during a surge situation.
 - d. Reach out to the other Regional Health Coordinators (RHCs) within the state to request hospitals statewide to update EMRsource to assist with patient movement.
 - e. Resource request are managed through the COTS HIL and local EMA using Coalition Healthcare Disaster Information Management System (COHDIMS) and a 213 RR form respectively. All medical supplies requests will be sent through the COTS HIL to all Zone 2 partners for mutual aid support.

E. Public Information Considerations

1. Emergency Public Information (EPI) requirements by plan activation level are outlined below.
 - a. During Level 1 activations, widespread EPI would most likely not be necessary.
 - b. During Level 2 activations, EPI would likely be coordinated on-scene, primarily through the security (i.e., law enforcement) function, or possibly through a Joint Information System (JIS) to control rumors.
 - c. During Levels 3 activations, all EPI resources available throughout the region and state of Ohio should be utilized.
2. Special public information considerations for Mass Casualty Incidents (MCI) including the following:
 - a. Where and how family members and friends can access information regarding loved ones.
 - b. Public protective measures to limit the number of future or “cascading” casualties.
 - c. Informing the public of where and how to access mental health services.

- d. All patient information must be kept secure and private. While the efficient transmission of information throughout the response command structure is vital, such regulations as the Health Insurance Portability and Accountability Act (HIPAA) still apply. For these reason, sensitive patient information (i.e., names, other identifying information) should only be transmitted over encrypted channels.
3. The State EOC's Joint Information Center (JIC) may be requested to produce press releases or conduct press conferences in response to needs identified by the Incident Commander (IC) or other entities.
4. Authorized JIC supporting agencies and individuals will be limited and will coordinate with other agencies, including the local Public Information Officers (PIOs), C/MEs to provide joint press releases at the JIC, if established.
5. To prevent or minimize loss of life, damage to property, and harm to the environment in Ohio, government on all levels will provide consistent, coordinated, accurate, and timely information to the at-risk public. The information flow will begin as early as possible, be maintained throughout the event and continue well after the event ends.
6. The public will be made aware of potential adverse effects and of actions recommended to safeguard lives and property. Information regarding prudent protective actions will be conveyed to the public as time allows during a real event, and will continue into the recovery stage.
7. State-level information that is of greatest public interest during and immediately following a mass casualty incident may include, but may not be limited to: where and when to seek medical care, quarantine and isolation issues, family assistance services, pet and livestock care issues, traffic management, law enforcement, transportation issues (including road closures), shelter locations, air quality, water quality and water-borne disease, nursing home issues, bridge closures, urban search and rescue issues, state office closings, state park closures, insurance issues, power outages, telephone service, and lodging availability.
8. In general, state-level news releases will be distributed to the mass news media statewide and to national and international media as appropriate, with priority consideration given to the media most able to effectively communicate with the at-risk population.

F. Initial Response / Field / Pre-Hospital Care

1. Field responders may find it advantageous to evacuate the scene immediately surrounding a Mass Casualty Incident (MCI), if evacuation can be done securely and efficiently.
2. It is important to keep fatalities together (at least initially) for the following reasons.
 - a. Families: From a tracking standpoint, it may be easier to facilitate family identification if fatalities are kept at a central location.
 - b. Investigation: If criminal activity is suspected or known, fatalities may serve as evidence.
 - c. Contamination: If fatalities are contaminated, keeping them in a central location limits the spread of contamination.
3. All personnel involved in the field-level response should follow local protocols as espoused by the local Medical Director.
 - a. Medical direction should not expect personnel to act outside of their scope of practice, unless, however, the order comes from higher levels of government (e.g., the Governor).
 - b. The Medical Director should monitor conditions to determine if alternate standards of care should be given.
 - i. "Alternate standards" typically mean a shift in providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast the traditional focus on saving individuals.
 - ii. Examples
 - Applying the principles of field triage to determine who gets care
 - Changing infection control standards to permit group isolation rather than single-person isolation
 - Creating alternate care sites at facilities not designed to provide medical care
 - Changing who provides various kinds of care
 - Temporarily changing privacy and/or confidentiality practices
4. There are approximately 137 EMS units within Ohio Homeland Security (OHS) Region 7, with a regional population of 456,798 there is one EMS unit for every 3,335 individuals (See map on next page).

EMS Units (incl. spares)



0 30 60 120 180 240 Miles



**OHS REGION 7
MASS CASUALTY /
MASS FATALITY
PLAN**

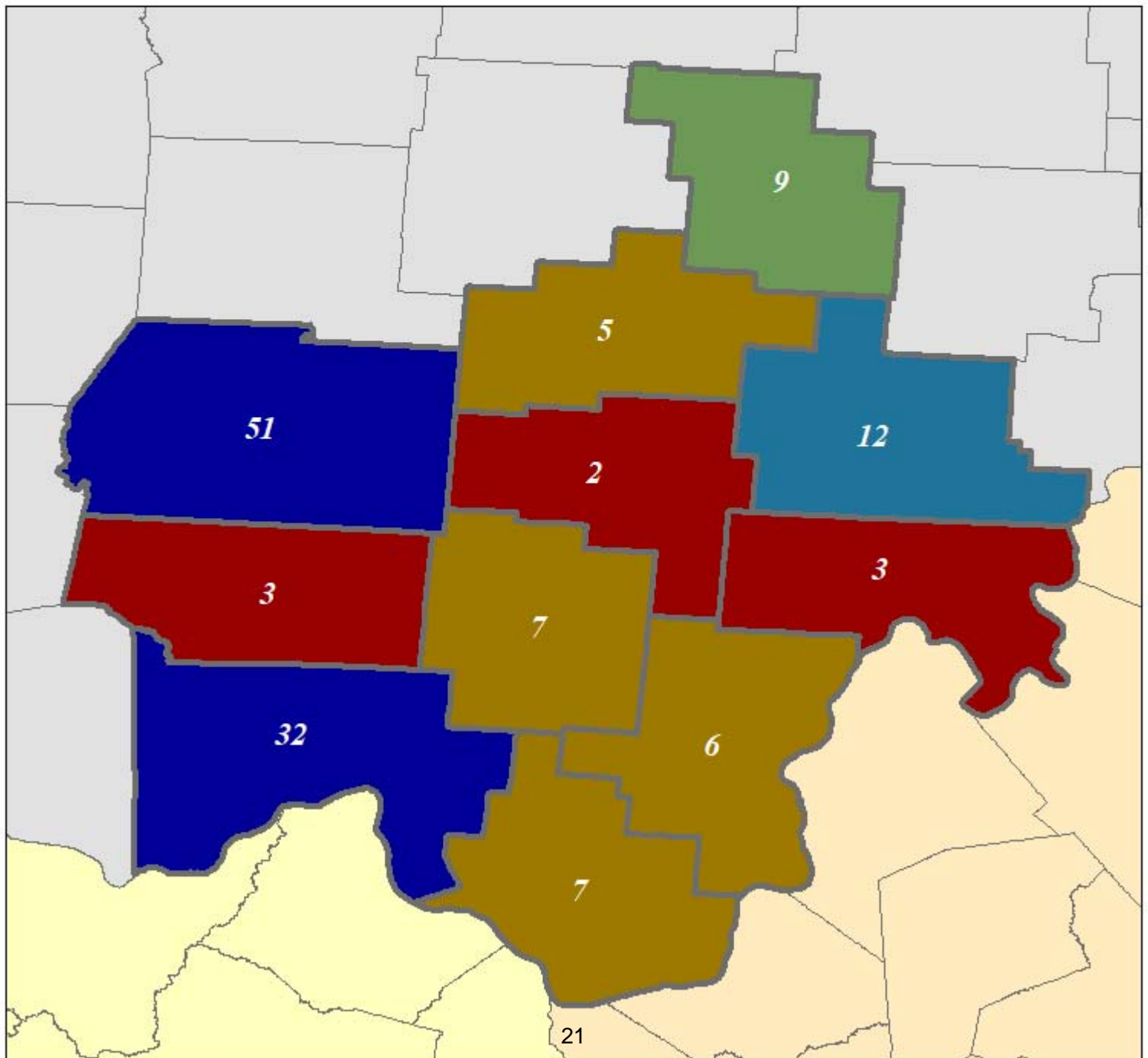
MCI / MFI Resources

Data Source(s):
See Appendix 1

Figure 3.1



DISCLAIMER: Data is meant for use as reference only. Some sources may be intended to be used at national or regional scales and are thus used beyond their original intent for demonstrative purposes.



G. Triage Operations

1. Simple Triage and Rapid Treatment (START) and Sort-Assess-Lifesaving Interventions-Treatment and/or Transport (SALT) triage are both still in practice throughout OHS Region 7 and should be maintained during a Mass Casualty Incident (MCI). The region is in the process of transitioning to SALT triage. (*NOTE: START triage should be used for adults; JumpSTART should be used for pediatric patients.) As such, *all* casualties at an incident site are classified as:
 - a. **Immediate (RED)**: Breathing, but unconscious; respirations over 30; capillary refill greater than two (2) or no pulse; or unable to follow simple commands (i.e., mental status);
 - b. **Delayed (YELLOW)**: All remaining cases; breathing has pulse, level of consciousness normal, may not be able to move due to incapacitating injury (i.e., burns, fractures, back injury, etc.).
 - c. **Minor (GREEN)**: Mobile, sometimes referred to as “walking wounded”; or
 - d. **Deceased (BLACK)**: No respirations after tilting the head; obvious mortal injuries where death appears reasonably certain or victim is already dead.
2. In accordance with START triage, tags should be used to denote the severity of a victim's injuries *and to begin the tracking process*. The bar codes that are on the tags allow the Transport Officer to maintain accountability for those treated and transported.
3. In 2008, a new triage paradigm was proposed by many of the major healthcare and disaster response organizations. Using aspects of existing systems and based on best evidence, SALT triage was developed as a national all-hazards Mass Casualty initial triage standard for all patients (e.g., adults, children, special populations). SALT was designed to allow all agencies to easily incorporate it into their Mass Casualty Incident (MCI) triage protocol through simple modification.
4. Someone who is bleeding can bleed to death in as little as 3 to 5 minutes. SALT triage allows for early hemorrhage control. In START triage, bleeding control doesn't occur until after respirations are counted and perfusion (cap refill) is checked.
5. Using SALT triage the individual assessment begins with limited rapid lifesaving interventions.
 - a. Control major hemorrhage with tourniquets or direct pressure provided by other patients or other devices.

- b. Open the air way through positioning or basic airway adjuncts (no advanced airway devices should be used).
- c. If the patient is a child, consider giving two rescue breaths.
- d. chest needle decompression.
- e. Chemical, Biological, Radiological and Nuclear (CBRN) Antidotes or Auto-injector antidotes.

SALT Mass Casualty Triage

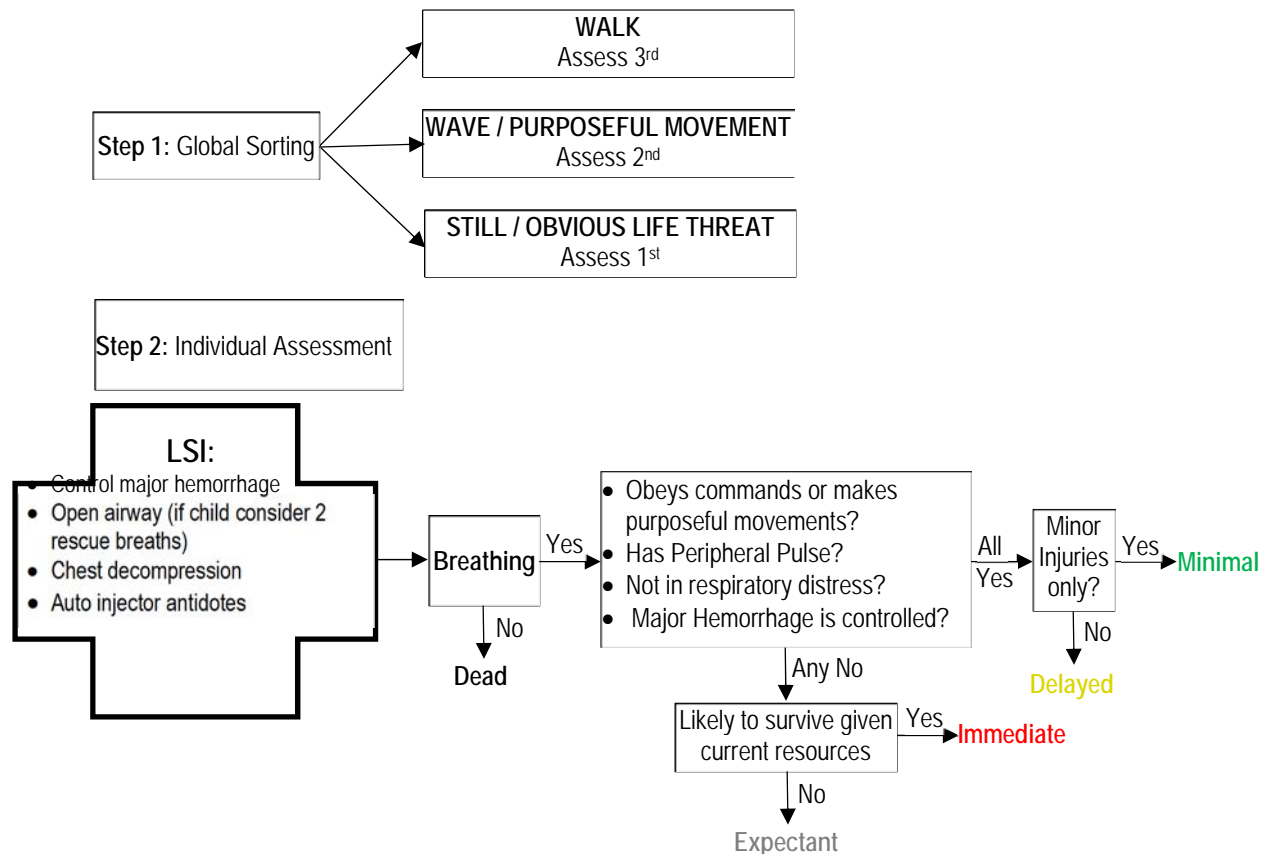
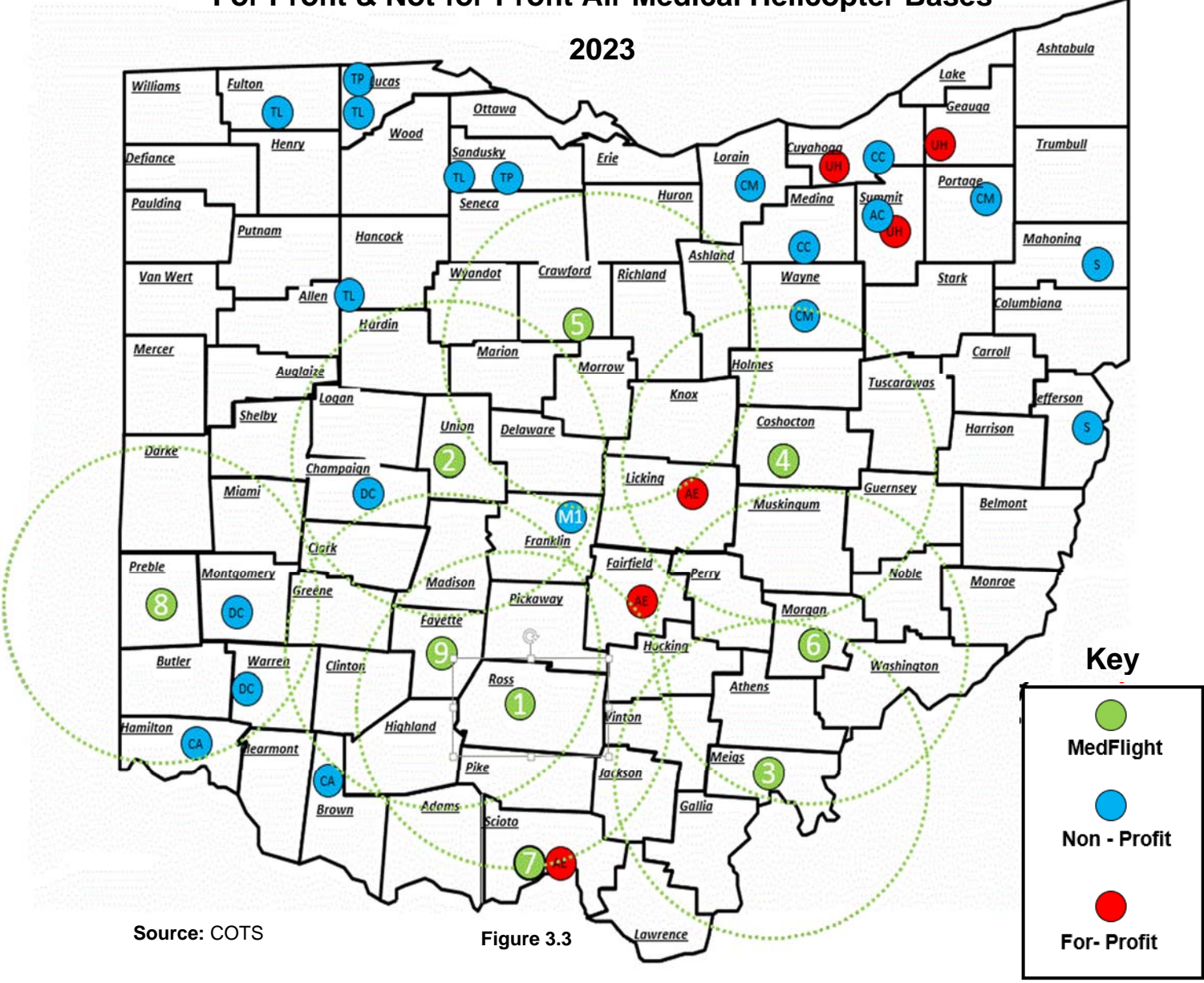


Figure 3.2

6. Command or, if designated, the Safety Officer (SO) shall decide if the area is safe or potentially hazardous. If safe, triage shall be accomplished before removal to a treatment area. If hazardous, the operations shall proceed to a rescue mode, (i.e., victims shall be moved rapidly to a safer area where triage shall then be completed.
7. Within the Incident Command System (ICS) structure, someone may be designated to fill the role of “Walking Wounded Supervisor”. This individual’s primary responsibility would be to maintain accountability of the walking wounded (i.e., green tagged) *and ensure that no one leaves the site without being registered in some way.*
 - a. It is especially important that the walking wounded be tagged, *even during smaller incidents.*
 - b. The Walking Wounded Supervisor serves as a sort of “questioning point”, where the walking wounded can be assessed and logged.
8. To reduce congestion at an MCI scene, responding EMS units may be requested to report to a designated Staging Area. Ambulances will then be brought in one at a time to load patients. The location of the staging area should be coordinated with Incident Command. The staging area should be readily accessible, easy to locate, and in proximity to the loading zone in the treatment area. EMS units in the staging area should be divided by personnel/squad capabilities:
 - a. Basic Life Support (BLS)
 - b. Intermediate Life Support (ILS)
 - c. Advanced Life Support (ALS)
9. If helicopters are utilized, a landing zone must be identified, using Global Positioning System (GPS) if available, at a safe distance from the scene. Communications with air medical transport shall be established on a separate frequency than that being used by other sectors. It may be necessary to use ambulances or other vehicles to move personnel and equipment between the helicopter and treatment area, and to carry patients to the landing zone. Air medical resources contained within the boundary of OHS Region 7 are stationed in Meigs, Ross, and Scioto Counties (See map on next page).

For Profit & Not-for-Profit Air Medical Helicopter Bases



H. Search & Rescue Operations / Human Remains Recovery

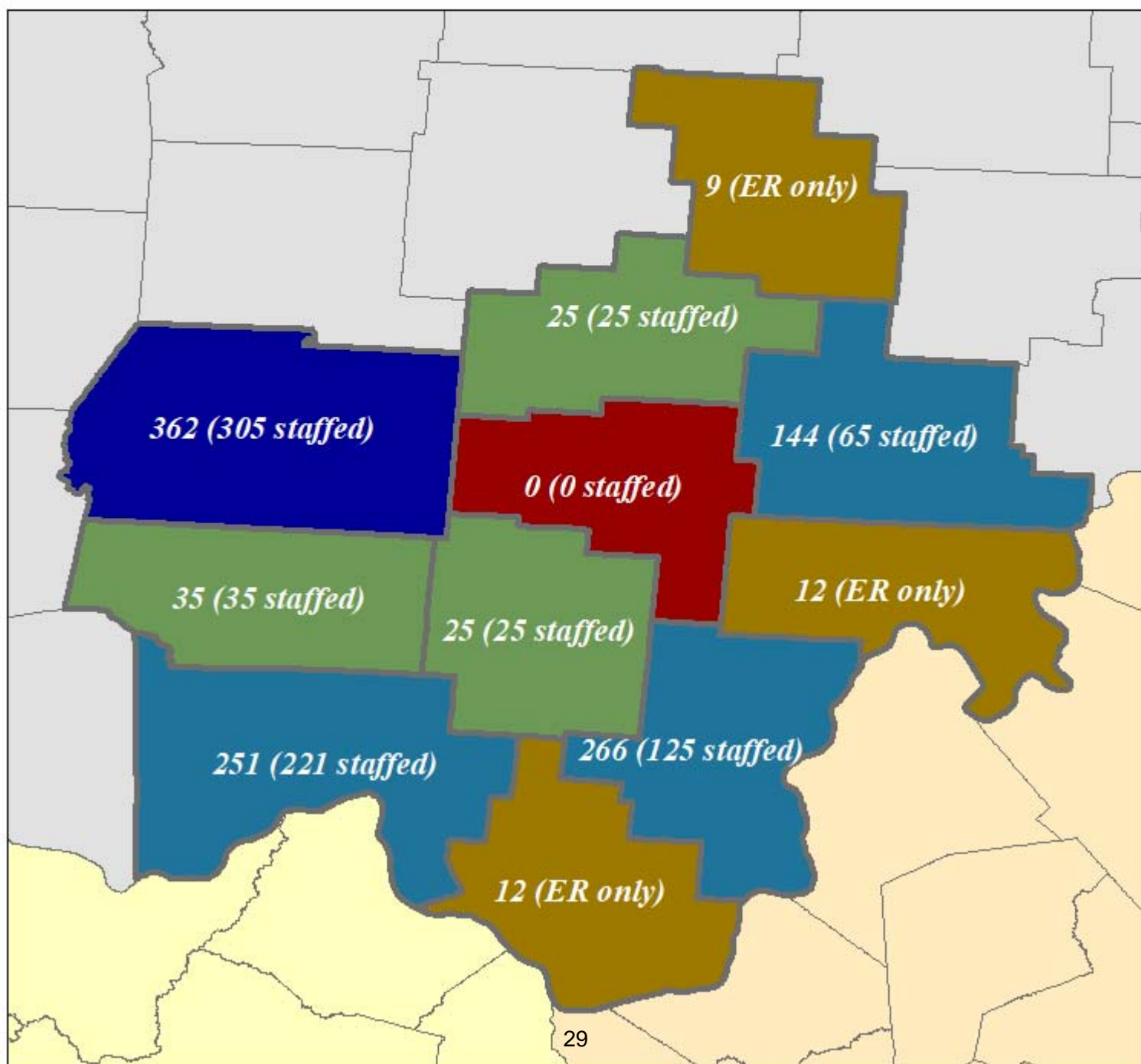
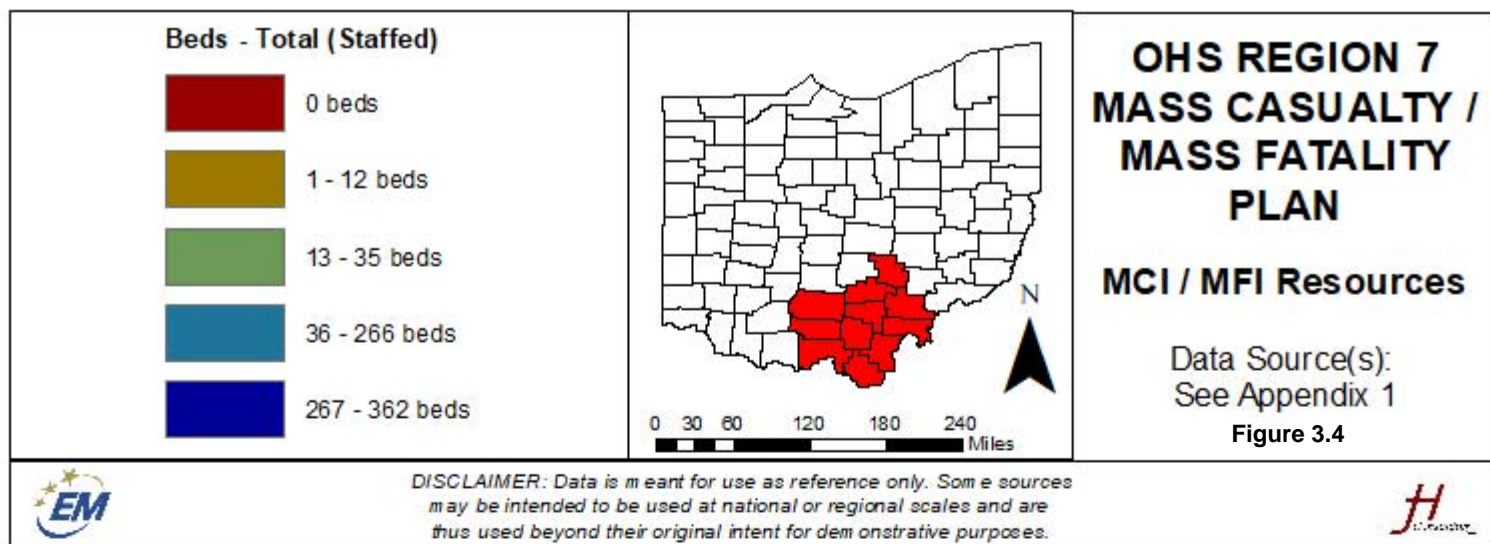
1. The C/ME Office is in charge of coordinating and managing human remains recovery. The only exceptions are incidents involving commercial airline accidents and/or when domestic terrorism is suspected. If this is the case then the Federal Bureau of Investigation (FBI) – Evidence Response Team provides personnel and management for the search and recovery of human remains, personal effects, and accident-related wreckage, with the local jurisdiction augmenting response.
2. All incident scenes should be treated like a crime scene until it has been formally determined that it is not one. When entering an out-of-hospital scene of death, the C/ME must be accompanied by police personnel at all times, and may not remain at a death scene without police escort being present.
3. A mass fatality scene that is contaminated or extremely hazardous may prohibit C/ME responders from evaluating in a timely manner, and may require additional local, regional, or state assistance.
4. Scene documentation, photographs, and other processes must be completed before human remains are removed. This ensures the integrity of chain of custody for evidence and improves the ability to make rapid and accurate identifications of the deceased.
5. An accurate and reliable numbering system for all human remains is crucial to an effective response mission and will be implemented by the C/ME at the onset of the incident.
6. Contaminated remains will not be transported to the incident morgue until they are decontaminated.
7. The bio-waste and other bodily fluids from human remains during phases of recovery may become a hazardous and toxic issue requiring collaboration with local County Health Departments.
 - a. The safe handling of human remains should always consider the cause of death (infectious disease versus trauma), but as a minimum, include universal precautions for the individual handling the remains and respectful treatment of the deceased individual.
 - b. Personal Protection Equipment (PPE) for handling remains of individuals who have died should take into consideration the risk of bodily fluids (sweat, blood, feces, etc.) penetrating the handlers clothing, mucus membranes (eyes, nose, and mouth) and/or abrasions of their skin.

- c. PPE for handling remains of individuals who have died from an infectious disease, radiological incident, or chemical incident should consider, the mode of transmission of the disease and communicability after death, radiological contamination of human remains, and/or chemical contamination/residual of human remains.
8. Initial scene evaluation considerations:
- a. Search and recovery officials, and hazmat response personnel in coordination with the C/ME will determine the following:
 - i. Potential or real number and location of remains.
 - ii. Condition of the bodies.
 - iii. Potential number of remains for autopsy.
 - iv. Complicating factors or level of difficulty in recovery – types and numbers of personnel and equipment needed.
 - v. Accessibility of the incident site.
 - vi. Possible biological, chemical, or physical hazards.
 - vii. Level of Personal Protective Equipment (PPE) required.
 - viii. Ensure that initial pictures of the site are taken.
9. The C/ME will consider allocating more resources for the recovery process when decomposition is an issue or when overall resources are limited. If remains are recovered and placed in cold storage in a time-critical manner, then the C/ME can process remains at a rate that coincides with available resources and personnel.
10. To provide postmortem care of remains they should be placed in fully sealed impermeable human remains pouches (i.e., body bag) prior to removal. The body and pouch should be clearly tagged with the individual decedent's identifiers such as name, date of birth, social security number, location of origination, medical record number, etc. Completed labeling reduces the number of times mortuary staff needs to open pouches to confirm the contents.
11. Numbering of the remains found will be simple and agreed upon by all responders to avoid multiple designators for the same remain. Each remain should receive its own numerical identifier. Co-packaging of remains reduces the possibility of a Deoxyribonucleic Acid (DNA) identification, therefore each remain will be packaged and numbered separately.

12. No family members will be allowed into the scene while recovery operations are under way. All family members will be directed to a Family Assistance Center (FAC).
13. Human remains recovery operations and morgue operations should be monitored at the FAC. Continuous and open communication is necessary in order to provide families and officials with current and timely information on the progress of the operation at the incident site and the morgue.

I. Casualty / Fatality Surge & Hospital Considerations

1. The surge capacity within the regional healthcare system considers full utilization of all “down time” areas within the health system.
2. Once capacity at regional facilities is exceeded, such tactics as diversion would be utilized on an as-needed basis. As patient numbers increase beyond the capacity of the impacted hospital, they will activate their internal Emergency Operations Plan (EOP), contact the COTS HIL, and contact their local EMA.
3. There are 12 hospitals in OHS Region 7. There is one hospital per 38,067 individuals, none of these hospitals are considered trauma hospitals. There are 1,141 total hospital beds available in the region. The total population of the region is 456,798, thus there is one hospital bed for every 400 individuals. There are approximately 834 staffed hospitals beds available throughout the region, creating one staffed hospital bed for every 550 individuals (this number will fluctuate with staffing availability, see map on next page). Hospital resource located just outside of the region include:
 - a. St. Mary's Medical Center, Huntington, WV (360 beds)
 - b. Kings Daughters Medical Center, Ashland, KY (350 beds)
4. Medical treatment facilities will expand their capacities by canceling or rescheduling elective surgical procedures, discharging non-critical patients, and diverting non-critical patients to other facilities. Specialized transportation assets will likely be required to support the discharge/diversion/transfer of patients.
5. In the event of patient transfers during a disaster, the Medical Director or his/her designee at the responding facility shall evaluate the patient census, patient treatment needs, and staffing plans to determine the number and type of patients to be transferred from the affected facility.
6. Sites such as EMResource and/or Real Time Activity Status (RTAS) could be utilized to gain information on numbers of available beds, the availability of medications, etc.



7. Regional health departments engage in on-going medical surge planning; it is not the intent of this plan to over-write any of those efforts.
8. Disaster Response Medical Units (DRMUs) may be activated through the State EOC when regional hospitals surge beyond capacity. DRMUs are designed to treat patients who need non-acute care.
9. When C/MEs determine that the number of fatalities exceeds local resources and capabilities to effectively handle the situation, they may request that the County EMA Director request state-level assistance.
10. When faced with a fatality surge that stresses the capacity for carrying out burials or cremation in a region, Ohio Department of Administrative Services (DAS), and the Ohio Board of Embalmers and Funeral Directors (OBEFD) will survey crematory facilities to identify the maximum number of cremations that can be performed, and identify cemeteries, crematory facilities, embalming facilities, and funeral homes within or accessible to the region. These agencies will also identify storage capacity, refrigeration requirements, backup generators, and the number of hearses/vehicles available to transport bodies.
11. It is estimated that approximately 500 cremations per day can be performed in Ohio (*ESF-8, Tab D Acute Mass Fatalities Incident Response Plan*).
12. Consider increasing throughput of Ohio's Electronic Death Registration System (EDRS) and the suspension of other non-essential activities, and increase the number of personnel involved in data entry. The EDRS is a web-based application that simplifies that data collection process and enhances communication between funeral directors, local registrars, coroner/MEs and certifying health care providers as they work together to register deaths online.
13. The local health department/registrar will act to streamline the death registration process when necessary. This may be done by limiting the use of EDRS for non-emergency tasks (issuance of birth certificates) on a short-term basis, as well as activating temporary assistance for the creation or filing of disposition permits and certificates of death.

J. Law Enforcement / Public Safety & Security

1. Local law enforcement and county Coroners/Medical Examiners (C/MEs) are responsible for investigating acute deaths that are not due to natural causes, or that do not occur in the presence of an attending physician.
2. Law enforcement resources would normally be relied upon to provide security for a MCI scene, morgue sites, and at Family Assistance Centers (FACs) at the direction and control of the IC. Security includes not only considerations for the actual scene, but also for body storage locations, transport routes, etc. Some hospitals in region do have their own security personnel.
3. Security resources may be requested to establish and staff control points at and/or near the incident scene to control access (i.e., provide perimeter security). Security personnel may further be asked to coordinate heavily with a Walking Wounded Supervisor, should one be activated.
4. Key consideration for securing all mass fatality operations sites include; controlling access into, within, and out of the facilities, perimeter protection, parking lot protection, traffic control, and crowd control.
5. All authorized personnel, volunteers, and approved visitors must have photo ID security badges that reference function and access.
6. Security will be provided to preserve evidence, and to protect response personnel and volunteers.
7. Security will be provided for escorting vehicles transporting human remains from the incident site to the morgue
8. Crime Scene Preservation
 - a. If criminal activity is suspected, all casualties – injuries and fatalities alike – should be considered as evidence and tracked accordingly.
 - b. Since many victims would need treatment and transport as part of life-saving efforts, photographs, logs, etc. should be taken/maintained as part of the triage and transport operation.
 - c. For investigative purposes, responders should not tamper with fatalities for as long as possible.
 - d. The IC may consider activating the Information and Intelligence function as a General Staff Section if the Mass Casualty Incident (MCI) is a part of a criminal-related emergency.

9. Fire marshals may also need access to MCIs that are fire-related to conduct investigations as to causes, injuries/deaths, etc.
10. The remains of deceased persons are brought to the Coroner's Office because Ohio Law requires that the Coroner investigate deaths of persons dying from:
 - a. Criminal Violence,
 - b. By accident,
 - c. By suicide,
 - d. Suddenly,
 - e. When unattended by a physician for a reasonable period of time,
 - f. In detention,
 - g. In any suspicious or unusual manner, or
 - h. The identity of the deceased or the next-of-kin is unknown.

K. Public Health Considerations

1. County level General Health District / Health Departments may fill the role of Incident Commander (IC) for MCIs caused by a public health emergency.
2. Environmental Monitoring
 - a. Monitoring would include efforts to identify any environmental factors that may have contributed to the MCI (if there are believed to be any) as well as assurance that the environmental impacts of a mass fatalities (e.g., contamination of water supply) are minimized.
 - b. "Environmental monitoring" includes laboratory service, knowledge, and authority. County level health departments throughout the region should seek to ensure that environmental monitoring is on-going and continuous.
 - c. County level/local health departments serve as the local Point of Contact (POC) for environmental concerns. If the necessary resources are not available locally, the health departments can employ mechanisms to secure external resources. As such, public health should be appropriately integrated into the command structure.

L. Workforce Depletion

1. During a non-acute mass fatalities event, many individuals may be sick or taking care of family members who are sick, and may not be available to perform their regular duties. Only individuals accustomed to processing and handling remains should handle bodies. This requirement; however, limits trained officials' abilities to assign anyone to perform most fatality processing related tasks.
2. Officials must be prepared to shift some of their staff members' function from 'worker' to 'manager'. Volunteers will need to be managed, trained, informed, directed, and coordinated for expansion of non-acute mass fatality response operations. Officials must incorporate a means to protect employee health and reduce the spread of infection to workers (to include volunteers). This may include social distancing and working from home.
3. In response to a non-acute mass fatality incident that affects one-or-more local jurisdictions, state-level resources may be needed to:
 - a. Assist in the identification and training of volunteer responders before an incident occurs.
 - b. Assist in the identification, acquisition and/or provision of just-in-time training programs and the training of volunteers on tasks, including training on personal protective equipment.
 - c. Assist in the identification, acquisition and/or provision of temporary housing for temporarily-placed emergency staff that respond to non-acute mass fatality events.
4. Emergency staff privileges and licensed employee verification shall be expedited by the responding facility(ies) but shall not compromise the quality medical care provided by responding facility to patients.
5. Per the requirements of the Joint Commission, hospitals are required to have a plan in place to conduct rapid credentialing and licensure verification.

M. Identification of Decedents / Dental Identification

1. Factors impacting the identification of decedents in a mass facility incident include:
 - a. Number of fatalities
 - b. Decedent population (open or closed)
 - i. Closed populations: when the number of individuals who have died and their names are known. A commercial airline accident would be an example.
 - ii. Open populations: Neither the number of individuals who have died nor their names are known. September 11, 2001 World Trade Center mass fatality incident is one example.
 - c. Availability of ante-mortem information
 - i. Collection and examination of antemortem information to help identify decedents can begin immediately in a closed population incident.
 - ii. The process of examining antemortem information does not begin until those who are confirmed missing are identified in an open population incident.
 - d. Condition of remains (completed or fragmentary, commingled remains).
 - i. Fragmented and commingled human remains require a significantly longer examination process.
2. Personal identification of a decedent is an important function for the completion of death certificates, and to return a body to the appropriate next of kin.
3. The primary means of initially identifying victims would be searches of wallets, purses, driver licenses, social security cards, etc. Other items to note include:
 - a. Presence of medical bracelets,
 - b. Presence of pacemakers and/or other special medical needs, and
 - c. Presence of organ donors.
4. The standard means of achieving positive identification of human remains are fingerprints, footprints, dental records and DNA.
5. Other accepted means of victim identification could include (but not be limited to) matching of unique anthropological features utilizing ante-mortem x-rays or medical records, matching of unique prosthetics devices (i.e., pacemakers, orthopedic appliances, etc.), scars, marks, or tattoos.

6. The Ohio State University (OSU) Wexner Medical Center, Regional Autopsy Center located in Columbus Ohio can be utilized to augment autopsy services.
7. Dental identification operations are divided into three sections; postmortem section, ante-mortem section, and comparison section.
8. Dental postmortem requires performing dental autopsy, including postmortem dental radiography and photography, and recording the results in WinID or in a standardized format compatible with WinID. WinID is a windows-based software program that stores data in a Microsoft Access Database, and provides extensive data filtering and data sorting capabilities.
9. The ante-mortem section is responsible for transcribing all available clinical information onto an ante-mortem record. Documentation for the ante-mortem section includes radiographs, written record of treatment, and charting of all dental structures and restorations.
10. The comparison section compares ante-mortem and postmortem dental records for the purpose of identification.
11. Field resources should attempt to keep fatalities at a central location for as long as possible. Doing so facilitates a more efficient examination by local C/MEs.
12. To secure proper identification of decedents; all who interface with decedents are encouraged to record official personal identification information for decedents who enter their systems, and to maintain this information in the decedent's police report and/or medical record.
13. If a deceased patient entered the system without official photo identification, and the identity is never established, healthcare facilities should report this person to the decedent's local police department.
14. The minimum information needed for personal identification includes:
 - a. First, middle, last name and suffix.
 - b. Race/Ethnicity, color of eyes, hair, height, and weight if unidentified.
 - c. Home address, city, state, zip code, and telephone number.
 - d. Location of death and place found (place of origination of the body before movement to the hospital or other facility).
 - e. Place of employment and employer's address.
 - f. Date of birth, social security number and age.
 - g. Next-of-Kin (or witness) name, contact number and address.

15. Once identity is confirmed by the Identification Team, the information is presented to the C/ME, who will review and, if approved, issue a death certificate.
16. There is an Unidentified Person Registry at the federal level in the National Crime Information Center (NCIC) that may be utilized by law enforcement if local efforts fail, or the decedent is not local.
17. When no human remains are recovered, or scientific efforts for identification prove insufficient, the C/ME will file a single verified petition with the superior court to judicially establish the fact, time, and place of death for individuals who die in a Mass Fatality Incident (MFI).
18. Law enforcement agencies as well as any “extra” fire service resources may assist in the identification of victims.

N. Family Assistance Centers (FACs)

1. In the immediate hours after a mass casualty or mass fatality incident, a Family Reception Center may need to be established as a centralized location for families and friends to go, before a Family Assistance Center (FAC) is operational. Depending on the nature of the incident, this could be established at a community location, a hospital or a hotel.
2. FACs will be set up at locations convenient to mass fatality incidents as necessary, but not adjacent to the mass fatality incident site.
3. Family members will begin to come to the incident site almost immediately. The FAC – with at least basic services, needs to be open and operating within 24-hours of the incident.
4. FAC staff should anticipate eight (8) to 10 family members per potential victim requesting assistance from the FAC.
5. There should only be one FAC established, where families interact and congregate. Other agencies who have a need to interact with victims’ families (i.e., military family assistance teams, first responder communities, etc.) should integrate into the FAC established for the incident.
6. The centers will provide for a secure location for the collection of information on the deceased to assist in their identification, and for the provision of social, mental health, and medical services to families of the deceased.

7. A family Victim Identification Center (VIC) should be located inside the FAC where C/ME and law enforcement officials can manage the necessary ante-mortem interviews, and notify the next of kin on the status of their loved ones.
8. Under the direction of the C/ME, FAC staff will ensure that proper victim identification forms and ante-mortem interviews are completed and will ensure the use of current Victim Identification Profile (VIP) interview forms. Victim Identification Profiles is an electronic database that has been used since 1994 from mass fatality events where federal government assistance has been requested to assist in the interview of families and ultimately in the identification of individuals who are deceased.
9. FAC operations will be managed by local jurisdictions with support from the state and the American Red Cross (ARC) as needed (i.e., interviewing families, facilitation of family care, counseling services, and referral services).
10. Human remains recovery operations and morgue operations should be monitored at the FAC. Continuous and open communication is necessary in order to provide families and officials with current and timely information on the progress of the operation at the incident site and the morgue.
11. FAC staff should maintain message boards, and post messages for staff and volunteers working at the FAC.
12. If a causal agent results in the possibility of a threat of infection resulting from social congregation, authorities will determine whether a virtual FAC is a better option.
13. Core family assistance services or functions may include, but not be limited to the following:

FAMILY ASSISTANCE FUNCTIONS	
Functions	Agency/Organization
Family briefings	C/ME Office, Priests, Chaplins, etc.
Collection of ante-mortem data for identification of human remains.	C/ME Office
Death notification to next of kin.	C/ME Office, Fire Dept. Chaplins, (ARC Assist)
Management/coordination of all family assistance operations, including all involved organizations and personnel.	Local ARC Chapters
Family support services: <ul style="list-style-type: none"> • Call center / Hotline • Reception and information desk • Spiritual care • Mental health services • First aid/medication • Translation/interpreter services • Child care • Food services/mass care • A wide range of additional services based on the incident. These may include: (lodging, clothing, transportation, financial assistance, financial services, legal services, crime victims services, etc.) 	A wide array of agencies, organizations, and volunteers that work collaboratively under the direction of the agency in charge of family assistance.

Table 3.2

14. For most mass fatalities, expect the FAC to operate 24 hours/seven days a week in the beginning. While some services will be needed during all open hours, many of the direct services can be provided at a time to be determined by the FAC operator/director.
15. Generally, the need for the FAC will decrease as more of the missing are found and identified. Once most of the victims have been identified and following any community memorial service that may be held, the active FAC may transition to a walk-in center for families with need for information and referral services and/or mental health counseling.
16. The following phases illustrate the changing needs of families as family assistance evolves, and are based on Pentagon FAC experience.

Phase 1 – Full FAC Operations	
Stage 1	Families will be seeking basic information about their loved one and be seeking basic emotional support.
Stage 2	Families will be seeking specific information about the disposition of remains, about benefits and entitlements, and will be seeking to bond as a group with other families.
Stage 3	Families will be seeking a wide range of services. Legal assistance will become important.
Stage 4	Families will begin to move on with the next phase of their lives.
Phase 2 – Scaled Down FAC	
Maintain a master locator list of all victim families.	
Provide a walk-in center for families with information and referral and mental health counseling.	
Provide death notifications – information on continued positive identification of human remains.	
Provide a toll-free number for information and referral, legal assistance, counseling, and referral to community agencies for housing and financial aid.	
Provide a FAC resource guide for families to assist them in their transition to longer-term assistance in their communities with information on relevant resources, information about relevant web sites, and information about financial grants, points of contact for donations and other benefits.	
Provide a process for donation acceptance, transfer, and referrals.	
Phase 3 – Long-term response	
A letter to all families notifying them that Phase 2 activities are closing and providing information to further transition to community-based resources.	
A secure, interactive web site for families to provide a single source of useful information, including resources, foundations, donations, plans for a memorial, and links to other related sites. The site will need to be regularly updated and modified to serve the changing needs of families.	
Information on family support groups.	

Table 3.3

O. Morgue Operations and Funeral Assets

1. Only after a field examination (even if it must be an expedient examination) can fatalities be transferred to funeral homes.
2. There are 11 coroners, eight deputy coroners, and 18 investigators (10 part-time) throughout Ohio Homeland Security (OHS) Region 7.
3. Temporary collection points/morgues should be established at the most appropriate local level that will centralize the storage and processing of decedents and maintain the death management community's ability to manage a large number of fatalities. Temporary collection points may not be feasible if the deceased are contagious or there is a risk of disease transmission.
4. Consideration should be given to the possible stigma that may be attached to a temporary morgue. Facilities such as school gymnasiums, public auditoriums, churches, or similar facilities that will be used by the general public after the disaster are not recommended.

5. An incident morgue is the location where forensic studies are completed on the remains from a particular event. The incident morgue could be existing C/ME facilities, or it could be a location retrofitted to support the incident.
6. The need to establish an incident morgue outside of an existing C/ME facility will depend on the scope of the incident, the hazards involved, and existing morgue space available.
7. All potential incident morgue sites should be evaluated by the C/ME and the Ohio State Highway Patrol (OSHP) for security considerations prior to final selection.
8. The purpose of morgue services is to determine the cause of death and to identify the victims.
9. The C/ME will determine layout/workflow for the temporary incident morgue considering the physical condition of the victims, the number of victims, and the number of personnel needed to perform morgue functions. The layout will have stations for all operational areas:
 - a. Administration (morgue management and administration).
 - b. Information Resource Center (electronic comparisons of ante-mortem and post-mortem records).
 - c. Receiving (unprocessed remains storage, chain of custody implementation, and radiograph of remains container).
 - d. Screening/Triage Station (sort remains, personal effects, and evidence; select remains having potential for ID based on incident guidelines and probative value; and determine path – short or long – for examination and identification).
 - e. Admitting Station (numbering, Disaster Victim Packet (DVP), and tracker assigned).
 - f. Documentation Station (photography and personal effects).
 - g. Print Station (finger, palm or foot printing).
 - h. Radiology/X-ray Station (radiology).
 - i. Dental Station (dental identification).
 - j. Pathology Station (complete or partial autopsies).
 - k. Anthropology/Morphology Station.
 - l. DNA Recovery Station.
 - m. Processed Remains Storage (in separate area of receiving station).
 - n. Identification Team Station (Identification confirmation and death certificates).
 - o. Embalming Station (if it is determined that it is needed).

- p. Release of Human Remains Station (may be same area as the receiving station).
- q. Area for rest and emotional, spiritual, and medical support, storage of personal belongings, briefings, restrooms and showers, and area for storing, donning, doffing, and disposal of PPE.

INCIDENT MORGUE FLOW CHART

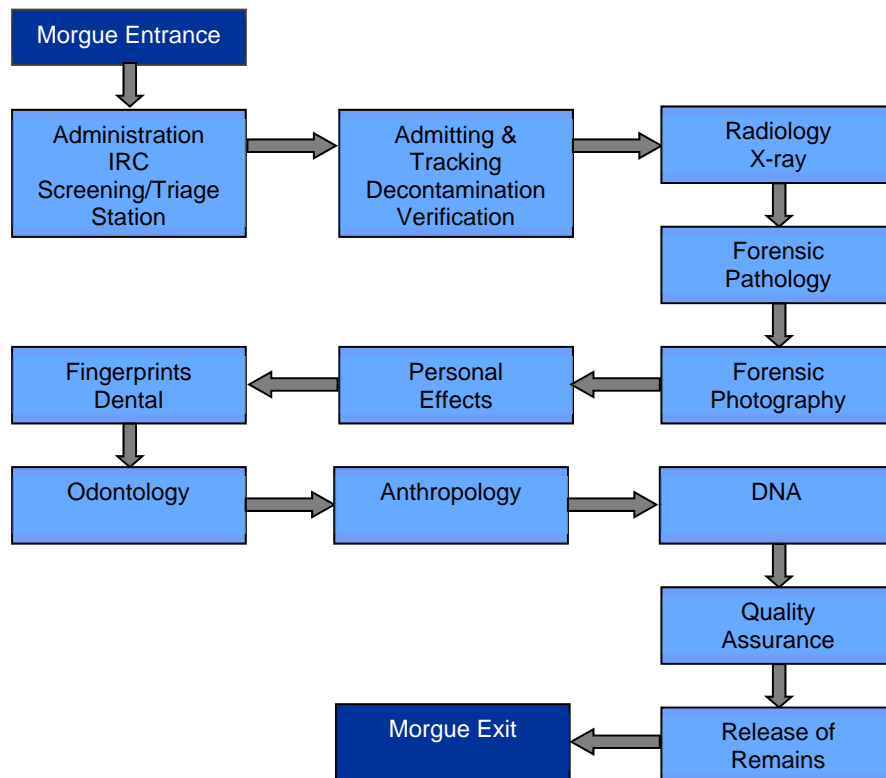


Figure 3.5

- 10. Prior to the commencement of morgue operations and at the beginning of each shift a briefing will be conducted. The briefing will include but not be limited to:
 - a. Orientation and/or updates.
 - b. Safety procedures.
 - c. Necessity for security and confidentiality of all records and data.
 - d. Workflow/procedural issues.
- 11. All agencies and organizations conducting operations at the incident morgue will ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191 and additional local laws that protect privacy of morgue information and records.

12. Religious and cultural customs concerning the handling of remains will be considered and adhered to if they do not impact the examination of remains.
13. In response to a non-acute mass fatality incident that affects one-or-more local jurisdictions, state-level resources may be needed to:
 - a. Assist in the pre-identification and/or acquisition of temporary morgue resources and central collection points/morgues at local and regional levels.
 - b. Assist in the development and maintenance of an ad hoc system for the identification and training of suitable drivers and handlers, and for the training of such, to support the recovery and final disposition process.
 - c. Assist in the identification, acquisition and/or provisions of refrigerated storage containers at collection points/morgues.
 - d. Assist in the drafting and distribution of public education messages, using mass media, to inform the public on the location of collection points/morgues, the need for personal protective equipment if they will be handling bodies.
 - e. Assist in the development, acquisition and/or provision of resources for the movement of remains from recovery through final disposition to conserve fuel consumption.
 - f. Assist in the identification and acquisition and/or provision of resources to accept remains arriving by citizens' private vehicles at collection points and morgues.

P. Tracking and Identification of Human Remains

1. The rapid and accurate identification of mass fatality victims is of critical importance. Issues of probate cannot be resolved until identification has been confirmed and a death certificate signed by the Coroner, or their representative, and issued by the registrar/local health department.
2. Identifying remains during a mass fatality incident could be challenging and impact the ability to release remains for final disposition. For this reason, identification and tracking should begin at the earliest possible stage, preferably at the time of body recovery.
3. Collect and compare ante-mortem and post-mortem data for victim identification (e.g., fingerprints, DNA, X-ray, dental, medical records, distinguishing marks/features, etc.).
4. Ante-mortem data can be obtained from a Victim Identification Center if established, or the use of a victim identification profile.

5. Ensure communication and the transfer of data from, and between, hospitals, physicians, coroners, local health commissioners, ODH, and others.
6. In response to a mass fatality incident that affects one-or-more local jurisdictions, state-level resources may be needed for the following:
 - a. Assist in the development of uniform systems for the numbering and tracking of remains. DMORT and OMORT have existing methods that may be utilized.
 - b. Assist in the development and/or provisions of systems for the gathering of ante-mortem identification material from decedents, including; identification photographs, fingerprints, and DNA samples.
 - c. Assist in the identification, acquisition and/or provision of computer resources and networks to link identification databases at all collection points/morgues.
 - d. Assist in the identification, acquisition and/or provision of systems to track and store daily death counts during a mass fatality event that differentiate between event-related and non-event related deaths.
7. Remains and personal effects will be given a morgue reference number for tracking purposes. Remains and associated personal effects will be numbered using the simple ascending numbering system which references the incident site number. Each body or fragment thereof will be assigned a separate morgue reference number.
8. A body tracker will be assigned (one per body bag with associated personal effects), who will remain with the assigned case while the case is processed in the morgue.
9. In an effort to track human remains, if the name of the deceased is known, seal and label each body, body bag, clothing and personal effects bag and medical record with the deceased's name and date of birth. If the name is unknown, mark each of the above with a unique identifier (i.e., Adena Regional Medical Center), with the chart number, and the address of origination. If bar coded triage tags are available, ensure each item listed above is marked with the same barcode number.

Q Decontamination of Human Remains

1. Following the completion of required forensic documentation of the scene, contaminated remains will be collected and transferred to a decontamination line for further processing.
2. C/ME, forensic staff, and possible DMORT or other qualified agencies shall ensure all physical evidence in, and on the remains are collected, documented and removed from the remains prior to decontamination.
3. Once the evidence collection phase is completed, the remains will be decontaminated, checked for further contaminants and, if clean, placed in an initial body bag, which will be secured and rinsed and placed into a second body bag, before being placed into a refrigerated unit.
4. Although the remains will be decontaminated prior to being transferred to the morgue, the C/ME and hazmat officer will have to determine the appropriate Personal Protective Equipment (PPE) to be used in conducting autopsies, as there may be the potential for exposure due to internal contamination or post mortem examinations operations.
5. Personal effects will also be decontaminated once they have been examined and the necessary evidence has been collected.
6. Remains and associated personal effects (which can be safely returned) will be given the same number which was assigned to the remains. The personal effects will be released to the next of kin once the needs of the C/ME and law enforcement have been satisfied, and when it has been determined that their release does not pose a hazard to the families or the investigation.
7. Mortuary responders should be monitored for contamination levels, appropriate PPE must be donned. For most tasks at a field morgue, standard medical precautions will provide sufficient protection against contamination. Because remains recovery teams will be working within the affected area (i.e., Hot Zone), their PPE requirements will likely be more stringent than those for field mortuary staff. Operational timing and work/rest schedules for responders should be observed. Time, distance, and shielding should be utilized as protective measures.

8. Effective provision of screening and decontamination services hinges on the establishment of contamination control zones. Typically, a response to any hazardous materials incident will include the establishment of three zones:
 - a. Hot Zone – the area that presents the greatest hazard due to the presence of hazardous materials.
 - b. Warm Zone – the area surrounding the hot zone, where transitional activities, such as decontamination of personnel and victims, takes place.
 - c. Cold Zone – the staging area for responders and supporting elements.

R. Transport of Human Remains

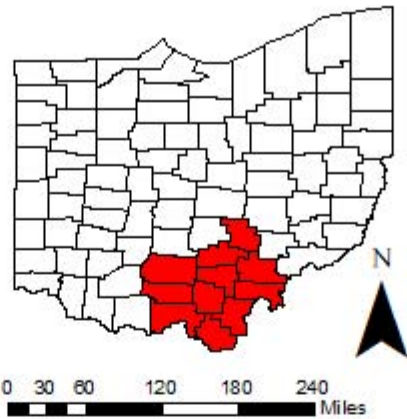
1. When the number of deaths rises dramatically, normal transportation resources available within a jurisdiction may be unable to meet demand. Non-traditional means of transportation such as buses, trucks, and vans; and non-traditional drivers and handlers may need to be employed/contracted to satisfy demands.
2. Even if the deceased can be recovered and transported in a timely manner, it is possible that funeral homes and morgues may not be able to process remains for final disposition at the pre-incident rate.
3. Pronouncement of Death – The Ohio Revised Code (ORC) does specify who may pronounce death if a pronouncement procedure is carried out. Otherwise, the presumption is that any citizen can identify someone who is clearly dead and if there is doubt that death has occurred, will treat the person as alive. Therefore, persons who are clearly dead should not be transported to a hospital, further overwhelming an already stressed medical care system and generating an unnecessary charge for families.
4. If refrigerated vehicles are used, they should be parked in a secure area near the site with easy access to load remains. When not in use, vehicle doors are locked and remain locked while human remains are inside.
5. Remains that have been bagged and tagged are loaded into the vehicle (never stack remains). If the body is unidentified, the tag should indicate when the sex of the decedent is assignable.

6. In the setting of a death under criminal investigation, it is imperative that all transient or fragile forensic evidence associated with the body, such as fingerprints or other imprints or indentations which exist in moisture, or spatter patterns, or fibers loosely adherent to the body should be documented and collected by the Principal Investigating Agency (PIA) at the scene, prior to transport.
7. To prevent loss of trace evidence during transport, the body should be placed on a clean white cotton sheet in the position that the body was first found; the sheet is then folded over the body, and the body thus wrapped, is then transferred to the body bag for transport. It is also desirable to utilize paper bags to enclose the hands and other areas of the body (head or feet) which might contain trace evidence possibly lost during transport.
8. Bodies should be transported in a manner which affects minimally the scene and the body. In cases where initial body posture or dried blood patterns on the body may be significant, the body should be carefully transferred in the position which it is found, to a moisture impervious body bag.
9. Driver transports remains following assigned route to the incident morgue with no deviations. Police escorts should be arranged.
10. When moving, storing, and/or releasing remains and personal effects, keep detailed records like that of a chain-of-evidence for each individual body and personal effects bag. Ensure dates, times, persons involved and locations are recorded.

S. Death Care Industry Operations

1. For the purposes of this plan the death care industry includes funeral homes, mortuary services, cremation services, and cemetery services.
2. There are 64 funeral homes and 10 crematories located throughout Ohio Homeland Security (OHS) Region 7 (See maps on following pages).
3. The death care industry will be tasked with final disposition of human remains to include; removing the deceased to a mortuary, preparing the remains, performing a ceremony that honors the deceased and addresses the spiritual needs of the family, and carrying out the final disposition of the deceased.
4. The death care industry will complete and file death certificates with the local health department/registrar within eight (8) days of the date of death and apply for and obtain a permit for final disposition from the local health department/registrar.

Funeral Homes



OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN

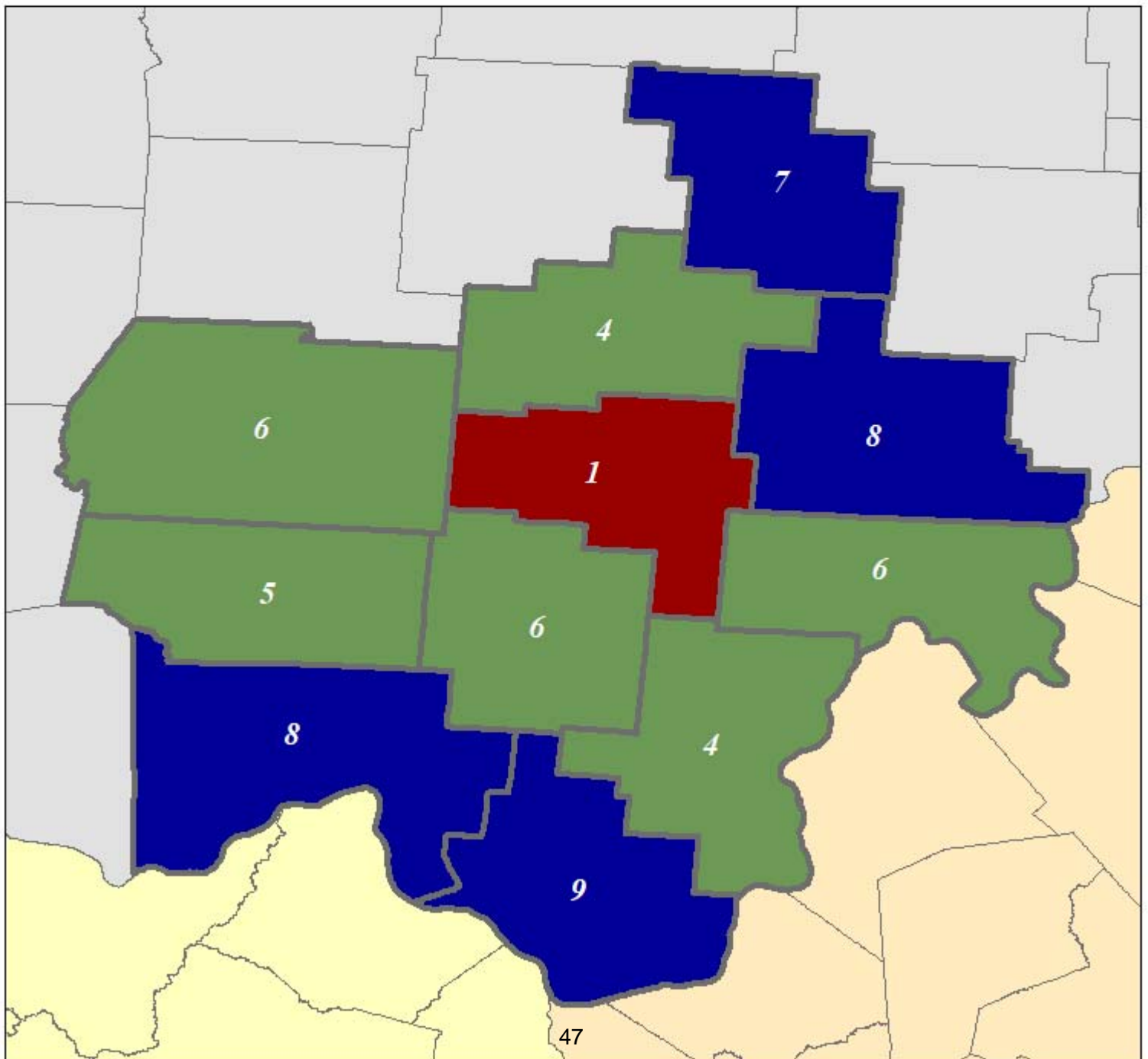
MCI / MFI Resources

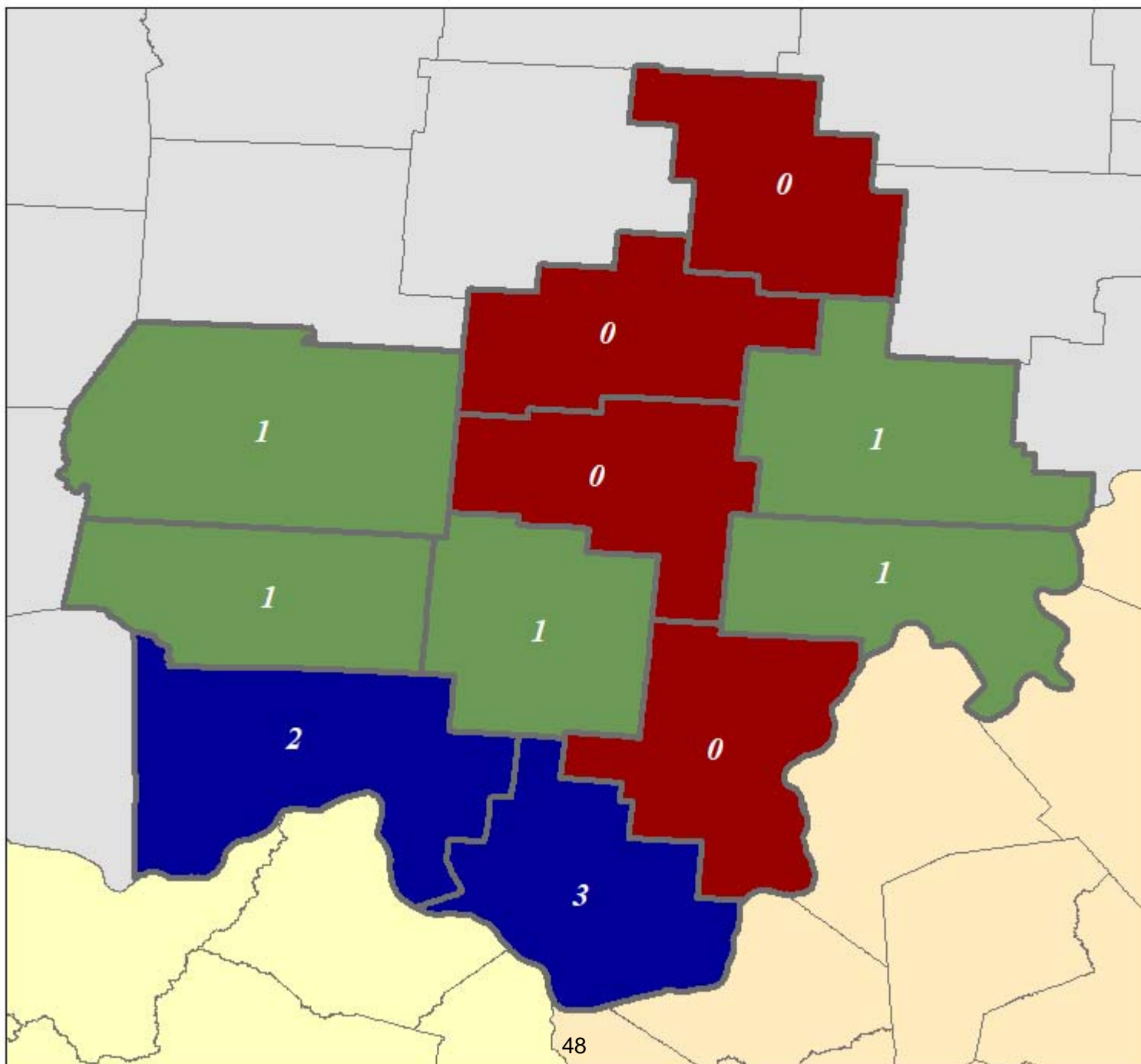
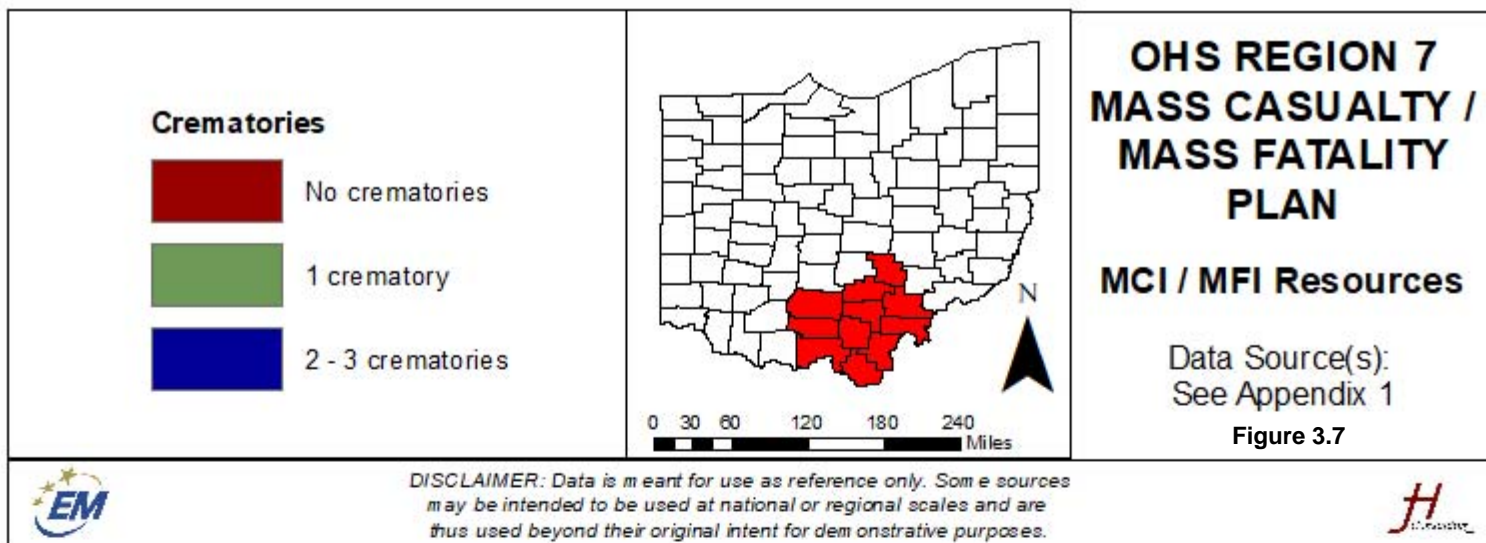
Data Source(s):
See Appendix 1

Figure 3.6



DISCLAIMER: Data is meant for use as reference only. Some sources may be intended to be used at national or regional scales and are thus used beyond their original intent for demonstrative purposes.





5. The death care industry will be contacted by the C/ME office of the Mass Fatality Incident (MFI).
6. As victims are identified, the C/ME Office will coordinate with the funeral home or cremation service requested by each victim's family to arrange for final disposition, the release of remains with a death certificate signed by the C/ME from the incident morgue to the funeral service selected by the family.
7. Once the local death care industry is overwhelmed, assistance will be requested through a County Health Department chain of command from funeral homes, cemeteries and cremation services in neighboring jurisdictions through a County Emergency Operations Center (EOC), if the mass fatality is a localized event.
8. The Board of Embalmers and Funeral Directors maintains a list of licensed crematories, funeral directors and funeral homes in Ohio.

T. Fatality Documentation (Death Registrations, Certifications, Vital Statistics)

1. Currently, there is no single system in place for tracking deceased patients during and immediately following Mass Fatality Incidents (MFIs).
2. Regardless of the size of the MFI, the Coroner/Medical Examiner (C/ME) is the legal authority to conduct victim identification, determine the cause and manner of death, and manage death certification. The C/ME is also responsible for notification of next of kin.
3. Each death must be registered with the local health department/registrar in the district in which the death was officially pronounced, or the body was found within eight days after the death and prior to any disposition. The purpose of a certified copy of a death certificate is:
 - a. To serve as the legal record of death and thus be prima facie evidence of the death in all courts.
 - b. To settle the decedent's estate.
 - c. To apply for insurance benefits.
 - d. To settle pension claims.
 - e. To verify transfer of title or real and personal property.
4. If the cause of death cannot be determined within 48 hours after taking charge of the case, the C/ME shall complete the medical certification with a "Pending" cause of death to be amended upon completion of medical investigation.

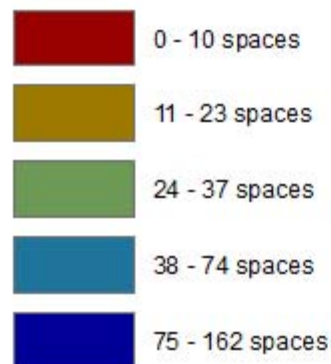
5. There could be an event where all the remains may not be recovered or identified due to the nature of the incident, associated consequences, and hazards present. Some or all of the remains may be fragmented and/or integrated with debris making the recovery and identification process more difficult and delay the collection process. In these cases, the Office of Chief Medical Examiner (OCME) will coordinate with the appropriate agencies and develop a process of segregating body fragments and personal effects from contaminated as well as non-contaminated debris.
6. Also, funeral homes typically initiate burial permits; this process should continue to be followed in the wake of a MFI. Local health departments cannot issue a burial permit without a death certificate in the case of cremation.
7. Consider the activation of emergency technical assistance from the ODH-Bureau of Vital Statistics through the local health department offices.
 - a. An emergency plan to address surge capacity for the processing of vital information used by 16 regional registration districts, two in each preparedness region has been developed. Ross and Athens Counties are the location for the south central region.
 - b. A coordinated effort to recruit and train Ohio funeral directors who would act as Emergency Sub-Registrars and assist in issuing burial transit permits and filing Ohio death certificates during a MFI is continually made.
8. The ODH – Bureau of Vital Statistics will provide administrative support of the Electronic Death Registration System (EDRS), and at the direction of the Director of Health will track the number of EDRS reported incident-related fatalities.
9. Reporting numbers of fatalities during an incident will likely vary due to multiple sources of information. These could include: first responders, media, and the public, as well as reporting through local health department/registrars. Additionally, there may be some uncertainty as to whether a death was caused by a disaster or from natural causes. To assist in the response to this situation, a choice can be added within EDRS for coroners to select to assist in identifying disaster-related fatalities.
10. A Victim Identification Center (VIC) within a Family Assistance Center (FAC) will be the locations for collection of ante-mortem information from family members, the preparation of necessary paperwork related to the final distribution of remains, and will be the point of coordination for the return of remains to the family's chosen funeral director.

11. The following agencies and organizations maybe involved with death registration and certification in a MFI.
 - a. Physicians
 - b. Local Health Commissioner's (Medical Directors)
 - c. Institutional Agency Medical Directors
 - d. Emergency Medical Services Medical Directors

U. Storage Capacity and Temporary Storage of Human Remains

1. Currently, the human remains storage capacity in OHS Region 7 is 229 fixed refrigerated and 164 mobile refrigerated, these numbers include those maintained by the Ohio University Gross Anatomy Lab in Athens County. This does not include resources located outside of the region (See map on next page). Additional human remains storage includes:
 - a. Two mobile morgues, each with 20 bed capacities (40 total), maintained by COTS, one of the two is housed at Holzer Medical Center in Gallia County.
 - b. Four mobile morgues, each with 18 bed capacities (72 total), maintained by the Ohio Department of Health (ODH)
2. Storage Considerations
 - a. Such resources as airports, civic centers, fairgrounds, state and county garages, etc. can be used.
 - b. Refrigerated trucks/trailers may also be used; however, these resources would likely be unusable following the MFI. A 40 foot refrigerated trailer can store 20-25 bodies or sets of remains.
 - c. Funeral homes may supplement storage capabilities, but only after field identification of bodies has been made. There are approximately 64 funeral homes located throughout OHS Region 7.
 - d. Construct temporary morgue facilities utilizing tents or trailers.
 - e. Schools should not be considered as potential storage locations.

Morgue Storage (Fixed, Mobile)



0 30 60 120 180 240 Miles

OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN

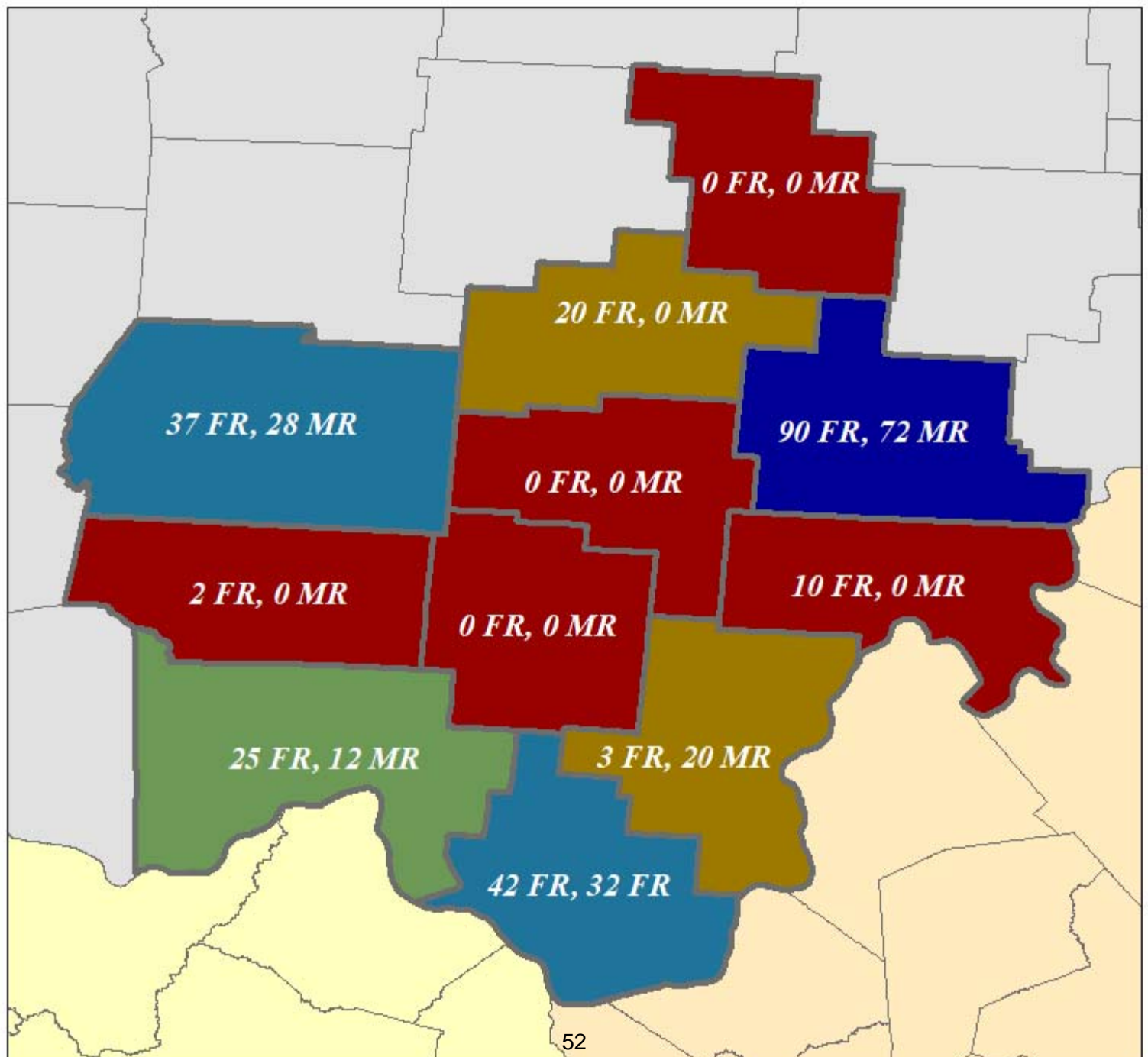
MCI / MFI Resources

Data Source(s):
See Appendix 1

Figure 3.8

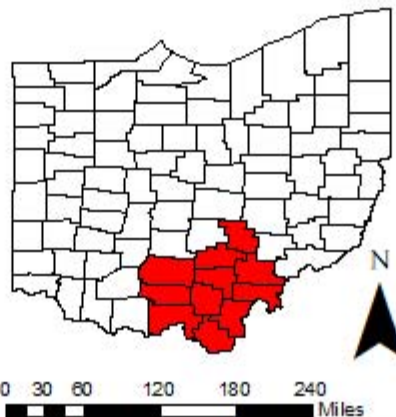


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- f. Dry ice (carbon dioxide CO₂ frozen at -78.5° Celsius) can be used for short-term storage. Approximately 22 pounds of dry ice will be needed daily for each individual set of remains. The dry ice should be applied by building a low wall with it around groups of about 20 remains and then covering with a plastic sheet. To prevent damaging the corpse, the ice should never be placed on top of remains, even when wrapped. Dry ice must be used in an area with good ventilation as it emits carbon dioxide as it melts.
 - g. Chemicals can be used to pack a decedent for a short period of time. Powdered formaldehyde and powdered calcium hydroxide may be useful for preserving fragmented remains. After these substances are applied, the body or fragments should be wrapped in several nylon or plastic bags and sealed completely.
- 3. There are a total of approximately 3,355 body bags maintained by EMS providers, hospitals, local Coroners/Medical Examiners (C/MEs) and various other organizations throughout OHS Region 7 (See map on next page).
- 4. C/MEs morgues, hospitals, and funeral homes do not have storage capacities to adequately respond to mass fatality events. Most of these entities' storage locations already operate at 90% capacity. Even if bodies can be recovered in a timely manner, it is possible that funeral homes will not be able to process remains for final disposition at the same rate as remains can be recovered.
- 5. It is likely that during a mass fatality event, the number of bodies needing to be stored may quickly, and for long periods, exceed local storage capabilities. Bodies may need to be stored for an extended period until the remains can be identified, the cause and manner of death can be determined, and death certificates can be processed and issued.
- 6. Temporary holding morgue facilities should be capable of maintaining a constant temperature of 35-38°F. Body decomposition slows once remains are placed in cold storage between (37-42 degrees Fahrenheit). Depending on the condition of individual remains, bodies of the deceased may be able to be stored long enough for the death management community to process all bodies in accordance with jurisdictional standards and traditional public expectations. For a large-scale acute mass fatality event, such as an airline crash, the typical size of the morgue should be 8,000 to 10,000 square feet.

Available Body Bags



OHS REGION 7 MASS CASUALTY / MASS FATALITY PLAN

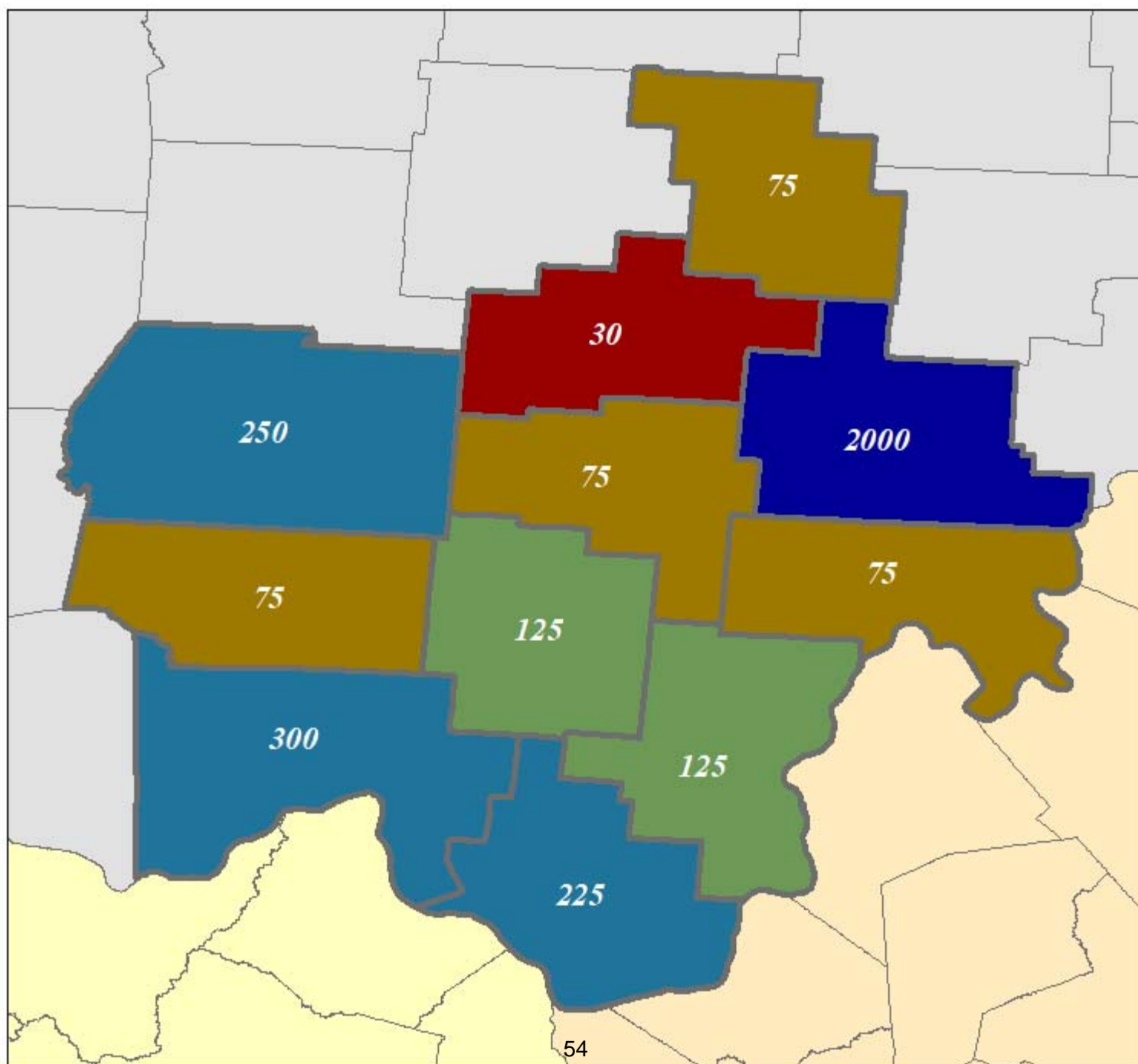
MCI / MFI Resources

Data Source(s):
See Appendix 1

Figure 3.9



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7. Human remains cannot be held in refrigerated storage indefinitely, and their condition must be continuously monitored. Placing all human remains in refrigerated storage may not be an option due to several factors:
 - a. Limited fuel to supply generators.
 - b. Limited maintenance personnel to repair broken units.
 - c. Limited refrigeration units due to high demand.
8. Human remains should be placed in impermeable bags after wiping visible soiling on outer bag surfaces with a disinfectant solution at the site of discovery. They can then be transported and stored (refrigerated).
9. Options to increase storage capacity include placing remains side-by-side, use of shelving, and use of refrigerated storage units.
10. If a C/ME determines that additional resources are necessary to store human remains in a suitable manner, the coroner can request, through their county EMA Director, the use of the appropriate number of state mobile cold storage trailers.
11. In response to a mass fatality incident that affects one or more local jurisdictions, state-level resources may be needed to:
 - a. Assist in the identification, acquisition and/or provision of facilities for the short and long-term storage of remains.
 - b. Assist in the identification, acquisition and/or provision of modular, temporary refrigerated morgues, racking systems, temporary storage supplies and non-traditional holding facilities; including warehouses, refrigerated vans, hangars, and refrigerated rail cars.

V. Disaster Mortuary Assistance & Mortuary Resources

1. The Ohio Mortuary Operational Response Team (OMORT) is made up trained personnel from multiple Ohio State, and local agencies, as well as other specialized resources. The investigative and identification process in a mass fatality situation is a multidisciplinary endeavor requiring multiple forensic and medical specialists to come together rapidly often under adverse conditions. OMORT can bring local Coroners a team with full identification capability, allowing the coroner to maintain focus on incident investigation and cause of death, while still overseeing the identification process.

2. OMORT maintains a cache of mortuary response equipment that is able to support site/recovery operations, temporary morgue operations, ante-mortem data collection, information resources operations, and administrative needs. Upon official request through the Ohio Emergency Management Agency (OEMA), the team and equipment can be rapidly deployed and arrive on the scene within hours of the request.
3. Currently DMORT Region V has three Disaster Portable Morgue Units (DPMUs) and OMORT has one.
4. The preferred way to activate OMORT is via a local Coroner/Medical Examiner (C/ME) requesting the team through a local EOC to the OEMA Watch Office.
5. DMORTs will be requested by the State EOC. DMORT and/or OMORT does not establish command and control over the fatality management operation, but will be integrated into the local ICS structures. Upon activation DMORT will be available to assist under the direction of local coroners.
6. DMORT can provide for the following capabilities:
 - a. Incident morgue facilities and operations
 - b. Victim identification (forensic examination, autopsy and pathologic examination)
 - c. DNA acquisition
 - d. VIC specialists
 - e. Remains identification (Fingerprinting, forensic dental pathology, forensic anthropology)
 - f. Personal effect processing
 - g. Search and Recovery operations
 - h. Family Assistance Center (FAC) assistance
 - i. Human remains processing
 - j. Ante-mortem and postmortem data collection
 - k. Embalming/casketing
 - l. Disposition of remains in cooperation with local funeral homes.

W. Final Disposition of Human Remains (Evidence & Personal Effects Recovery)

1. County C/MEs, pursuant to ORC Chapter 313, are responsible for determining cause and manner of deaths that did not occur under natural circumstances, authorizing autopsies to determine the cause of death, authorizing forensic investigations to identify unidentified bodies, and authorizing removal of bodies from incident sites.
2. Information regarding the status of morgue operations will be coordinated by, and through C/MEs. There is no corresponding authority at the state level.
3. Remains will be recovered and evacuated, while preserving the scene, to the incident morgue for identification and to safeguard personal effects found on and with decedents. When authorized by appropriate officials and the family, the mortuary response team will process and release the remains for final disposition.
4. Once remains have been positively identified, the next of kin or their representative will be contacted. The C/ME, or at the direction of the C/ME, the mortuary response team, will coordinate the release of the remains and personal effects to the next of kin of their representative. If the remains are unidentified, the Coroner will make the decision and provide direction regarding the disposition of the remains.
5. The C/ME will coordinate the recovery, processing, and disposition of animal remains in coordination with the State Veterinarian, the Incident Commander and the appropriate law enforcement officials. Animal remains, like human remains will be considered evidence and will be segregated and processed accordingly at the scene. Once the C/ME identifies the remains as non-human, the remains may be released to the State Veterinarian for disposition.
6. A permit for disposition of remains can only be issued by the local health department/registrar after the death certificate has been registered. The purpose of the permit for disposition is:
 - a. To specify the disposition being authorized by the local health department/registrar – burial, cremation, disposition of cremated remains other than in a cemetery, scientific use, temporary envaultment, and/or transit to another state or country for disposition.
 - b. To allow for the disposition of human remains.
7. As a last resort, temporary human remains storage will be performed under the direction of the C/ME.

8. In accordance with ORC 4717.13, mass temporary human remains storage operations will use tags encased in durable and long-lasting material that contains name, date of birth, date of death and social security number which accompany the deceased, and the prohibitions of operators of crematory facilities from simultaneously cremating more than one body in the same cremation chamber or cremating human bodies in the same cremation chamber used for animals.
9. In a mass fatality incident, situations may arise where family and others are not available to decide on the disposition of the deceased. C/MEs may coordinate with local funeral homes and others for the temporary storage of the deceased in cases where family/others are not available and where the system cannot keep up with the demand for burial of the deceased.
10. C/MEs will coordinate with mortuary service providers to collect bodies of victims from incident scenes, hospitals, morgues, and other locations, and will coordinate with next of kin for the disposition of remains.
11. Final disposition of remains includes the following:
 - a. Individual burial
 - b. State sponsored individual burial
 - c. Concrete vaulting
 - d. Mass burial
 - e. Voluntary cremation
 - f. Involuntary cremation
 - g. Burial at sea

X. Behavioral/Mental Health Services/Counseling (Families of Victims & Responders)

1. Mental health services staffing will contain a mix of social workers; marriage, family and child therapists; psychologists, psychiatrists, and grief counselors.
2. Mental health staff members should walk around the Family Assistance Center (FAC), visiting and talking to people and monitoring how families and how FAC staff and volunteers are holding up over time, and guide family members to private rooms for counseling.
3. Assist with ante-mortem interviews and death notifications as needed.
4. Provide behavioral health assessment and appropriate interventions for callers to the call center as needed.

5. Provide mental health services for the FAC staff and volunteers and direct staff and volunteers to additional counseling resources as needed.
6. For many families, being able to go to the incident site is extremely beneficial. It allows them to feel close to their deceased loved ones imagine their last moments, honor them and say good-bye. Visits to the incident site should always be coordinated with the organization that has jurisdiction at the site (local C/ME, FBI for crimes, and National Transportation Safety Board [NTSB] for commercial airline accidents).
7. Religious and cultural beliefs and practices surrounding death will be important to survivors. There will likely be specific concerns regarding; autopsies, timeframe and handling of the body, including ceremonial washing of the deceased, and religious ceremonies and/or items to be left with the dead.
8. Child Care Center Considerations:
 - a. Provide a safe and secure environment for FAC families' children during main FAC operating hours. Providing structure, comfort and acknowledgement to minimize the impact of traumatic stress and to meet children's unique needs.
 - b. To ensure security, take a photo of each child and his/her parent when the child is brought to child care. Check the photo and/or identification prior to releasing the child.
 - c. Organize play areas with toys accessible to children, set up bathroom and diaper changing areas, arrange for snacks, juice, and meals.
 - d. If a television is available, only use it for tapes and DVDS, not for general television programs to avoid news broadcasts.
9. If local resources are unable to adequately respond to behavioral and mental health needs, state agency-level behavioral and mental health support agencies will assist in securing these services through mutual aid agreements with Behavioral and Mental Health Boards and other local entities that provide such services. Select agencies will provide assistance for the acquisition and coordination of mental and behavioral health teams to provide psychological aid to fatality management workers and families of victims at FACs.

IV. ORGANIZATION & ASSIGNMENT OF RESPONSIBILITIES

A. Organization

1. Agency or facility – Local healthcare and death-care agencies and facilities will conduct mass casualty, medical surge, and mass fatality response in accordance with their respective Standard Operating Guidelines (SOGs).
2. County – Specific county-level response activities to mass casualty and mass fatality producing events are identified in county-level Emergency Operations Plans (EOPs), county-level MCI / MFI plans, and are outlined in this regional plan.
3. Regional – healthcare and death-care agencies and organizations will serve as the primary stakeholders and custodial agents of the plan.
4. State – Departments and agencies within the state government will conduct emergency operations in accordance with the State Emergency Operations Plan (SEOP). Additional specific responsibilities are identified within this Plan, and specific operational procedures are detailed within agency-based SOGs.
5. Federal – The United States Department of Health and Human Services (HHS) is the principal Federal agency for protecting the health of all Americans. State response operations will interface with Federal response assets through ESF-8 and through liaison between the ODH and the CDC as well as with the FEMA Liaison between the State EOC and the U.S. Department of Homeland Security will provide access to additional Federal health and medical assets.
6. For ICS Command & General Staff position responsibilities, refer to agency specific SOGs, Incident Command System (ICS) pocket guides, etc. Command & General staff positions include:

ICS COMMAND & GENERAL STAFF POSITIONS	
Incident Commander	
Command Staff	General Staff
Public Information Officer	Operations Section Chief
Safety Officer	Planning Section Chief
Liaison Officer	Logistics Section Chief
	Finance/Administration Section Chief

Table 4.1

7. The following diagram highlights the OHS Region 7 Incident Command System (ICS) organization for the Mass Casualty Branch under the Operations Section. Positions may be added or deleted from this diagram based on the nature and scope of the event.

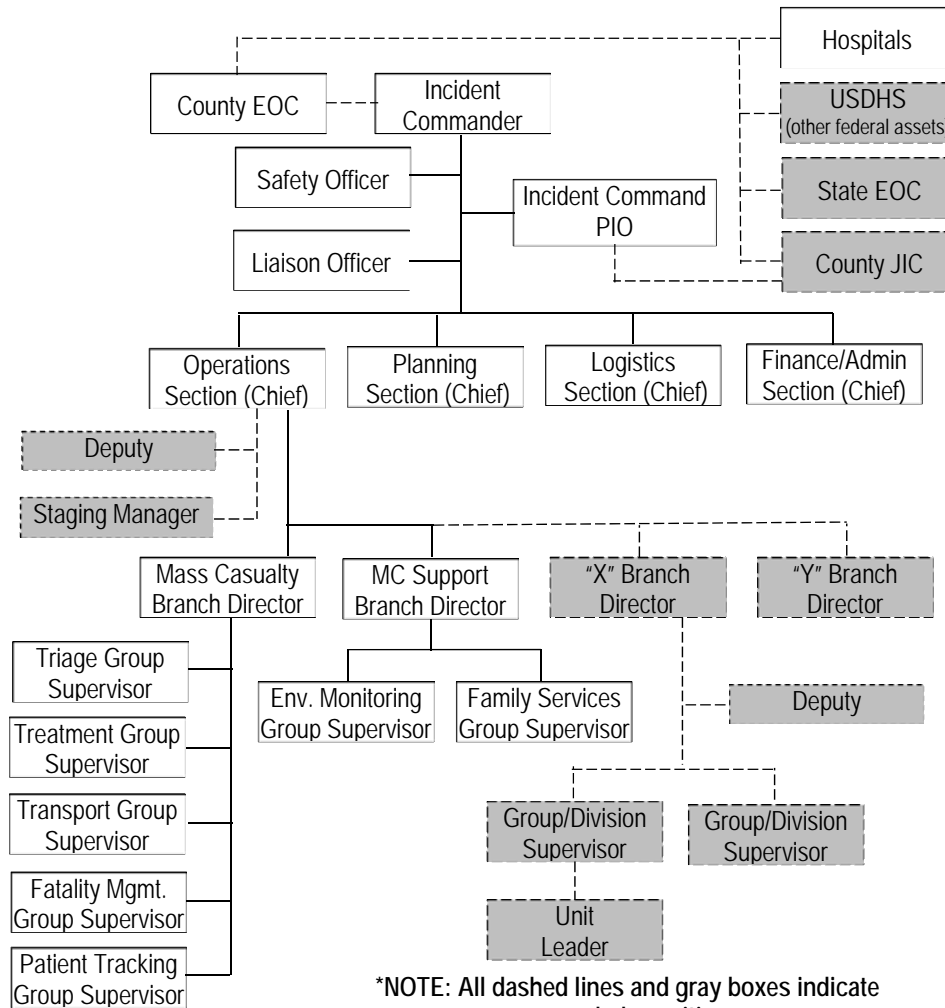


Figure 4.1

8. The following diagram highlights the OHS Region 7 Incident Command System (ICS) organization for the Mass Fatality Branch under the Operations Section. Positions may be added or deleted from this diagram based on the nature and scope of the event.

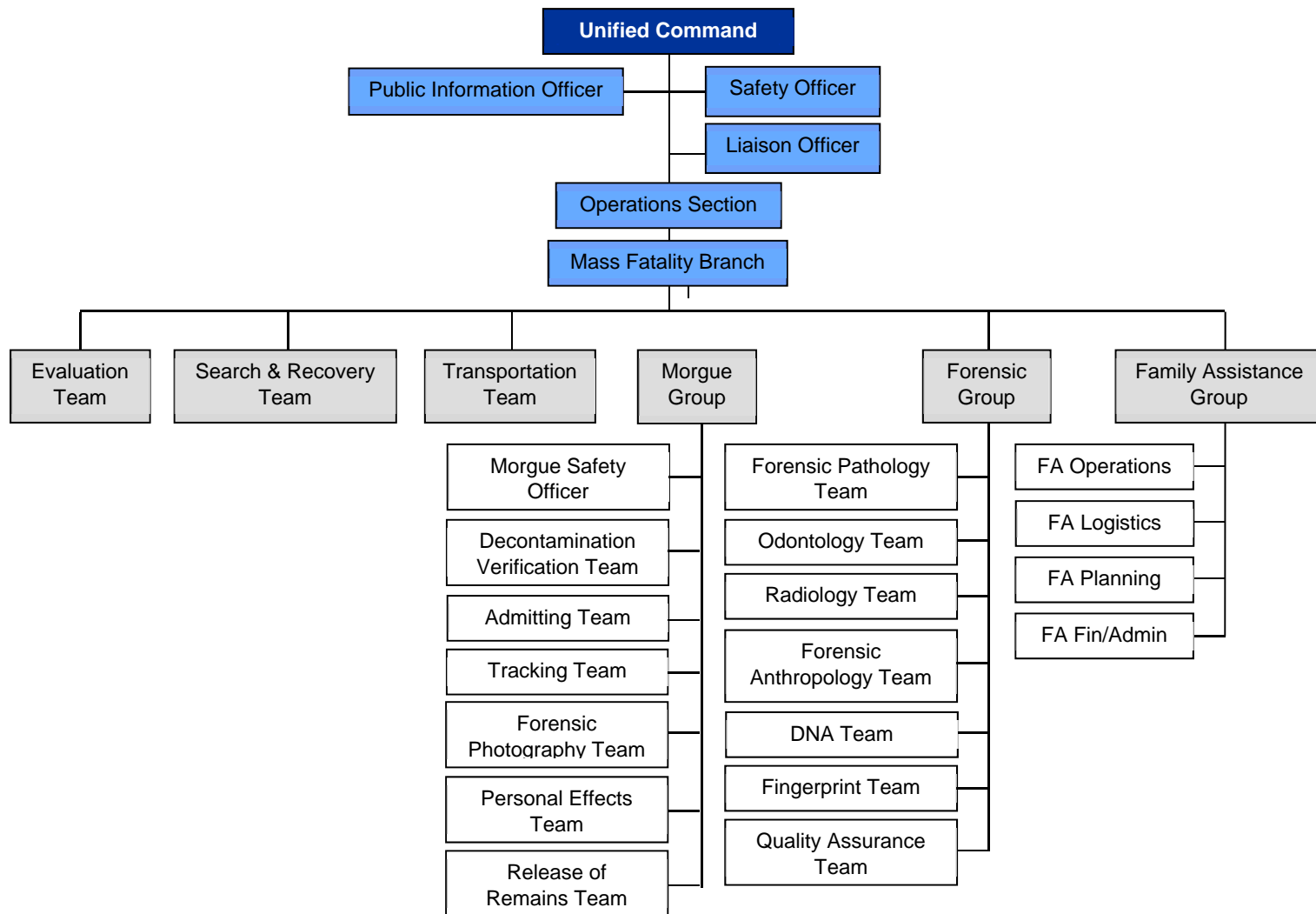


Figure 4.2

B. Responsibilities

1. County Coroners/Medical Examiners (C/MEs)

- a. Establish Coroner/Medical Examiner (C/ME) jurisdiction over any death which occurs at the county level under circumstances as defined by law.
- b. Document the place of death, in order to pronounce death under certain circumstances.
- c. Take custody of human remains and associated materials and possessions found with or near the body to scientifically examine the body and investigate the circumstances of death, which includes lawful inspection of decedent medical records as well as police and other investigative records which pertain to the decedent.
- d. Determine and establish the cause and manner of deaths.
- e. Document relevant findings in a report, and complete death certificates.
- f. Provide formulation of conclusions, opinions or testimony in judicial proceedings.
- g. Provide scene evaluation, investigation, and Incident Action Plan (IAP) development during Mass Fatality Incidents (MFIs).
- h. Provide for the collection and documentation of post-mortem human remains, property, and evidence at the incident site.
- i. Alert funeral homes, cemeteries, and cremation services in the event of a mass fatality event.
- j. Liaison with neighboring county C/MEs to ascertain the availability of morgue space should local capacities be exceeded.

2. County Health Departments

- a. Serve as a first responder in medical disasters.
- b. Provide for workers health/safety – assist in monitoring health and well-being of emergency workers.
- c. Perform field investigations and studies addressing worker health and safety issues.
- d. Ensure completeness of death certificates and issuance of death certificate.
- e. Assist in assessing health and medical effects of chemical, and biological exposures on the general population and on high-risk population groups.
- f. Conduct field investigations, including collection and analysis of relevant samples.

- g. Advise on protective actions related to direct human and animal exposure, and on indirect exposure through chemically or biologically contaminated food, drugs, water supply and other media.
- h. Provide technical assistance and consultation on medical treatment and decontamination of chemically, or biologically injured/ contaminated victims.
- i. Assist with the recognition, surveillance, investigation, and prevention of the spread of communicable diseases.
- j. Assist in establishing surveillance system to monitor the general population and special high-risk population segments, especially during an influenza pandemic.
- k. Assess the threat of vector-borne diseases following a major disaster or emergency.

3. Regional Death Care Industry (funeral homes, crematories, & cemeteries)

- a. Manage the final disposition of human remains.
- b. Assist C/ME operations with staff for such support duties as transcribing case file data in the morgue, and collecting ante-mortem data.
- c. Assisting with grieving families and gathering information from families regarding final disposition wishes.
- d. Escorting bodies from station to station in the morgue.
- e. Assist with the transportation of human remains.
- f. Provide supplemental morgue storage as available.

4. Regional Hospitals

- a. Coordinate with fire/EMS personnel regarding the receipt of patients at facilities.
- b. Provide triage, assessment, decontamination, emergency care/treatment, and isolation/quarantine of patients as necessary.
- c. Maintain surge capabilities.
- d. Coordinate with law enforcement officials if the MCI is a part of a potential criminal or terrorist incident.
- e. Track patients within hospital system, to the extent possible.
- f. Assist C/ME in providing morgue storage space, body bags, and personnel who are accustomed to handling human remains.
- g. Provide medical staff for first aid/medication at the mass fatality operations sites.
- h. Assist family members of possible victims as they arrive.

- i. Identify, assess, and control infectious disease and other health and safety threats.

5. Local/County Emergency Medical Services

- a. Assume appropriate role within the ICS, follow all local protocols as espoused by the Medical Director.
- b. Utilize SALT, START, and/or JumpSTART triage; maintain tags not only for use in the SALT system but also for patient accountability.
- c. Triage Officer responsibilities include the following
 - i. Size-up the situation, determining whether triage and treatment are to be conducted on-scene, or at a separate treatment area.
 - ii. Evaluation of resources needed for extrication of trapped victims and the removal of victims to treatment areas.
 - iii. Evaluation of resources needed for triage and the primary treatment of patients, and resource allocations as necessary.
 - iv. Supervision of assigned personnel and units.
 - v. Develop and submit Situation Reports (SitReps) to command and “All Clear” once all victims have been removed from the scene.
- d. The Transportation Group will assist in recovery and transport to care for injured survivors. The Transportation Officer is responsible for the following:
 - i. Determination of patient transportation requirements and availability of ambulances and other transportation available.
 - ii. Identification of ambulance staging and loading areas and coordinate with helicopter landing zones.
 - iii. Communication with hospitals to maintain the Hospital Capability status and transportation log for routing of patients.
 - iv. Procurement of transportation related supplies needed at the scene.
 - v. Coordination of patient transportation and allocation with the treatment group.
- e. Report to area hospitals the estimated number of injured persons as well as the severity and type of injuries.
- f. Provide physical monitoring of response personnel if the environmental conditions at the site necessitate.
- g. Provide personnel to assist in operations at the incident morgue as required.

6 Local Law Enforcement Agencies

- a. Assist in evaluating incident/scene safety.
- b. Provide ongoing security for mass casualty / mass fatality management operations.
- c. Assist the C/ME with scene investigation, human remains recovery, and identification of the deceased.
- d. Provide forensics/crime scene investigation staff as available. Ensure records are maintained, as to the whereabouts of victims if they leave the incident scene.
- e. Assist with death notifications as and when necessary.
- f. Provide security and traffic control at the incident site, incident morgue, and the Family Assistance Center (FAC).
- g. Request municipal law enforcement personnel to assist as, and when necessary outside of their municipalities.

7. Local Fire and Rescue Departments

- a. Assist with evaluation of the incident site/scene safety.
- b. Provide lifesaving operations to include assisting in search, rescue, and transport to care for injured survivors.
- c. Protect property from fire and fire hazards.
- d. Assist with decontamination of remains.
- e. Assist with incident morgue facility set-up and management.

8. Local/Regional Search & Recovery Teams

- a. Locate, collect, and document postmortem human remains, personal property, and evidence at the incident site.
- b. Oversee the search, evaluation, removal, and transfer of human remains from the incident site to the morgue.
- c. Provide written and photographic documentation of remains, property, and evidence at the incident site prior to any movement. Documentation may include video, digital images, and notes and sketches of remains, property, and evidence.
- d. Coordinate human remains transportation needs and requests with logistics.
- e. Conduct a comprehensive search of assigned grids or search patterns and consider the use of aides such as global positioning devices for each body or body part discovered.

9. COTS / Regional Healthcare Coordinator (RHC)

- a. The COTS Healthcare Incident Liaison (HIL) 24/7 leads a regional effort to coordinate information sharing, situational awareness and resource coordination by using established communication systems.
- b. COTS HIL can be activated via the following numbers:
 - i. COTS HIL Pager: 855-266-7243 enter ID # 26874451
 - ii. Email: 26874451@onpage.com
- c. Coordinate the Southeast Central Ohio Healthcare Coalition (SEOHC) and regional responses to Mass Casualty Incidents (MCIs). A mass notification group for trauma surgeons and trauma program managers in the region has been developed to alert them of a MCI declaration in the region.
- d. The COTS HIL provides SEOHC members an avenue for regional resources requests and assistance through coordination, distribution of regional resources, and information sharing to prepare for, and respond to a disaster event. The SharePoint site outlines the regional resources available and request, tracking and deployment process.
- e. If an event may affect, or resources are needed from healthcare facilities in a boarding state (i.e., West Virginia, Kentucky, Pennsylvania) the COTS HIL will contact the RHC/Coalition lead of the boarding state to share information related to the event.
- f. COTS offers the following resources and regional caches:
 - i. Blood Conservation Level Guidelines
 - ii. Health Incident Liaison (HIL)
 - iii. Mental Health Resources
 - iv. SALT Mass Casualty Triage Training
 - v. Coordinates Stop-the-Bleed training through the coalition.
 - vi. COTS maintains a mobile morgue for the region, two trailers with 20 beds each.
 - vii. BluMeds (i.e., field hospitals) – four total in the Southeast/Southeast Central region.

- g. COTS offers the following Situational Awareness Platforms used by hospitals and coalition members:
 - i. TENS mass notification system
 - ii. Coalition Healthcare Disaster Information Management System (COHDIMS) – a secured SharePoint website that provides coalition situational awareness platforms and resource requests.
 - iii. Real Time Activity Status (RTAS) – A web-based program (<https://www.cotsrtas.org>) used by RTAS participating Emergency Departments (EDs) to notify public and private EMS units when their EDs are overly busy and/or requesting EMS patients be diverted to less busy EDs.
 - iv. EMResource – hospital bed availability and situational awareness.
 - v. EMTrack/OHTrac – statewide patient tracking system.

10. County Emergency Management Agencies

- a. Facilitate interagency coordination, provide centralized situation assessment and public information, and provide resource support as necessary.
- b. Coordinate the integration of local, regional, state, and federal resources into the local response and recovery operations.
- c. Request assets required in casualty / fatality management efforts, when asked to do so by responders.
- d. Maintain the county's Emergency Operations Center (EOC) as necessary.
- e. Coordinate with the County Emergency Communications Center (911-center) to provide for emergency response communications support, and Emergency Public Information (EPI) support.
- f. Provide staffing for the Volunteer Mobilization Center as needed.
- g. Activate OMORT as necessary via the OEMA Watch Office.

11. County Medical Reserve Corps (MRC)

- a. Continue to recruit volunteers to assist with a variety of needs related to meeting the health and social services needs during a disaster.
- b. Provide personnel to assist in operations at the incident morgue.
- c. Provide the eleven counties of OHS Region 7 with a ready corps of medical and public health volunteers to assist in cases of Mass Fatality Incidents (MFIs).

- d. Ensure that MRC members who deploy are fully and seamlessly integrated as part of the local, State, and Federal response for public health and medical disasters.
- e. The MRC has six local units within the SEC region with medical and non-medical volunteers who can assist in a public health or medical emergency. These volunteers are registered within the state Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) system, the Ohio Responds Volunteer Registry, which is maintained by the Ohio Department Health (ODH).

12. Faith-Based & Non-Governmental Organizations (NGOs)

- a. Support operations at Family Assistance Centers (FACs).
- b. Provide faith-based counseling upon request of those affected by a MCI / MFI.

13. Ohio Department of Health (ODH)

- a. As the lead state-agency for Tabs D & E – Acute and Non-Acute Mass Fatalities Incident Response Plans, as well as Tab F – Mass Casualties Medical Surge Plan, to Emergency Support Function 8 (ESF-8), of the State Emergency Operations Plan (EOP), ODH is responsible for providing public health and medical-related services, supplies, and personnel when a Mass Casualty Incident (MCI) or Mass Fatality Incident (MFI) has exhausted regional resources.
- b. Provide for the coordination of federal, state, regional, and local assets assigned to respond to MCIs / MFIs through the State Emergency Operations Center (State EOC) for assessment, response, and recovery operations.
- c. Provide coordination among, and logistical support to, various health and medical organizations affected by MCIs / MFIs.
- d. Conduct health assessments of conditions based on information at MCIs / MFIs to determine health needs and priorities. Assess and make recommendations concerning the health and medical needs of emergency responders.
- e. Perform assigned responsibilities as part of the Mass Casualty Incident Assessment Team upon request from the State EOC Executive Group.
- f. Share information to develop a common operating picture and assure on-going situational awareness during MCIs / MFIs in coordination with Regional Healthcare Coordinators (RHC), and the Ohio Hospital Association (OHA).

- g. Assist in monitoring patient movements and provide information on available bed space by request.
- h. Upon request from local unites and/or the EMA, facilitate and/or assist with activation, and deployment, of Ohio Medical Reserve Corp (OMRC) volunteers.
- i. Assist with the coordinate of supplies, restocking and prioritization of health, medical, mortuary related resources. Provide limited warehoused medical resources to support local health and medical response and services, as feasible (i.e., mobile cooling units, Personal Protective Equipment (PPE), body bags, etc.).
- j. Assist the local health department with ensuring that the morgue process facilitates the use of the Electronic Death Registration System (EDRS). As necessary, complete proper and timely death registrations utilizing the EDRS.
- k. Through ODH – Bureau of Vital Statistics, and at the direction of the Director of Health, track the number of EDRS reported incident-related fatalities. Estimate the number of confirmed deaths using EDRS and information from Incident Commanders (ICs) or Unified Command (UC) in consultation with county Coroner/Medical Examiners (C/MEs), local health departments/commissioners, or other local authorities and provide the estimate to the Joint Information Center (JIC) for proper dissemination.
- l. Provide health and medical advisories and news releases; and health and medical-related information to the state's general public.
- m. Assist with the coordination of behavioral and mental health assistance to disaster survivors and responders.
- n. Provide support for the continued delivery of non-emergency health care programs by local health districts throughout the duration of large-scale emergencies.

14. Ohio Mortuary Operational Response Team (OMORT)

Note: The Ohio Funeral Directors Association – Mortuary Response Team (OFDA-MRT) is now known as the Ohio Mortuary Operational Response Team (OMORT).

- a. When authorized by Coroner/Medical Examiners (C/MEs), assist with the recovery, storage, preparation, identification, processing, and release of human remains for final disposition, as well as the release of personal effects to the next of kin or their representative.
- b. Assist with victim identification, disposition of human remains (embalming/casketing), and documentation of personal effects, evidence collection and administrative recordkeeping.
- c. Coordinate with mortuary service providers to collect bodies of victims from the scene, hospital, morgues, and other locations, and coordinate with next of kin for the disposition of remains.
- d. Under the direction of C/MEs, assist in the establishment of Family Assistance Centers (FACs) at locations convenient to Mass Fatality Incidents (MFIs), but removed from the mainstream of activities. Assist appropriate agencies in providing services to families of the deceased.
- e. Assisting with Victim Identification Center (VIC) operations, including collecting ante-mortem identification information through family interviews.
- f. Provide assistance to ensure that proper victim identification forms are used and that ante-mortem interviews are completed using the proper Victim Identification Profile (VIP) forms at FACs.
- g. When necessary, and when authorized, assist the C/MEs office in determining the cause and manner of death, authorizing autopsies to determine the cause of death, authorizing forensic investigations to identify unidentified bodies, and authorizing removal of bodies from incident sites.
- h. Assist with planning and coordination during Mass Fatality Incidents (MFIs) regarding the storage of equipment (i.e., body bags) at member funeral homes.
- i. Identify storage capacity, refrigeration, and number of hearses/vehicles available to transport bodies.
- j. Under the direction of C/MEs, provide management in the deployment and operation of the Ohio Portable Morgue Unit (OPMU). Provide staffing at various forensic examination areas within temporary morgues where assistance is needed.

- k. In coordination with local funeral homes, assist C/MEs on the logistics of obtaining temporary storage for the deceased when family and others are not available to decide on the disposition of the deceased, or when the burial system cannot keep up with the demand for burials.
- l. When faced with a fatality surge that stresses the capacity for carrying out cremations in a region, assist in the surveying of crematory facilities, embalming facilities, and funeral homes within, or accessible to a region. Assist in the determination of the maximum number of cremations that can be performed.
- m. Provide assistance to make estimates of the number of confirmed deaths using the Electronic Death Registration System (EDRS) and information from Incident Commanders (ICs) in consultation with C/MEs and provide the estimate to the Joint Information Center (JIC) and State Emergency Operations Center (EOC).
- n. Provide assistance in the coordination of psychosocial teams to provide psychological aid to fatality management workers and families of victims at FACs and at incident scenes.

15. Ohio Hospital Association (OHA)

- a. Assist in providing resources to local fire-based Emergency Medical Services (EMS) units.
- b. Monitor, facilitate, and support communication between hospitals and other mass casualty / mass fatality support operation agencies and sites.
- c. Assure that patient tracking and hospital bed data is being properly collected and assist with its interpretation.
- d. Provide healthcare situational awareness by supporting statewide data collection systems (e.g., OHTRAC, SurgeNet).
- e. Monitor and report on hospital morgue space.
- f. Support the use of the Electronic Death Registration System (EDRS) among local Health Commissioners, Medical Directors, hospitals, and Institutional Agency Medical Directors.
- g. Perform assigned responsibilities as part of the Mass Casualty Incident Assessment Team upon request from the State EOC Executive Group.
- h. Provide services to assist local organizations in providing for the emergency needs of developmentally disabled emergency victims.

16. Ohio Division of Emergency Medical Services (OEMS)

- a. Perform assigned responsibilities as part of the Mass Casualty Incident Assessment Team upon request from the State EOC Executive Group.
- b. During emergency operations, acquire reports pertaining to casualties, injuries, damages and evacuations from fire and rescue organizations, and provide them to the State EOC.
- c. Provide information on the availability of Emergency Medical Services (EMS) resources on a statewide or area basis.
- d. If local, private EMS providers are unable, or unavailable to respond, ODPS/EMS will assist in securing EMS assets to assist with patient evacuation, and transportation of patients to medical facilities.
- e. Manage the typing and tracking of emergency response resources in and via the Emergency Response System (ERS).
- f. Coordinate and facilitate the dissemination of information to local response organizations regarding resource requests through regional and county ERS coordinators.
- g. Coordinate and facilitate the dissemination of information with the Ohio Department of Health (ODH) through the State EOC.

17. Ohio State Coroners/Medical Examiners Association (OSCA)

- a. When necessary, assist in arranging for additional resources to assist Coroners/Medical Examiners (C/MEs) with the investigation of deaths that are not due to natural causes, or that do not occur in the presence of an attending physician.
- b. Performing autopsies to determine the cause of death, performing forensic investigations to identify unidentified bodies.
- c. Assist individual C/MEs by identifying backup resources for collecting, identifying and processing human remains.
- d. As needed, provide assistance to ensure that proper victim identification forms are used and that ante-mortem interviews are completed using the proper Victim Identification Profile (VIP) forms at Family Assistance Centers (FACs).
- e. In coordination with, and at the direction of C/MEs, assist in arranging for additional resources to coordinate the release of human remains and personal effects to the next of kin or their representative.

18. Ohio Board of Embalmers and Funeral Directors (OBEFD)

- a. Assist in identifying storage capacity, refrigeration, and number of hearses/vehicles available to transport bodies.
- b. Assist in identification, acquisition and/or provision of facilities that could serve the purpose of centralized, temporary, collection points/morgues, in close proximity to densely populated areas where death rates are likely to be highest.
- c. When faced with a fatality surge that stresses the capacity for carrying out cremations in a region or localized area, assist in the surveying of crematory facilities, embalming facilities, and funeral homes within, or accessible to the impacted region.
- d. Assist in the determination of the maximum number of cremations that can be performed. It is estimated that approximately 500 cremations per day can be performed in Ohio (*ESF-8, Tab D Acute Mass Fatalities Incident Response Plan*).
- e. Maintains a list of licensed crematories, funeral directors and funeral homes in Ohio.

19. Adjutant General's Department, Ohio National Guard (OHNG)

- a. Provide, and/or assist with, transportation and/or communication resources for local and state level volunteer management operations during MCIs / MFIs.
- b. Assist with the procurement, delivery, and storage of health and medical supplies and equipment for affected communities as required and permissible.
- c. Perform assigned responsibilities as part of the Mass Casualty Incident Assessment Team upon request from the State EOC Executive Group.
- d. Assist with patient movement.
- e. Provide the resources of the Fatality Search and Recovery Team (FSRT) to assist with the search for, recovery and transportation of, fatalities to applicable collection points in a CBRNE or non-CBRNE environment.
- f. Provide security support to law enforcement operations at MCI / MFI scenes, collection points, morgue sites, Family Assistance Centers (FACs) and other locations as required.

Note: A Governor's declaration allows Ohio National Guard response and/or resources including security support and fatality search and recovery.

20. Ohio Department of Mental Health and Addiction Services (ODMH/AS)

- a. Assist with state emergency response to health and medical problems through the State EOC for assessment, response, and recovery.
- b. Coordinate the acquisition and movement of healthcare supplies.
- c. Conduct analysis of healthcare facilities data entered in the SurgeNet platform.
- d. Coordinate and monitor state behavioral health activities to address survivor needs in coordination with local mental health boards.
- e. Provide Crisis Communication assistance to hospitals through Regional Coordinators and other means.
- f. Provide assistance, as able, for the acquisition and coordination of psychosocial teams to provide psychological aid to fatality management workers and families of victims at Family Assistance Centers (FACs) and at MCI / MFI scenes.

21. Ohio Emergency Management Agency (OEMA)

- a. Serve as the lead state agency for Emergency Support Function 6 (ESF-6) – Mass Care, to the State Emergency Operations Plan (State EOP); and coordinate and report on mass care missions and activities throughout incident response and recovery operations.
- b. Assist in the planning between, and the coordination of, mass casualty and mass fatality management stakeholders.
- c. Perform assigned responsibilities as part of the Mass Casualty Incident Assessment Team upon request from the State EOC Executive Group.
- d. If necessary, request federal assistance including Federal Medical Stations (FMS), Disaster Medical Assistant Teams (DMATs), Federal Incident Management Teams (IMTs) and/or other resources.
- e. Request additional resources (EMAC, federal, private sector, etc.) to fulfill mission requirements when state-level ESF-6 resources and capabilities are exceeded, or have been exhausted.
- f. Activate and coordinate the Department of Public Safety Emergency Response Team (DPS ERT) for local assistance, or for state-level volunteer reception center staffing.
- g. Assist in the development of MOUs between jurisdictions and professional organizations (e.g., pathologists, dentists, anthropologists, funeral directors, etc.) to obtain an ad hoc staff with specific skill sets.

22. Ohio State Highway Patrol (OSHP)

- a. When needed, and with proper authority, assist local law enforcement with security at incident scenes, morgue sites, Family Assistance Centers (FACs) and Volunteer Reception Centers (VRCs). If a MCI or MFI reaches a state level of response, the OSHP will maintain security at all entry/exit points, and can assist with evacuations.
- b. Serve as lead law enforcement agency for all plane crash MCI/MFI incidents in Ohio.
- c. Assist local law enforcement with volunteer credential verification through the Law Enforcement Automated Data System (LEADS).
- d. When needed, and with proper authority, assist with the evacuation of human remains and preservation of a mass casualty or mass fatality scene, and assist Coroners/Medical Examiners (C/MEs) in safeguarding personal effects found on, and with the deceased.
- e. Assist with the implementation of site-specific traffic control and security plans as necessary.
- f. Secure transportation routes to temporary morgue sites and FACs.

23. Ohio Fire Chief's Association (OFCA)

- a. Maintain and implement the Ohio Fire Response Plan, which can be used to identify and deploy public (e.g., fire department-based) EMS assets in a disaster.
- b. Perform assigned responsibilities as part of the Mass Casualty Incident Assessment Team upon request from the State EOC Executive Group.

24. Ohio Voluntary Organizations Active in Disasters (Ohio VOAD)

- a. Coordinate the activities of VOAD member agencies in support of local and state volunteer management operations.
- b. Through member organizations, provide early services and material support to incident survivors, including, but not limited to:
 - i. Debris removal,
 - ii. Child care services,
 - iii. Donations management, warehousing and transportation services,
 - iv. Humanitarian and emotional care services, and

- v. Provide consultation on cultural/religious considerations, and emotional support/crisis intervention as needed.
- vi. Amateur radio support.

25. Salvation Army

- a. Under the direction of a Coroner/Medical Examiner (C/ME), assist appropriate agencies in interviewing and otherwise assisting families of the deceased at Family Assistance Centers (FACs).
- b. Under the direction of a C/ME, assist in efforts to maintain a secure comfortable location for the collection of information on the deceased to assist in their identification, and for the provisions of comforting services to families of the deceased at FACs.
- c. If local resources are unable to adequately respond to needs, assist in providing disaster mental health support services to victims' families.

26. Department of Health and Human Services (US HHS)

- a. Declare Public Health Emergencies through the HHS Secretary.
- b. Activate Emergency Support Function 8 (ESF #8) resources and lead the federal effort to provide public health and medical assistance to the affected area in an incident requiring a coordinated federal response.
- c. Assume operational control of federal emergency public health and medical response assets, as necessary.
- d. Determine the appropriate level of response capability based on the requirement contained in the action request form and developing status updates and assessments.
- e. In cooperation with local and state officials, conduct health surveillance to assess morbidity, mortality, and community needs related to the emergency.
- f. Activate the National Disaster Medical System (NDMS) as necessary to support response operations.
- g. Deploy, or redeploy the Strategic National Stockpile (SNS) or other pharmaceutical or medical resources as appropriate.
- h. Provide public health risk communication messages and advisories. Disseminate public health information or protective actions related to exposure to health threats or environmental threats.

27. Disaster Mortuary Operational Response Teams (DMORT) – Region V

- a. Respond to mass fatality events through the National Disaster Medical System (NDMS).
- b. Provide Disaster Portable Morgue Units (DPMUs) to assist local Coroners/Medical Examiners (C/MEs).
- c. Provide for the following capabilities:
 - i. Incident morgue facilities operation,
 - ii. Victim identification autopsy and pathologic examination,
 - iii. DNA specialists,
 - iv. VIC specialists,
 - v. Fingerprint specialists,
 - vi. Forensic dental pathology,
 - vii. Forensic anthropology,
 - viii. Human remains processing, and
 - ix. Disposition of remains in cooperation with local funeral homes.

28. Department of Homeland Security (US DHS)

- a. Establish Disaster Recovery Centers to provide survivors with a central location where they can receive information and services.
- b. Provide financial assistance to eligible disaster survivors to repair damage to their pre-disaster primary residence.
- c. Provide assistance regarding funeral expenses resulting from disasters.
- d. Provide supplemental funding to states for short-term crisis counseling services.
- e. Provide transportation resources to relocate or return individuals displaced from their pre-disaster primary residencies, or to an alternative location.

29. Federal Emergency Management Agency (FEMA)

- a. Provide logistical support for deploying ESF #8 medical elements required, and coordinate the use of mobilization centers/staging areas, transportation resources, emergency meals, potable water, base camp services.
- b. Provide support with the National Ambulance Contract for evacuating patients who are too seriously ill, or otherwise incapable of being evacuated in general evacuation conveyances.

- c. Coordinate response efforts such as the Strategic National Stockpile, the National Disaster Medical System (NDMS), DMORT, Metropolitan Medical Response Systems, with local C/MEs.
- d. Provide tactical communications support through Mobile Emergency Response Support (i.e., deployable satellite and radio frequency/radio communications).

30. US Department of Justice (US DOJ) / Federal Bureau of Investigation (FBI)

- a. Provide US Department of Health and Human Services (US HHS) with relevant information of any credible threat or other situation that could potential threaten public health.
- b. Provide crowd control at fixed and deployed healthcare facilities for the protection of workers and to address public safety and security.
- c. Provide quarantine assistance.
- d. Provide security for the Strategic National Stockpile (SNS) and secure the movement of inbound medical equipment, supplies, blood, and tissues.
- e. Support local death scene investigations and evidence recovery.
- f. Conduct evidence collection and analysis of all CBRN-related materials and control potential crime scenes.
- g. Assist in victim identification.
- h. Provide local and state officials with legal advice concerning identification of the deceased consistent with cultural sensitivity practices.
- i. Serve as the lead agency for investigation and evidence recovery in a mass fatality incident resulting from acts of terrorism.

31. Department of Defense (US DOD)

- a. Provide available logistical support (e.g., transportation) to public health/medical response operations.
- b. Deploy healthcare providers in a limited capacity to augment civilian hospital staff.
- c. Mobilize and deploy available Active Component, Reserve, and/or National Guard medical units, or individuals, when authorized for public health and medical response.

- d. At the request of the US HHS, and in coordination with interagency partners, provide National Disaster Medical System (NDMS) support for the aeromedical evacuation and medical management of NDMS patients from DOD patient collection points to patient reception areas.
- e. Deploy available medical, surgical, and behavioral health personnel for casualty clearing and staging, patient management, and treatment.
- f. Provide available DOD medical supplies and material for use at Points of Distribution (PODs), hospitals, clinics, or medical care locations operated for exposed populations, incident victims, or ill patients.
- g. Provide available assistance for human fatality management services including remains collection, remains transport, mortuary services, and victim identification. Track decedents transported on DOD assets to fatality management facilities (e.g., mortuary, funeral homes).
- h. Provide a Joint Task Force Civil Support (JTF CS) Command that manages military assets in civil disasters. A mortuary affairs unit: 54th Quartermaster Company is a component of the Military's Mortuary Affairs Unit, the Office of the Armed Forces Medical Examiner (OAFME) which consist of pathologists and odontologists and enough disposable equipment on a mobile team capable of processing 1,000 remains.

32. American Red Cross (ARC)

- a. Provide mass care technical assistance to DHS/FEMA and serve as its principal mass care Subject Matter Expert (SME).
- b. Provide available personnel to assist in temporary infirmaries, immunization clinics, morgues, hospitals, and nursing homes.
- c. Assist appropriate agencies in interviewing and otherwise assisting families of the deceased at Family Assistance Centers (FACs).
- d. As the request of the US HHS, coordinate with the American Association of Blood Banks (AABB) Task Force to provide blood and services as needed through regional blood centers.
- e. Provide mortality and morbidity information to requesting agencies.
- f. Provide for disaster-related health and behavior health needs through direct services and/or referrals as necessary.

- g. Provide supportive counseling for family members of the dead, injured, and others affected by the incident.
- h. Provide, as able, behavioral health and spiritual care teams to provide psychological aid to fatality management workers and families of victims at FACs and at the incident site.

33. National Voluntary Organizations Active in Disaster (NVOAD)

- a. Provide members with information pertaining to the severity of disasters, needs identified, and actions of volunteers throughout the response, and recovery process.
- b. Provide guidance in case management, sharing client information, promoting spiritual and emotional care, and managing unaffiliated volunteers and unsolicited donated goods, and long-term recovery.
- c. Provide cleanup assistance including debris removal, mud-out, tear-out, tree removal, and other services expediting survivor return to normal.
- d. Receive, process, and distribute clothing, bedding, and food products.

V. DIRECTION, CONTROL, AND COORDINATION

A. General

- 1. The Ohio Revised Code (ORC) assigns responsibility for fatality management to county Coroners/Medical Examiners (C/MEs). Local C/MEs should coordinate all field examinations of fatalities. There is no corresponding authority for fatality management at the state level. County level C/MEs have jurisdiction over acute mass fatalities within their jurisdictions.
- 2. Activities of Emergency Medical Services (EMS) units in Ohio are directed by fire chiefs when the units are attached to fire departments and by the owners/operators of private or government-owned entities. On-site Incident Commanders (ICs) coordinate EMS response.
- 3. Upon arrival at the scene, representatives from the C/ME will receive a briefing from the Incident Commander regarding the type of incident involved, general characteristics of the scene, condition of the remains (e.g., whole, fragmented, commingled, burned, contaminated, integrated with debris, etc.), anticipated hazards, and investigative issues.

4. The Ohio Department of Health (ODH) is the lead state agency for health and medical needs of a Mass Casualty Incident (MCI), including determining the need for and activation of the Ohio Medical Coordination Plan (OMCP). The State Emergency Operations Center (EOC) is responsible for accessing and coordinating state- and federal-level assets and response to mass casualty incidents through the State EOC.
5. The Director of the ODH has the authority to issue Public Health Orders under his/her traditional public health authority; including ordering quarantines, isolations, school closings, and cancellations of public gatherings in order to protect the public from disease or other public health threats.
6. ODH is the lead agency for distributing medical equipment and supplies, and pharmaceuticals stored in state caches; and for acquiring additional resources from vendors (in conjunction with the Ohio Department of Administrative Services) and the federal government (e.g., SNS assets).
7. In transportation incident, which fall under the Federal Aviation Disaster Family Assistance Act of 1996, the transportation company is responsible for the processing and return of personal effects.
8. Command and control actions and decisions may be made directly by the State EOC Executive Group, or through forward-deployed Incident Management Teams (IMTs) during large scale MCIs/ MFIs.
 - a. Single Command – If a catastrophic incident occurs within a single jurisdiction and there is no jurisdictional or functional agency overlap, the incident will be managed by a single Incident Commander who has overall incident management responsibility.
 - b. Area Command – If a catastrophic incident initially impacts a wide area of the state, the impacted area crosses jurisdictional boundaries, or the incident site evolves and becomes geographically dispersed over time, Area Command may be established to oversee the management of a single incident or multiple incidents that are each being managed by a separate ICS organization.
 - c. Unified Command – If a catastrophic incident involves the response of more than one responding agency with responsibility for the incident, or if an incident site(s) cross political jurisdictions, Unified Command may be established, or an existing Area Command may be transitioned to a Unified Command. Under a Unified Command, response agencies and/or multiple jurisdictions will work together to analyze intelligence information, and establish a common set of objectives and

strategies for a single Incident Action Plan to allow all involved agencies/jurisdictions to participate in the decision making process.

- i. For MCIs with numerous fatalities, the IC may choose to bring the Coroner into a Unified Command Structure.
 - d. Incident Management Teams – If all available local and regional command and control mutual aid resources have been exhausted, an IMT may be assigned to an incident and supplemental resources may be assembled to assist local authorities who are unable to establish or maintain an effective incident command structure due to catastrophic conditions. The State EOC Executive Group will establish and assign IMTs, under the authority of the Governor, to exercise command and control of an incident and to make resources allocation and application decisions on behalf of a local jurisdiction.
9. In Ohio, an assigned IMT would consist of one of the following listed below. These IMTs are all-hazard national level teams, and to a lesser extent the state and metropolitan area level teams, are self-contained and bring everything they need to operate.
- a. Type 3 IMT (State or Metropolitan area level; usually 4-20 positions),
 - b. Type 2 IMT (National or State level; usually 10-30 positions), or
 - c. Type 1 IMT (National or State level; usually 20-50 positions).
10. If needed, a State- or Federal-level IMT or IMAT would be requested by an impacted local jurisdiction through the State EOC, and a local-level IMT would be requested through the Ohio Fire Service or through the Law Enforcement Emergency Response System.
11. DMORT and/or OMORT does not establish command and control over the fatality management operation, but will be integrated into the local ICS structures.

12. **Ohio ESF-6:** The Ohio Emergency Management Agency (OEMA) is the lead state agency for ESF-6 (i.e., sheltering, feeding, counseling, points of distribution operations, and social services). Each ESF-6 support agency will maintain internal, agency-based Standard Operating Guidelines (SOGs) and checklists that detail the logistical and administrative support arrangements specific to each agency. When State-level ESF-6 support agencies have exhausted their available resources and/or are unable to effectively respond to a mission assignment, they will work within the State EOC to obtain additional resources via the Emergency Management Assistance Compact (EMAC), Ohio's Public-Private Partnership Program, or other federal, private sector sources.
13. **Federal ESF-6:** Emergency Support Function (ESF) #6 Mass Care, Emergency Assistance, Temporary Housing, and Human Services; to the National Response Framework (NRF) coordinates and provides life-sustaining resources, essential services, and statutory programs when the needs of disaster survivors exceed local and state government capabilities. Fatality Management Services provided under ESF #6 include; providing mechanisms to support notification/transportation of family members to make appropriate arrangements for deceased relatives, and crisis counseling services. Non-Governmental Organizations (NGOs), together with academia and the private sector, are integral elements of the whole community response. Resources from national-level NGOs and the private sector may augment local and state response capabilities. When these resources are insufficient, Federal assistance may be requested through the Federal Emergency Management Agency (FEMA) Regional Office.
14. **Ohio ESF-8:** The governor may request federal assets to include National Disaster Medical System (NDMS) activation that include Disaster Medical Assistance Team (DMAT) and a Disaster Mortuary Operational Response Team (DMORT) when state capabilities are overwhelmed. The Ohio Department of Health (ODH) will prioritize and coordinate federal mass casualty/fatality assets deployed to Ohio.
15. **Federal ESF-8:** Emergency Support Function (ESF) #8 – Public Health and Medical Services; to the National Response Framework (NRF) provides the mechanism for Federal assistance to supplement local, state, tribal, territorial, and insular area resources in response to a disaster, emergency, or incident that may lead to a public health, medical, behavioral, or human services emergency.

- a. ESF #8 resources can be used by jurisdictional medico-legal authorities in carrying out fatality management responsibilities by providing specialized teams, and equipment, to conduct victim identification, grief counseling and consultation, and reunification of human remains and effects to authorized persons.
16. In accordance *National Response Framework – Catastrophic Incident Annex (NRF-CIA)* all deploying federal resources remain under the control of their respective federal department or agency during mobilization and deployment. Some federal departments and agencies have the authority, under their own statutes, to deploy directly to the incident scene. States are encouraged to conduct planning in collaboration with the federal government for catastrophic incidents as part of their steady-state preparedness activities.
17. The site and/or remains resulting from a Weapons of Mass Destruction (WMD) – Chemical, Biological, Radiological, Nuclear, or Explosive (CBRNE) event is a crime scene, thereby making all remains and personal effects associated with the event forensic evidence. The Federal Bureau of Investigation (FBI) is the lead investigative agency for WMD/CBRNE events.
18. If a MCI / MFI is the result of a transportation related-incident, the lead federal agency would likely be the National Transportation Safety Board (NTSB). The NTSB would consult with the county-level C/ME; who would request all state and federal resources.

VI. INFORMATION COLLECTION, ANALYSIS AND DISSEMINATION

- A. The Law Enforcement Agencies' Data System (LEADS) is normally monitored at all county level communication centers (E-911) and at Emergency Operations Centers (EOCs), such a practice should be intensified during Mass Casualty or Mass Fatality incidents. An individual should be assigned to monitor LEADS during MCI / MFI to ensure an efficient transmission of relevant information to field units.
- B. Local Health Departments (LHDs) may request the activation of the Regional Communication Center and Regional Vital Statistics Office (Ross County & Athens County).

- C. The initial and continuing MCI / MFI progress reports will include the following information:
 - 1. Type of situation
 - 2. Number, types, and condition of casualties
 - 3. Number of known deceased
 - 4. Prioritized resource requirements at the scene, to include specialized equipment and supplies
 - 5. Overall stability of the incident scene
 - 6. Hospital notifications

- D. The following categories of death cases, as determined by initial notification by either police or hospital personnel to the C/ME, require immediate notification, prior to any investigation, by the C/ME.
 - 1. All homicides or cases which are being handled as possible homicides, or cases which should be handled as possible homicides.
 - 2. All sudden or unexpected deaths of children 17 years or younger, including possible suicides, where not due to transportation accidents.
 - 3. All fatality events causing two (2) or more deaths.
 - 4. All deaths associated with fire or explosion.
 - 5. All discovered unidentifiable human remains, or material thought to be human remains.

- E. In the event of a mass fatality, the Incident or Unified Commander (UC) will appoint a Lead Public Information Officer (PIO) to establish a Joint Information Center (JIC) within the Incident Command System (ICS). The Lead PIO reports to the Incident Commander (IC) and is a member of the Incident Command Staff.

- F. All communication objectives (i.e., gathering of information and intelligence, development of consistent and coordinated messages, and the dissemination of messages and information) will be met through working in a JIC reporting to the IC/UC.

- G. The JIC will allow for the co-location of key PIOs and provides a one-stop-shop for the media and public to get all of their communication needs met. It enhances the likelihood that information released to the public will be accurate and coordinated across responding agencies and jurisdictions.

- H. The JIC should be located distant from the location of deceased victims and from the Family Assistance Center (FAC).

- I. The Lead PIO in a JIC is responsible for overall JIC operations and for providing prompt and organized responses to the news media. The Lead PIO coordinates all public information efforts out of the JIC, ensures protocols are followed, ensures that all messages are approved by the Incident Commander before release, attends EOC Command briefings, and coordinates these efforts with local, state, and federal partners.
- J. The Coroner/Medical Examiner (C/ME) has a significant role in the approval of information released regarding the mass fatality operation, determining the sensitivity of information releases and how they affect the surviving families.
- K. The Federal Bureau of Investigation (FBI) will be in charge of the investigation if terrorism is suspected. The FBI can provide consultation regarding public information.
- L. The Incident Command Post (ICP) should have at least one person at the incident site that is dedicated to assuring that media representatives have appropriate access when possible without creating safety hazards.
- M. Incident Morgue Considerations
 - 1. Restrict the media from entering the morgue. If media tours are provided, do not allow any pictures, cameras or cell phones.
 - 2. Establish a morgue briefing area near but not in the morgue.
 - 3. Remind the media of the morgue's critical objectives and to consider victims' families when information on morgue services is communicated.
- N. Local Health Department will coordinate with the PIO to provide public health and disease and injury prevention information that can be transmitted to members of the general public who are located in or near areas affected by a major disaster or emergency.
- O. Out-of-state deaths, will require the involvement of the state to assist the C/ME in sending death notification information to the appropriate out-of-state law enforcement agency for notifying next of kin.
- P. For deaths of citizens of other countries, the Agency for International Development, Office of Foreign Disaster Assistance will assist in contacting a deceased foreigner's family through the appropriate embassy. DMORT's Victim Identification Program (VIP) software can be used to assist in managing the information, if the local C/ME does not have a system in place.
- Q. The C/ME is responsible for all death notification procedures. The C/ME will determine the next of kin wishes.

- R. The C/ME will release names of decedents to the EOC and JIC after next of kin have been notified.
- S. Death Notifications or Pronouncement of Deaths
 - 1. Always notify family members of a loved one's death in person, if at all possible. A team rather than an individual is preferred for notification.
 - 2. If the family's selected location is too far for the local ME/C Office to go to, enlist the assistance of local law enforcement for that area.
 - 3. In cases where local law enforcement in another area is making the notification, encourage them to bring a local mental health professional or member of the clergy.
 - 4. When assistance is needed to find next of kin, notify appropriate authorities. If the victim lived out-of-state, the OEMA may assist by contacting the law enforcement agency where next of kin lives. If the victim is from another country, the Agency for International Development, Office of Foreign Disaster Assistance may assist in contacting a deceased foreigner's family through the appropriate embassy.
 - 5. In cases of fragmentation or commingling of remains, counsel families on the available options for disposition of any subsequently identified remains.
 - 6. Ask family members and loved ones if they desire crisis assistance or someone to talk to. If family members are undecided or say no, give them the family assistance call center number to use if they change their mind in the future.
 - 7. Coordinate the release of the remains between the family, the morgue and the selected funeral home.

VII. ADMINISTRATION, FINANCE, AND LOGISTICS

- A. Administration
 - 1. Field patient tracking should include adding patient names, if possible, to SALT or START triage tags (or JumpSTART pediatric tags). With names on tags, tracking would be facilitated into the hospital, where the individual's name could be entered into the hospital system.
 - 2. All original records pertaining to identification, postmortem documentation, and ante-mortem records will be transferred to the C/ME.
 - 3. Within the discretion of the chief medical examiner, or of the person making the autopsy, or if requested by the prosecuting attorney of the county, or of the county where any injury contributing to or causing the death was sustained, a copy of the report of the autopsy shall be furnished to the prosecuting attorney.

4. The office of the chief medical examiner shall keep full, complete and properly indexed records of all deaths investigated, containing all relevant information concerning the death and the autopsy report if an autopsy report is made. Any prosecuting attorney or law-enforcement officer may secure copies of these records or information necessary for the performance of his or her official duties.
5. Ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191 and additional local laws that protect privacy of morgue information and records.
6. Keep an inventory of and track all equipment and supplies donated, loaned and/or purchased.
7. Arrange for adequate number of required forms associated with morgue services (i.e., personnel log that includes name, agency, social security number, and in and out time, postmortem forms, ante-mortem forms, etc.).
8. The Administration Station of the Incident Morgue will maintain adequate supplies of General morgue forms, Disaster Victim Packets (DVP), Embalming forms, Death certificates, and Release forms.
9. The Information Resource Center (IRC) will serve as the central repository for collection, recording, and storage of ante-mortem and post mortem information. No information will be released to any person(s) or agencies without proper authorization from the ME/C. At the conclusion of the incident, all records and data collected become the property of the local ME/C.
10. Establish procedures for postmortem and ante-mortem records management into four (4) major file categories:
 - a. Unidentified remains case files in morgue case number order.
 - b. Missing person reports case files (ante-mortem data collection interviews) in last name alphabetical order.
 - c. Identified remains (the ME determines which master number to use and merges all related materials into one file).
 - d. Court issued presumptive death certificates and related documents (if applicable).
11. Monitor broadcast and print news coverage of events to anticipate impact of information on families and FAC operations.

12. Volunteers can be obtained from Disaster Medical Assistance Teams (DMAT) and the National Nurse Response Team (NNRT) both of which are part of the National Disaster Medical System (NDMS), the Medical Reserve Corps (MRC), and/or the American Red Cross (ARC).

B. Finance

1. Following a Presidentially Declared Disaster, counties within the region may be eligible for reimbursement for some costs incurred during the response. Accurate financial records for the incident are essential.
 - a. By the triggers listed in Table 3.1 above, a Level 1 activation would not necessitate a declaration of emergency or disaster.
 - b. A Level 2 activation may, or may not result in a declaration of emergency or disaster.
 - c. A Level 3 – 5 activation should trigger the declaration of a local emergency.
2. Each participating department/agency is required to submit an initial documentation of funds spent on the incident to their respective EOCs within 10 days after the termination of mass fatality management activities. Records of expenditures and obligations in mass fatality operations must be maintained by local governments and agencies employing their own bookkeeping procedures (including personnel overtime, equipment used, contracts initiated, etc.). Emphasis must be placed on meeting applicable audit requirements. The State and FEMA will assist each agency filing out Public Assistance Forms if the incident is declared eligible under public assistance.
 - a. **Resource Procurement Actions before a Declaration of Local “State of Emergency”:** Every effort should be made to meet requirements with local government resources. Local government officials should be contacted without regard to normal business hours to assist in obtaining those necessary items that are not readily available in the stocks of committed local governments. Unless specifically authorized by the appropriate municipal/county official, normal procurement guidelines should prevail.

3. Donations of funds, supplies, or services are deductible items for tax purposes; therefore, it is necessary for the Resource Manager to provide receipts to the donors. Receipt of donations of any nature will be recorded with a reasonable value assigned. Signed receipts will be used as soon as possible.
4. The Family Assistance Center (FAC) should employ an accounting system to accurately record cost data in specific cost categories and track personnel for later reimbursement, including but not limited to: daily attendance rosters and time worked logs, tracking of all supplies and equipment requested, loaned, received, and used.
5. DNA analysis is expensive and its funding must be addressed. FEMA provides funding for the DNA identification effort if the incident meets its criteria for a disaster.
6. Whenever an examination of a body is ordered, and the body of the deceased is transported to a laboratory or other place of examination, the reasonable cost of the transportation shall be paid by the state out of funds appropriated to, or for the use of, the C/ME. Transportation at state expense shall be provided from the place where the body is being kept at the time the examination is ordered to a laboratory, or other place of examination, and, upon completion of the examination, other place designated by the person entitled to possession of the body.

C. Logistics

1. In the instance of a Mass Fatality Incident (MFI) that exceeds the capabilities of a county, the request for additional state and federal resources will be coordinated by the C/ME through the County's EOC and/or the State EOC. Support from the Disaster Mortuary Response Team (DMORT), the DMORT Disaster Portable Morgue Unit (DPMU), the DMORT WMD Team, DNA Team, and/or the DMORT Family Assistance Team (FAC) requires requests be forwarded to the Federal Emergency Management Agency (FEMA) via the C/ME and State EOC. Other federal assets (e.g., Urban Search and Rescue [USAR] Teams, Chemical Biological Incident Response Force [CBIRF], National Transportation Safety Board [NSTB], Center for Disease Control and Prevention [CDC], Disaster Medical Assistance Teams [DMATs], etc.) may also be requested by the OCME and, if available, mobilized to support fatality response and recovery operations.

2. In the instance of a MFI that exceeds the capabilities of state assets, the Governor may assist the C/ME by calling upon the Emergency Management Assistance Compact (EMAC) to obtain additional staff from the surrounding states and ensuring licensing requirements are waived for those persons who come to aid the C/ME from surrounding states.
3. Mass fatality incidents that exceed local, regional and state resources may result in requests for Federal DMORT. DMORT does not establish command and control over the fatality management operation, but will be integrated into the local ICS structure.
4. A logistics officer will be responsible for working with EOC logistics on the acquisition, storage, issue, and accountability of all supplies, equipment, facilities, personnel and services necessary to support the incident site/human remains recovery operations.
5. The logistics officer will have a system in place to track supplies requested, loaned and used for human remains recovery, and assure re-supply and billing information.
6. Local, state and federal resources assistance will be requested as needed based on the nature and complexity of the incident.
7. Federal resources will be requested via local EOCs, through the OEMA – State EOC to FEMA. Federal resources include the Disaster Mortuary Operational Response Team (DMORT), Department of Justice (DOJ) Missing/Unidentified Persons Section, DOJ Bureau of Forensic Services Section, and DOJ DNA Analysis.
8. Support for mass fatality workers should include the following:
 - a. Work practice and administrative controls (e.g., time off, breaks, and monitoring how staff and volunteers are holding up over time).
 - b. Providing Personal Protective Equipment (PPE) to the hazard and level of exposure.
 - c. Helping staff and volunteers cope with the common stress symptoms that result from mass fatality work and preventing/mitigating traumatic stress and its symptoms; physical illness and disease, mental and psychological disorders, and relationship problems.
9. The transportation of human remains, property and evidence to the incident morgue, as well as transportation of personnel and equipment to and from the incident site will be tasked and staffed through EOC logistics based on needs identified by the C/ME.

10. A respite center should be established for long-term operations near the incident site.
The respite center should provide the following services:
 - a. Basic first aid.
 - b. Food and beverages.
 - c. Mental health services (Psychological First Aid).
 - d. Spiritual care services.
11. Arrange for daily back-ups of all electronic files associated with human remains identification, and morgue services.
12. Arrange for communications (telephones, cell phones, radios, fax, and paging systems) necessary to conduct mass fatality operations.
13. Arrange for staff support (rest areas, toilet facilities, showers, food and beverages, mental health services, places to secure staff possessions while working, etc.).
14. Make arrangements for laboratory analysis (toxicology, histology, DNA, etc.). The Armed Forces DNA Identification Laboratory (AFDIL) may be a resource for assistance with the DNA Station and/or with DNA analysis.
15. The Morgue Services Logistics Officer will identify ME/C incident site service and support needs and will work closely with EOC logistics to procure and allocate service and support needs. The logistics officer will also work closely with morgue leadership to track and maintain required documentation for supplies, equipment and personnel.
16. DMORT's Disaster Portable Morgue Unit (DPMU) is a packaged system containing all forensic equipment, instrumentation, support equipment, and administrative supplies required to operate an incident morgue facility under field conditions, or support an existing morgue facility. The DPMU carries computers and related equipment to support the FAC and Information Resource Center (IRC) in the management of postmortem and ante-mortem information. Three (3) fully equipped DPMUs are maintained, the closest of which is located in Frederick, Maryland. A DPMU can be requested even if DMORT staffing assistance is not needed.
17. Family Assistance Center management should appoint a logistics officer. The FAC logistics officer will be responsible for working with the EOC logistics on the acquisition, storage, issue, and accountability of all supplies, equipment, facilities, personnel and services necessary to support the family assistance operation.

18. The FAC should manage resource requirements, maintain inventories of donated, purchased, and leased equipment and supplies, and work with EOC Logistics to manage distribution of donated items to families.
19. Transport of Remains – funeral homes will be utilized to transport remains; however, the anticipated workload for the funeral homes will be extensive and additional resources may be required for vehicles and drivers. These resources (rented utility vans, station wagons, church groups, prison guards, etc.) will be requested through local EOCs.

VIII. PLAN DEVELOPMENT AND MAINTENANCE

A. Updating the Document

1. As the agency that sponsored this planning effort (and coordinated the emergency preparedness planning), the Jackson County Emergency Management Agency (JCEMA) should coordinate updates to this document.
 - a. “Coordination” entails reconvening the stakeholder group (i.e., planning committee) on a regular basis.
 - b. Stakeholder meetings can be held on a regular schedule, under which cases the JCEMA would be the pre-emptive agency, or requested by individual stakeholders.
2. Each agency tasked with an assignment in this plan that participates in the National Incident Management System (NIMS) will review its portion of the plan at least once a year, usually at the termination of an exercise designed to test the plan. Representatives from those agencies will submit their changes to their county EMA Director, who will forward them on the JCEMA.
3. The stakeholder group should meet not less than bi-annually (i.e., every two [2] years) to review this plan, and as needed following exercises or real-world incidents.

B. Distribution of the Document

1. The EMA's that make up OHS Region 7 are responsible for ensuring that necessary additions and revisions to this plan are prepared, coordinated, published, and distributed. The EMA's should distribute changes to this document in an electronic format to stakeholders.
2. Stakeholders would be responsible for distributing the document throughout their agency and/or municipal jurisdiction.

C. Training and Exercises

1. Training

- a. The regional stakeholders involved in this planning process bear the responsibility of training their own personnel in mass casualty / mass fatality response techniques.
- b. As training capabilities and resources are strengthened (i.e., new skills and/or resources acquired), this plan should be revised.
- c. Training should support the development of exercises and should be evaluated, along with this document itself, during exercises.

2. Exercises

- a. As with other emergency preparedness plans, this document should be tested regularly via emergency exercises (i.e., table-top, functional, full-scale), that are compliant with Homeland Security Exercise and Evaluation Program (HSEEP) requirements.
- b. To ensure that this plan is tested fairly and fully, it should be provided to exercise designers so that appropriate evaluative materials can be developed. Only an evaluation based on the guidance contained within this plan (as opposed to theoretical metrics) can determine its effectiveness.
- c. These exercises should be followed by an After-Action Review (AAR) and the compilation of an AAR/Improvement Plan (IP) that may address specific elements of this plan. If an element of this plan proves to be unsuccessful, the AAR/IP should identify it, suggest a plan revision, and place a timeframe for completion of the revision.

IX. LIST OF APPENDICES

Appendix 1 – Ohio Homeland Security (OHS) Region 7 MCI / MFI Assets

Appendix 2 – Planning Subcommittees

Appendix 3 – Job Action Guides

Appendix 4 – Mass Fatality NIMS Organization Charts

Appendix 5 – Mass Fatality Incident Forms

Appendix 6 – Guidelines for Selecting a Temporary Morgue Site

Appendix 7 – Personal Effects and Property Disposition

Appendix 8 – Glossary of Terms & Acronyms

APPENDIX 1

OHS REGION 7 MCI / MFI ASSETS

County	Population 2021 Est.	Hospitals	# Total Beds	EMS Units	Coroner	Funeral Homes	Morgue Space	Crematories	Body Bags
Athens	62,056	OhioHealth O'Bleness Hospital	144 (65)	12	1 Coroner 3 Investigators	8	90 FR 72 MR	1	2,000
Gallia	29,158	Holzer Emerg. Medical Ctr.	266 (125)	6	1 Coroner	4	3 FR 20 MR	0	125
Hocking	28,097	Hocking Valley Comm. Hospital	25* (25)	5	1 Coroner 2 Investigators	4	20 FR 0 MR	0	30
Jackson	32,511	Holzer Medical Ctr. – Jackson	25* (25)	7	1 Coroner 1 Deputy 1 Investigator	6	0 FR 0 MR	1	125
Lawrence	57,445	St. Mary's Medical Center	12 Free Standing ER	7	1 Coroner 2 Deputy 3 Investigators	9	42 FR 32 MR	3	225
Meigs	22,049	Holzer Meigs Emerg. Dept.	12 Free Standing ER	3	1 Coroner 2 Investigators	6	10 FR 0 MR	1	75
Perry	35,460	Genesis Perry Co. Medical Ctr.	9 Free Standing ER	9	1 Coroner	7	0 FR 0 MR	0	75
Pike	27,089	Adena Pike Medical Center	35* (35)	3	1 Coroner	5	2 FR 0 MR	1	75
Ross	76,891	Adena Regional Medical Ctr. VA Medical Ctr. Chillicothe	266 (209) 96 (96)	51 ¹	1 Coroner 1 Deputy 7 Investigators	6	37 FR 28 MR	1	250
Scioto	73,346	Southern Ohio Medical Ctr. King's Daughters Medical Ctr.	241 (211) 10 (10)	17 15 ²	1 Coroner 4 Deputy	8	25 FR 12 MR	2	300
Vinton	12,696	N/A	0 (0)	2	1 Coroner	1	0 FR 0 MR	0	75
Totals	456,798	12 Medical Facilities	1,141 (834)	137	11 Coroner's 8 Deputies 18 Investigators	64	229 FR 164 MR	10	3,355

(#) = number of staffed beds / * Critical Access Beds / ¹ – 17 dept. avg. 3 EMS units (total 51) / ² – backup EMS units / FR – Fixed Refrigerated Body Storage / MR – Mobile Refrigerated Body Storage

Sources:

- Population = US Census Bureau
- Hospitals & Bed Totals = Ohio Emergency Medical Services (confirmed by each hospital)
- EMS Units = County EMAs
- Coroner/ME = Ohio State Coroners Association (confirmed by county coroners)
- Funeral Homes = Southeast Central Ohio Region – Public Health Emergency Response Plan (confirmed by each county EMA & funeral home directors)
- Morgue Space = Central Ohio Trauma System (COTS) (confirmed by each county EMA & funeral home directors)
- Crematories = County EMAs, Coroners, funeral home directors
- Body Bags = Southeast Central Ohio Region – Public Health Emergency Response Plan (confirmed by each county EMA)

APPENDIX 2

PLANNING SUBCOMMITTEES

The following appendix contains Mass Casualty / Mass Fatality planning subcommittees for each of the Ohio Homeland Security (OHS) Region 7 counties.

ATHENS COUNTY PLANNING SUBCOMMITTEE					
Organization	Representative 1			Representative 2	
	Name	Email	Phone #	Name	Phone #
EMS Providers	Chief Rick Callebs	rcallebs@acems.org	740-592-0196	Asst. Chief Amber Pyle	7405920195
Air Medical Resource	Matt Hynus	mhyus@medflight.com	304-989-0055		
Hospitals / ED	Lianne Dickerson	lianne.dickerson@ohiohealth.org	740-592-9250	Sierra Miller	614-558-4654
Health Department	Kate Cottrill	kcottrill@athenspublichealth.org	740-447-5924	Jack Pepper	740-592-4431
Medical Reserve Corp (MRC)	Kate Cottrill	kcottrill@athenspublichealth.org	740-447-5924		
Law Enforcement	Capt. Aaron Maynard	amaynard@athenssheriff.com	740-593-6633		
Fire/Rescue	Chief Robert Rymer	rrymer@ci.athens.oh.us	740-517-0234		
Search & Recovery Teams					
Coroners/Medical Examiner	Dr. Carl Ortman, Coroner	cortman@athensoh.org	740-707-4989	Ben Ashcraft	740-818-3031
Funeral Home Director					
Morgues					
Embalmers					
Crematories					
ARC Chapter	David Bradley	david.bradley2@redcross.org	740-517-2015	John Eckleberry	740-591-8349
Faith Based Organizations	Chuck Carroll	chuckcarroll47@gmail.com	740-517-8348		
Non-Governmental Organizations	Jill Harris, Ohio University	harrisj4@ohio.edu	740-593-9532		
Other:	Laura George, COTS	lgeorge@cotshealth.org	614-255-4413		

GALLIA COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Keith Wilson	740-446-0010		
Air Medical Resource				
Hospitals / ED	Jennifer DeWitt	740-446-5000		
Health Department	Kirk Carmouche	740-709-9716		
Medical Reserve Corp (MRC)				
Law Enforcement	Matt Champlin	740-645-1088		
Fire/Rescue	Matt Neal	740-208-1238		
Search & Recovery Teams				
Coroners/Medical Examiner	Dr Daniel Whitley	740-446-5000		
Funeral Home Director	Fred Workman	740-645-9002		
Morgues				
Embalmers				
Crematories				
ARC Chapter	Roy Grimmett	304-544-9207		
Faith Based Organizations	Bob Hood	740-709-6107		
Non-Governmental Organizations				
Other:				

HOCKING COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Chief Scott Brooker	740-385-0919	N/A	
Air Medical Resource	Leslie Aquino	740-475-8003	N/A	
Hospitals / ED	Stacey Gabriel	740-380-8000	Michele Matheny	740-380-8000
Health Department	Commissioner Doug Fisher	740-385-3030	Jamie Carrell	740-385-3030
Medical Reserve Corp (MRC)	Laura Gossel	740-385-3030	N/A	
Law Enforcement	Chief Deputy Caleb Moritz	740-385-2131	Chief Jerry Mellinger	740-385-6866
Fire/Rescue	Chief Chris Maley	740-385-3955	Ass. Chief Melissa Fickel	740-385-2307
Search & Recovery Teams	N/A		N/A	
Coroners/Medical Examiner	Dr. David Cummins	740-808-1387	N/A	
Funeral Home Director	Van Cardaras	740-385-3028	David Brown	740-385-3535
Morgues	N/A		N/A	
Embalmers	Van Cardaras	740-385-3028	David Brown	740-385-3535
Crematories	N/A		N/A	
ARC Chapter	David Bradley	740-593-5273	John Eckelberry	740-591-8349
Faith Based Organizations	Roger Davis	740-603-3407	N/A	
Non-Governmental Organizations	Roman Wilshinetsky	740-385-1745	Dave Brimner	740-385-9531
Other:	N/A		N/A	

JACKSON COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Chris Johnson (JCEMS Director)	740-286-0783	Ryan Foster (JCEMS Supervisor)	740-418-4099
Air Medical Resource	None			
Hospitals / ED	Jennifer DeWitt (Holzer)	740-441-3301	Marsha Baisden (Adena Jackson)	740-418-4810
Health Department	Terry Barr (Jackson Co. HD)	740-286-5094	Kevin Aston (Health Comm.)	740-286-5094
Medical Reserve Corp (MRC)	Robert Czechlewski (JCEMA)	740-286-5630	Jodi Strite (JCHD)	740-286-5094
Law Enforcement	Scott Conley (Chief Deputy, JCSO)	740-286-6464	David Ward (Chief, Oak Hill PD)	740-682-6301
Fire/Rescue	Darrell Wright (Asst. Chief WFD)	740-978-7711	Aaron Dupree (Ast. Chief Wellston)	740-418-1941
Search & Recovery Teams	Darrell Wright (Asst. Chief WFD)	740-978-7711	Aaron Dupree (Ast. Chief Wellston)	740-418-1941
Coroners/Medical Examiner	Alice Frazier (Coroner)	614-325-1011	Buster Hall (Assistant Coroner)	740-286-6464
Funeral Home Director	Mayhew Brown Funeral Home	740-286-4161	Lewis Gillum Funeral Homes	740-286-2010
Morgues	None			
Embalmers	Mayhew Brown Funeral Home	740-286-4161	Lewis Gillum Funeral Homes	740-286-2010
Crematories	None			
ARC Chapter	Roy Grimmer	304-544-9277	Amber Dean	304-400-5207
Faith Based Organizations	Tim Jones	740-577-4316	Terry Barr	740-286-5094
Non-Governmental Organizations	Abbott Home Health Care	740-988-3000	ProMedica Hospice	740-682-0270
Other: Regional Public Health	Debbie Elloitt (Regional Coord.)	740-974-8001	Kelsey Blackburn (COTS)	740-601-6901

LAWRENCE COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Mac Yates	(c) 740-646-2030	* David Zornes	(c) 606-615-7219
Air Medical Resource	Paul Conley (HealthNet)	859-608-0607	* Jordan Walker (HealthNet)	(c) 681-220-4200
Hospitals / ED	Angela Hanley (St Mary's)	(o) 740-533-9719	Jenny Murray (Cabell Huntington)	(c) 304-638-9764
Health Department	Georgia Dillon	(c) 740-550-1473	Debbie Fisher	(c) 740-533-6850
Medical Reserve Corp (MRC)	Cindy Quillen	(c) 740-285-6528	Josh Haney	(o) 740-532-3962
Law Enforcement	Michael Gore	(c) 740-646-5173	Nick Lunsford	(c) 740-547-6544
Fire/Rescue	Michael Mahlmeister	(c) 740-533-7969	Joey McMaster	(c) 304-963-1528
Search & Recovery Teams	Matthew Jenkins	740-573-5019	Lee Hanners	(c) 606-571-3716
Coroners/Medical Examiner	Dr. Benjamin Mack	(c) 419-788-0764	Drew Artis	(c) 740-646-2861
Funeral Home Director	Ernie Hall	(o) 740-886-6164	Chad Pemberton	(c) 740-646-0826
Morgues	(N/A we have no morgues)	-	(see Coroner Info above)	-
Embalmers	Evan Hall (Hall Funeral Home)	(c) 304-360-5553	Chad Pemberton (Phillips Funeral)	(c) 740-646-0826
Crematories	Evan Hall	(c) 304-360-5553	Ernie Hall	
ARC Chapter	Roy Grimmett	(c) 304-544-9207	Amber Dean	(c) 304-400-5207
Faith Based Organizations	Terry Jones	(c) 740-646-0694		
Non-Governmental Organizations	Laura Brown, RN (Home health)	(c) 740-646-2795	Krista Ellison	(c) 740-237-0432
Other: Regional Public Health	Debbie Elliott	(c) 740-974-8001	Kelsey Blackburn	(c) 740-601-6901
Other: 911 Communications	Lonnie Best, 911 Director	(c) 740-646-1199	Nicholas Kuhn (911 Coordinator)	(c) 740-302-2157

MEIGS COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Ryan Hill	740.444.3333	Shannon Altzan	225.802.2197
Air Medical Resource	Matt Hynus	304.989.0085		
Hospitals / ED	Jen Celand	740.416.7902		
Health Department	Shawn Cunningham	740.416.0420		
Medical Reserve Corp (MRC)	Shawn Cunningham	740.416.0420		
Law Enforcement	Frank Stewart	740.416.5524		
Fire/Rescue	Derek Miller	740.416.1830		
Search & Recovery Teams	N/A	N/A		
Coroners/Medical Examiner	Susan Mansfield	740.508.1578		
Funeral Home Director	Adam McDaniel	740.416.2507		
Morgues	N/A	N/A		
Embalmers	N/A	N/A		
Crematories	N/A	N/A		
ARC Chapter	Roy Grimmett	304.544.9207		
Faith Based Organizations	N/A	N/A		
Non-Governmental Organizations	N/A	N/A		
Other:				
Other:				

PERRY COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Justin Morrow EMS Chief	740-252-8007		
Air Medical Resource				
Hospitals / ED	Jason Adams- Genesis ER	740-252-7163		
Health Department	Jim Mickey	740-342-5179		
Medical Reserve Corp (MRC)	Jim Mickey	740-342-5179		
Law Enforcement	Doug Gill, Chief Deputy	740-808-5140		
Fire/Rescue	Jeff Wilson, FF	740-683-6628		
Search & Recovery Teams				
Coroners/Medical Examiner	Dr. Bradley Wilson	740-342-3540		
Funeral Home Director	Chad Winegardner	740-342-1951		
Morgues				
Embalmers				
Crematories				
ARC Chapter	Tim Callahan	614-869-7120		
Faith Based Organizations				
Non-Governmental Organizations				
Other:				

PIKE COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Mike Adkins (PA)	740.464.0982		
Air Medical Resource	Cody Caron (Medcare)	614.464.7012		
Hospitals / ED	Jennifer Abner	740.779.8166		
Health Department	Ginny Dickerson	740.947.7721		
Medical Reserve Corp (MRC)	Ginny Dickerson	740.947.7721		
Law Enforcement	Tracy Evans	740.947.2111		
Fire/Rescue	Jeff Minshaw	740.947.2826		
Search & Recovery Teams	Jeff Minshaw	740.947.2826		
Coroners/Medical Examiner	Dr. Kessler	740.947.7591		
Funeral Home Director	N/A			
Morgues	N/A			
Embalmers	N/A			
Crematories	N/A			
ARC Chapter	Roy Grimmer	304.544.9027		
Faith Based Organizations	Tracy Evans			
Non-Governmental Organizations	N/A			
Other:				

ROSS COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers				
Air Medical Resource	MedFlight	877-633-3598		
Hospitals / ED	Adens Regional Medical Center	740-779-8206		
Health Department	Ross County Health District	740-779-9652		
Medical Reserve Corp (MRC)	Ross County Health District	740-779-9652		
Law Enforcement	Ross County Sheriffs Office	740-773-1185		
Fire/Rescue	Chillicothe FD and EMS	740-773-2212		
Search & Recovery Teams	Ross County SAR	740-656-6726		
Coroners/Medical Examiner	Ben Trotter	740-775-7464		
Funeral Home Director	Mike Haller	740-702-2149		
Morgues	Adena Regional Medical Center	740-779-7500	Veterans Admin Hospital	740-773-1141
Embalmers	Mike Haller	740-702-2149		
Crematories	Haller Funeral Home	740-702-2149		
ARC Chapter	Mary McCord	740-466-7557		
Faith Based Organizations	Pastor John Evans	740-701-6356		
Non-Governmental Organizations				
Other:				

SCIOTO COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Dr. Brian Barhorst	740-356-8165	Kera Horsley	740-352-5353
Air Medical Resource	Stuart Baldwin	740-876-8502		
Hospitals / ED	Zack Germann	1-606-541-6618	Dr. Jason Cheatham	740-356-8165
Health Department	Chris Smith	740-353-5153	Mellisa Spears	740-355-8358
Medical Reserve Corp (MRC)	Chris Smith	740-353-5153		
Law Enforcement	David Thoroughman	740-355-8261	Debby Brewer	740-353-4101
Fire/Rescue	George Moore	740-354-9641	Joe Rawlins	740-820-9268
Search & Recovery Teams	Bob Long	740-354-1200		
Coroners/Medical Examiner	Dr. Aaron Adams	740-529-1095	Amy Cox	740-529-1095
Funeral Home Director	Scott Davis	740-858-4100		
Morgues				
Embalmers	Scott Davis	740-858-4100		
Crematories	Scott Davis	740-858-4100		
ARC Chapter	Roy Grimmett	1-304-544-9207	Amber Dean	1-304-400-5207
Faith Based Organizations	Pete Shaffer	740-370-5490	John Gowdy	740-250-4062
Non-Governmental Organizations	Dan Simco (Salvation Army)	740-353-2400	Jane Geraldts (Salvation Army)	740-353-2400
Other:	Shanna Shank	740-354-7702	Jake Schultd (OSP Post 73)	740-354-2888
Other:	Sandy Mers (South Central ESC)	740-354-7761	Doug Buckle (911 Coordinator)	740-355-8261
Other:	Paul "AJ" Foit (SSU)	740-351-3238	Paul Conley (OVFA)	740-456-7254
Other:	Jon Peters (SSU Public Safety)	740-351-3243	Justin Clark (SOMC)	740-352-3400
Other:	James Neal (KDMC Ohio)	740-727-5166		

VINTON COUNTY PLANNING SUBCOMMITTEE				
Organization	Representative 1		Representative 2	
	Name	Phone #	Name	Phone #
EMS Providers	Vinton County EMS-V.McQuirt	740-596-4122		
Air Medical Resource	Med Flight-Brandon Carter	740-856-8428		
Hospitals / ED	Adena Regional Hospital	740-779-7500	Holzer Hospital-Jackson/Gallia	740-446-5000
Hospitals / ED	Hocking Valley Comm. Hospital	740-380-8000	O'Bleness Hospital	740-593-5551
Health Department	VCHD - Janelle McManis	740-596-5233		
Medical Reserve Corp (MRC)	VCHD - MacKenzie Newlun	740-596-5233		
Law Enforcement	VCSO - Sheriff Cain	740-596-5242	McArthur PD - Chief M.Kight	740-596-2980
Fire/Rescue	McArthur FD - Chief Curt Russ	740-596-2346	Hamden FD - Chief J.Potts	740-384-2651
Fire/Rescue	Wilkesville FD - Chief J.Wood	740-517-1019	Zaleski FD - Chief M.Peters	740-596-5300
Fire/Rescue	Harrison Twp FD - Chief D.Cartee	740-887-5961		
Search & Recovery Teams	OHIO TEAM 4	855-711-8885	Southern Ohio Canine SAR	740-649-8098
Coroners/Medical Examiner	Cristina Kremer-Goodson	740-352-5111		
Funeral Home Director	Garrett-Cardaras Funeral Home	740-596-5222		
Morgues				
Embalmers				
Crematories				
ARC Chapter	Athens Office	740-593-5273		
Faith Based Organizations				
Non-Governmental Organizations	United Way Vinton - M.Hammond	740-804-0110		
Other:				

APPENDIX 3

JOB ACTION GUIDES

The following Job Action Guides have been developed to serve as responsibility checklists for different position titles that could be activated during a Mass Fatality Incident (MFI). The Job Action Guides can be removed from the plan, and kept with, and utilized by the person(s) filling the position titles. Briefings and reporting requirements are not included.

- Scene Evaluation Team – Job Action Guide
- Scene Investigation/Human Remains Recovery Officer in Charge – Job Action Guide
- Human Remains Recovery Logistics Officer – Job Action Guide
- Morgue Services Officer in Charge – Job Action Guide
- Morgue Logistics Officer – Job Action Guide
- Family Assistance Branch ME/C Officer in Charge – Job Action Guide
- Family Assistance Center Officer in Charge – Job Action Guide
- FAC Team Leaders-Common Responsibilities – Job Action Guide
- FAC Logistics Officer

SCENE EVALUATION TEAM – JOB ACTION GUIDE

Description of Position

The Scene Evaluation Team reports to the Coroner's Services Branch Director and is responsible for evaluating and investigating the scene, developing a field action plan for ME/C operations, and determining incident objectives and strategy in coordination with unified command.

Duties

- _____ Assess the situation.
- _____ Expand the scene evaluation team as needed to include law enforcement, Hazmat, the FBI, Public Health, Environmental Health, and other agencies based on the nature of the mass fatality incident.
- _____ Evaluate the scene:
 - Potential or real number and location of remains.
 - Condition of the bodies.
 - Locations of atypical cases.
 - Potential number of remains for autopsy.
 - Complicating factors or level of difficulty in recovery—types and numbers of personnel and equipment needed.
 - Accessibility of the incident site.
 - Possible biological, chemical, physical or radiological hazards.
 - Level of Personal Protective Equipment (PPE) required.
 - Ensure that initial pictures of the site are taken.
- _____ Establish tactical and support resource needs for ME/C operations.
- _____ Establish immediate priorities and assign on-scene resources.
- _____ Establish a Coroner Incident Command Post (ICP) or co-locate in Unified Command.
- _____ Ensure that adequate safety measures are in place.

SCENE INVESTIGATION/HUMAN REMAINS RECOVERY OFFICER IN CHARGE – JOB ACTION GUIDES

Description of Position

The Scene Investigation Branch Officer in Charge (OIC) reports to the Coroner's Services Branch Deputy Director and oversees the collection and documentation of postmortem remains, property and evidence at the incident scene. He/she supervises the Search and Recovery Team Leaders.

Duties

Obtain briefing from the Coroner's Services Branch Deputy Director.

- _____ Request and receive briefings from the Coroner's Services Branch Deputy Director.
- _____ Obtain the Incident Action Plan (IAP).

Identify resources assigned to the Division.

- _____ Review Division assignment to identify resources specifically assigned to the Division.
- _____ Request clarifying information or resolution as needed from Coroner's Services Branch Deputy Director.

Review Division assignments.

- _____ Review general incident activities with subordinates to determine specific tasks or resources.
- _____ Assign Search and Recovery Teams.
- _____ Implement Incident Action Plan (IAP) for Division.

Supervise Division operations.

- _____ Maintain close communication with Unified Command at the incident site and with the Coroner's Services Branch Director and Deputy Director.
- _____ Assist teams in establishing grid or search patterns as required.
- _____ Ensure all teams are operating in accordance with the Incident Safety Plan.

SCENE INVESTIGATION/HUMAN REMAINS RECOVERY OFFICER IN CHARGE – JOB ACTION GUIDES

- _____ Ensure that assigned personnel and equipment get to and from assignments in a timely and orderly manner.
- _____ Monitor Search and Recovery Teams.
 - Obtain information concerning progress on assigned tasks from subordinates by:
 - Special request.
 - Periodic/routine reports.
 - Personal observation.
 - Take corrective actions as appropriate.
 - Ensure the general safety and welfare of Division personnel.
 - Maintain communications with subordinates.
- _____ Request additional resources as needed to support assigned teams.
- _____ Resolve logistics problems within the Division.
- _____ Advise of any surplus of resources.
- _____ Coordinate activities with other Divisions/Groups.
- _____ Respond to information requests from other team elements.

Report to Coroner's Services Branch Deputy Director on human remains recovery activities.

- _____ Provide periodic updates to the Coroner's Services Branch Deputy Director.
 - Situation and resource status information.
- _____ Recommend expedient changes to the Incident Action Plan (IAP) during the operational period as necessary.
- _____ Inform Deputy Director of:
 - Conditions affecting Division operations.
 - Hazardous conditions.
 - Significant events (e.g., injuries).
 - Problems with Logistics.
 - Unresolved conflicts with other Divisions/Groups.
- _____ Assist in the development of the IAP for the next operational period.

HUMAN REMAINS RECOVERY LOGISTICS OFFICER

JOB ACTION GUIDE

Description of Position

The Human Remains Recovery Logistics Officer reports to the Scene Investigation Officer in Charge (OIC) and is responsible for the acquisition, storage, issue, and accountability of all supplies, equipment, facilities, personnel and services necessary to support Human Remains Recovery. He/she will monitor the status of all procurement actions and staffing requirements and interface with Emergency Operations Center (EOC) Logistics to ensure that Human Remains Recovery service and support needs are met.

Human Remains Recovery Logistics operations will be dependent on determination of who approves supply/personnel requests and establishment of spending thresholds, e.g., the level of spending authority for the site versus requirement of EOC Logistics approval.

Duties

- _____ Identify and track all necessary communication supplies and equipment to support Human Remains Recovery and consult with EOC Logistics to locate, allocate, and procure communication supplies and equipment needed for Human Remains Recovery.
- _____ Identify and track all necessary health and medical services, supplies and equipment to support Human Remains Recovery and consult with EOC Logistics to locate, allocate, and procure health and medical services, supplies and equipment needed for Human Remains Recovery.
- _____ Identify all necessary food services, supplies, and equipment needed to support Human Remains Recovery and consult with EOC Logistics to locate, allocate, and procure food services, supplies, and equipment needed for Human Remains Recovery staff through the Respite Center.
- _____ Identify and track all necessary supplies and equipment to support Human Remains Recovery and consult with EOC Logistics to locate, allocate, and procure supplies and equipment needed for Human Remains Recovery.

HUMAN REMAINS RECOVERY LOGISTICS OFFICER JOB ACTION GUIDE

- _____ Identify and track facility needs and consult with EOC Logistics on locating and procuring Human Remains Recovery temporary morgue space and/or refrigerated vehicles to transport human remains.
- _____ Identify and track transportation needs and consult with EOC Logistics to locate and procure transportation needed for Human Remains Recovery personnel and for transport of human remains.
- _____ Identify and track staff/volunteer needs and consult with EOC Logistics to locate and procure staff and volunteers needed for Human Remains Recovery.
- _____ Identify and track information systems needs and consult with EOC Logistics to locate and procure information systems equipment, software, networks, and technical support needed for Human Remains Recovery.
- _____ Make requests using EOC logistics request forms.
- _____ Hand-carry, as necessary, logistics request forms for all high-priority supply actions to Scene Investigation Branch OIC and/or fax/email to EOC Logistics.
- _____ Maintain expense data, accountability documents, procurement documents, and other information pertaining to the Human Remains Recovery Logistics operation as directed by EOC Logistics.
- _____ Ensure that the Human Remains Recovery Logistics is staffed at all times during operating hours.
- _____ Ensure that personnel logs include the name, agency, driver's license number and in/out times are maintained.
- _____ Ensure that facilities, transportation, and communications plans are implemented.

MORGUE SERVICES OFFICER IN CHARGE

JOB ACTION GUIDE

Description of Position

The Morgue Services Officer in Charge reports to the Coroner's Services Branch Deputy Director and is responsible for all morgue operations including body processing, examination, positive identification, receiving, and release. He/she supervises the Morgue Operations Group Officer in Charge (OIC) and the Examination Group OIC.

Duties

Obtain briefing from the Coroner's Services Branch Deputy Director.

- _____ Request and receive briefings from the Coroner's Services Branch Deputy Director.
- _____ Obtain the Incident Action Plan (IAP).

Identify resources assigned to the Division.

- _____ Review Division assignment to identify resources specifically assigned to the Division.
- _____ Request clarifying information or resolution as needed from Coroner's Services Branch Deputy Director.

Review Division assignments.

- _____ Review general incident activities with subordinates to determine specific tasks or resources.
- _____ Assign Morgue Operations Group OIC, Examination Group OIC, Station Team Leaders, and Supervisors.
- _____ Implement IAP for Division.

Supervise Division operations.

- _____ Maintain close communication with Unified Command at the incident site and with the Coroner's Services Branch Director and Deputy Director.
- _____ Ensure that morgue operations function in accordance with the Safety Plan.

MORGUE SERVICES OFFICER IN CHARGE

JOB ACTION GUIDE

- _____ Ensure that assigned personnel and equipment get to and from assignments in a timely and orderly manner.
- _____ Supervise morgue services:
 - Assign specific work tasks to Group Supervisors.
 - Obtain information concerning progress on assigned tasks from subordinates by:
 - Special request.
 - Periodic/routine reports.
 - Personal observation.
 - Ensure the general safety and welfare of Division personnel.
 - Maintain communications with subordinates.
- _____ Develop alternatives for morgue operations as required.
- _____ Request additional resources as needed to support assigned teams.
- _____ Resolve logistics problems within the Division.
- _____ Advise of any surplus of resources.
- _____ Coordinate activities with other Divisions/Groups.
- _____ Respond to information requests from other team elements.

Report to Coroner's Services Branch Deputy Director on morgue activities.

- _____ Provide periodic updates to the Coroner's Services Branch Deputy Director.
 - Situation and resource status information.
- _____ Recommend expedient changes to the IAP during the operational period as necessary.
- _____ Inform Deputy Director of:
 - Conditions affecting Division operations.
 - Hazardous conditions.
 - Significant events (e.g., injuries).
 - Problems with Logistics.
 - Unresolved conflicts with other Divisions/Groups.

MORGUE LOGISTICS OFFICER – JOB ACTION GUIDE

Description of Position

The Morgue Logistics Officer reports to the Morgue Services Officer in Charge (OIC) and is responsible for the acquisition, storage, issue, and accountability of all supplies, equipment, facilities, personnel and services necessary to support the morgue. He/she will monitor the status of all procurement actions and staffing requirements and interface with Emergency Operations Center (EOC) Logistics to ensure that morgue service and support needs are met.

Morgue Logistics operations will be dependent on determination of who approves supply/personnel requests and establishment of spending thresholds, e.g., the level of spending authority for the site versus requirement of EOC Logistics approval.

Duties

- _____ Identify and track all necessary communication supplies and equipment to support morgue services and consult with EOC Logistics to locate, allocate, and procure communication supplies and equipment needed for the morgue.
- _____ Identify and track all necessary health and medical services, supplies and equipment to support the morgue and consult with EOC Logistics to locate, allocate, and procure health and medical services, supplies and equipment needed for morgue services.
- _____ Identify all necessary food services, supplies, and equipment needed to support the morgue and consult with EOC Logistics to locate, allocate, and procure food services, supplies, and equipment needed for morgue staff.
- _____ Identify and track all necessary supplies and equipment to support the morgue and consult with EOC Logistics to locate, allocate, and procure supplies and equipment needed for morgue services.
- _____ Identify and track facility needs and consult with EOC Logistics on locating and procuring a temporary incident morgue and/or refrigerated vehicles to store/transport human remains.
- _____ Identify and track transportation needs and consult with EOC Logistics to locate and procure transportation needed for morgue personnel and for transport of human remains.

MORGUE LOGISTICS OFFICER – JOB ACTION GUIDE

- _____ Identify and track staff/volunteer needs and consult with EOC Logistics to locate and procure staff and volunteers needed for morgue services.
- _____ Identify and track information systems needs and consult with EOC Logistics to locate and procure information systems equipment, software, networks, and technical support needed for morgue services.
- _____ Make requests using EOC logistics request forms.
- _____ Hand-carry, as necessary, logistics request forms for all high-priority supply actions to Morgue Services OIC and/or fax to EOC Logistics.
- _____ Maintain expense data, accountability documents, procurement documents, and other information pertaining to the Morgue Logistics operation as directed by EOC Logistics.
- _____ Ensure that Morgue Logistics is staffed at all times during operating hours.
- _____ Ensure that personnel logs include the name, agency, driver's license number, and in/out times are maintained.
- _____ Ensure that facilities, transportation, and communications plans are implemented.

FAMILY ASSISTANCE BRANCH ME/C OFFICER IN CHARGE

JOB ACTION GUIDE

Description of Position

The Family Assistance Branch ME/C Officer in Charge (OIC) works closely with the JFAC Officer in Charge, conducts family briefings, and oversees ME/C responsibilities at the Family Assistance Center (FAC)—family briefings, antemortem data collection, and death notifications.

Duties

- _____ Select ME/C Representatives (e.g., experienced death investigators and funeral directors familiar with Medical Examiner/Coroner's Administration operations as members of the death notification team and DMORT, law enforcement agents, social workers, and funeral personnel as coroner investigators for antemortem data collection, etc.) and assign ME/C responsibilities at the FAC.
- _____ Assist the agency to which the ME/C Office has delegated JFAC management in coordinating services to meet family needs at the FAC.
- _____ Establish and supervise family briefing procedures.
- _____ Conduct 1 – 2 daily family briefings providing accurate and timely information to families prior to media briefings.
- _____ Coordinate release of information to the media/consult with the Joint Information Center/Public Information Officer regarding daily briefings with media that will be conducted in a secure area away from the FAC, families and friends.
- _____ Serve as Liaison between the ME/C Office and families.
- _____ Establish and supervise death notification procedures with members of the death notification teams.
- _____ Ensure collection of antemortem data and efficient transfer to the Morgue Information Resource Center.
- _____ Ensure collection of DNA as directed by the ME/C office and its transfer to the selected DNA lab.
- _____ Serve as liaison with outside agencies at the FAC.

FAMILY ASSISTANCE CENTER OFFICE IN CHARGE

JOB ACTION GUIDE

Description of Position

The Joint Family Assistance Center Officer in Charge (OIC) oversees and operates the Family Assistance Center (FAC) for the local ME/C Office and ensures that needed services are provided and available resources are maximized.

Duties

- _____ With the FAC Logistics Officer and EOC Logistics, identify the FAC site and coordinate its setup with the FAC Logistics Officer.
- _____ Establish the physical operation of the FAC.
- _____ Ensure security and privacy of families at the FAC.
- _____ Establish a JFAC Management Team and convene daily JFAC Management Team Meetings.
- _____ Develop FAC mission and objectives.
- _____ Establish consistent policies and procedures on FAC staff and volunteer roles, responsibilities and requirements and communicate to all staff and volunteers early in the process.
- _____ Manage day to day family assistance activities.
- _____ Maintain and update daily FAC plan and plan for future operations.
- _____ Assign responsibilities and tasks to the management team and team leaders.
- _____ Facilitate the exchange of information among team leaders at daily briefings. Team leaders will facilitate information exchange among team members at the team's daily briefings.
- _____ Monitor incident site, morgue operations and the media. Ensure critical information is kept current.
- _____ Inform management team and team leaders of significant developments.
- _____ Ensure individual logs are kept current.
- _____ Ensure services to meet family needs by monitoring ongoing FAC activities (including daily status reports) and tracking mission activities of each organization.
- _____ Participate in daily family briefings, providing input as requested.

FAMILY ASSISTANCE CENTER OFFICE IN CHARGE

JOB ACTION GUIDE

- _____ Ensure assignment of duties for FAC services' staff and volunteers to meet families' physical, behavioral health, psychosocial, and spiritual needs.
- _____ Coordinate with FAC Logistics and the Staff Processing Center to ensure staffing of key functional areas and to ensure all FAC services' staff and volunteers have appropriate credentials (licensure/certification/approval) to provide services to families.
- _____ Ensure maintenance of strict confidentiality standards by all FAC staff and volunteers.
- _____ Ensure provision of on-site childcare by approved providers.
- _____ Assess needs of families and coordinate access to additional services as needed.
- _____ Assess needs of FAC staff and volunteers and coordinate access to mental health services/spiritual care services and additional services as needed.
- _____ Coordinate release of information to the media with the Family Assistance Branch ME/C Officer in Charge and with the Joint Information Center (JIC) regarding daily briefings with media that will be conducted in a secure outside of/area away from the FAC, families and friends.
- _____ Collect information that may be used for family briefings.
- _____ Coordinate with JIC on information to be placed on Web site(s).
- _____ Ensure implementation of FAC safety, transportation and security plans.
- _____ Serve as liaison between FAC and outside human services agencies.
- _____ Maintain daily journal of organizational activities and responses.
- _____ Develop a transition plan for when the FAC closes to provide longer-term support to families.
- _____ Oversee deactivation of the FAC.
- _____ Complete JFAC After Action Report (AAR).

FAC TEAM LEADERS COMMON RESPONSIBILITIES

JOB ACTION GUIDE

Description of Position

The FAC Team Leaders oversee the team activities within the Family Assistance Center (FAC) in order to meet families' needs in the specific service area. The FAC Team Leaders report directly to the JFAC Officer in Charge (OIC) or, for ME/C FAC teams, to the Family Assistance ME/C Officer in Charge (OIC).

Duties

- _____ Establish team procedures.
- _____ Supervise subordinates.
- _____ Participate in JFAC Management Team Meetings as requested.
- _____ Convene team meetings at the beginning and end of shifts.
- _____ Monitor how staff and volunteers are holding up over time. Ensure that mental health and spiritual care services are available for team members and encourage their participation.
- _____ Maintain daily log and collects data on services from each team member.
- _____ Provide JFAC Officer in Charge with requested team performance statistics daily.
- _____ Consult with FAC Logistics Officer regarding team staffing, equipment and supply needs.
- _____ Prepare performance evaluations for assigned staff and volunteers as requested.

FAC TEAM LEADERS COMMON RESPONSIBILITIES

JOB ACTION GUIDE

On-site Operations

- _____ Receive FAC assignment from JFAC Officer in Charge and/or the Family Assistance ME/C Officer in Charge.
- _____ Assist in the setup of team service area.
- _____ Ensure accountability and confidentiality of family and victim information and records.
- _____ Provide direction to team members as needed.

Deactivation

- _____ Ensure all records and documentation are completed and submitted to the JFAC Officer in Charge and/or the Family Assistance ME/C Officer in Charge.
- _____ Assist in the critique of the FAC performance for the After Action Report (AAR).

FAC LOGISTICS OFFICER – JOB ACTION GUIDE

Description of Position

The FAC Logistics Officer reports to the Joint Family Assistance Center Officer in Charge (JFAC OIC) and is responsible for the acquisition, storage, issue, and accountability of all supplies, equipment, facilities, personnel and services necessary to support the Family Assistance Center (FAC). He/she will monitor the status of all procurement actions and staffing requirements and interface with Emergency Operations Center (EOC) Logistics to ensure that FAC service and support needs are met. FAC Logistics operations will be dependent on determination of who approves supply/personnel requests and establishment of spending thresholds, e.g., the level of spending authority for the site versus requirement of EOC Logistics approval.

Duties

- _____ Identify and track all necessary communication supplies and equipment to support the FAC and consult with EOC Logistics to locate, allocate, and procure communication supplies and equipment needed for the FAC.
- _____ Identify and track all necessary health and medical services, supplies and equipment to support the FAC and consult with EOC Logistics to locate, allocate, and procure health and medical services, supplies and equipment needed for the FAC.
- _____ Identify all necessary food services, supplies, and equipment needed to support the FAC—staff and families—and consult with EOC Logistics to locate, allocate, and procure food services, supplies, and equipment needed for the FAC.
- _____ Identify and track all necessary supplies and equipment to support the FAC and consult with EOC Logistics to locate, allocate, and procure supplies and equipment needed for the FAC.
- _____ Identify and track facility needs and consult with EOC Logistics on locating and procuring FAC facility(s).
- _____ Identify and track transportation needs and consult with EOC Logistics to locate and procure transportation needed for the FAC—for staff and for families.

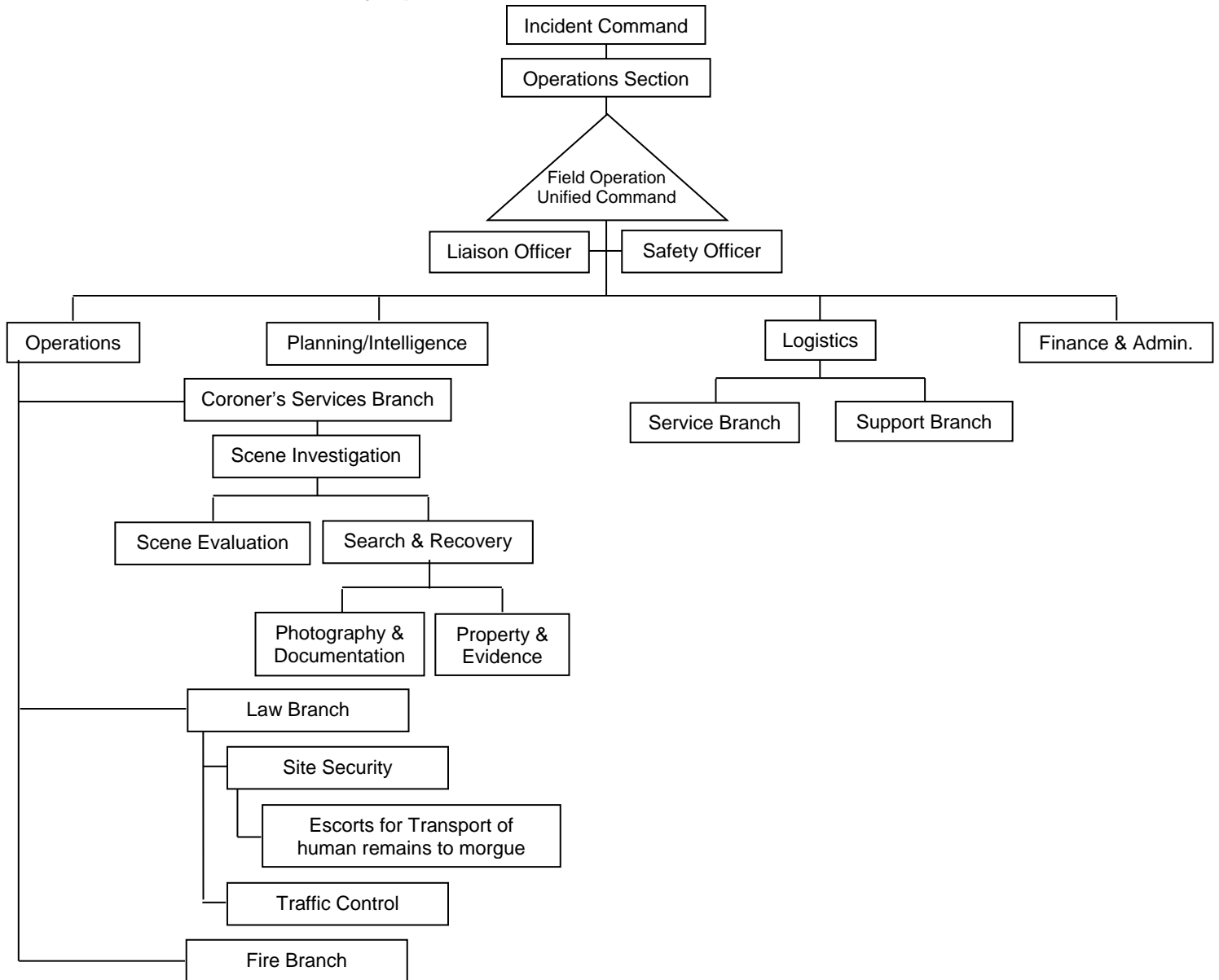
FAC LOGISTICS OFFICER – JOB ACTION GUIDE

- _____ Identify and track staff/volunteer needs and consult with EOC Logistics and the Staff/Volunteer Processing Center to locate and procure staff and volunteers needed for the FAC.
- _____ Identify and track information systems needs and consult with EOC Logistics to locate and procure information systems equipment, software, networks, and technical support needed for the FAC—for staff and for families.
- _____ Make requests using EOC logistics request forms.
- _____ Hand-carry, as necessary, logistics request forms for all high-priority supply actions to FAC OIC and/or fax to EOC Logistics.
- _____ Maintain expense data, accountability documents, procurement documents, and other information pertaining to the FAC logistics operation as directed by EOC Logistics.
- _____ Ensure that the FAC Logistics is staffed at all times during operating hours.
- _____ Ensure that personnel logs include the name, agency, driver's license number and in/out times are maintained.
- _____ Ensure that facilities, transportation, medical, and communications plans are implemented.
- _____ Coordinate appropriate memorial site visits and services.

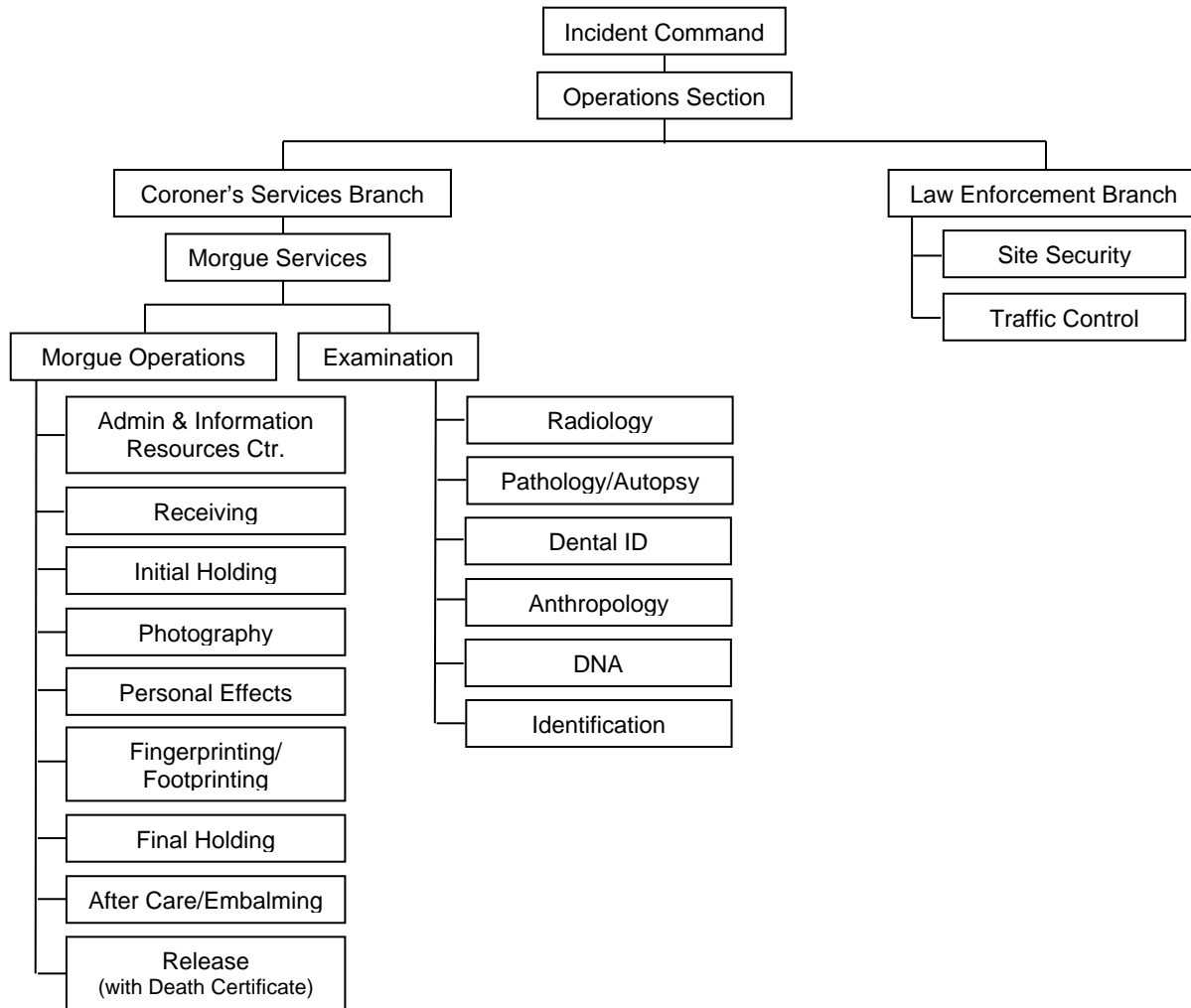
APPENDIX 4

NIMS ORGANIZATIONAL CHARTS

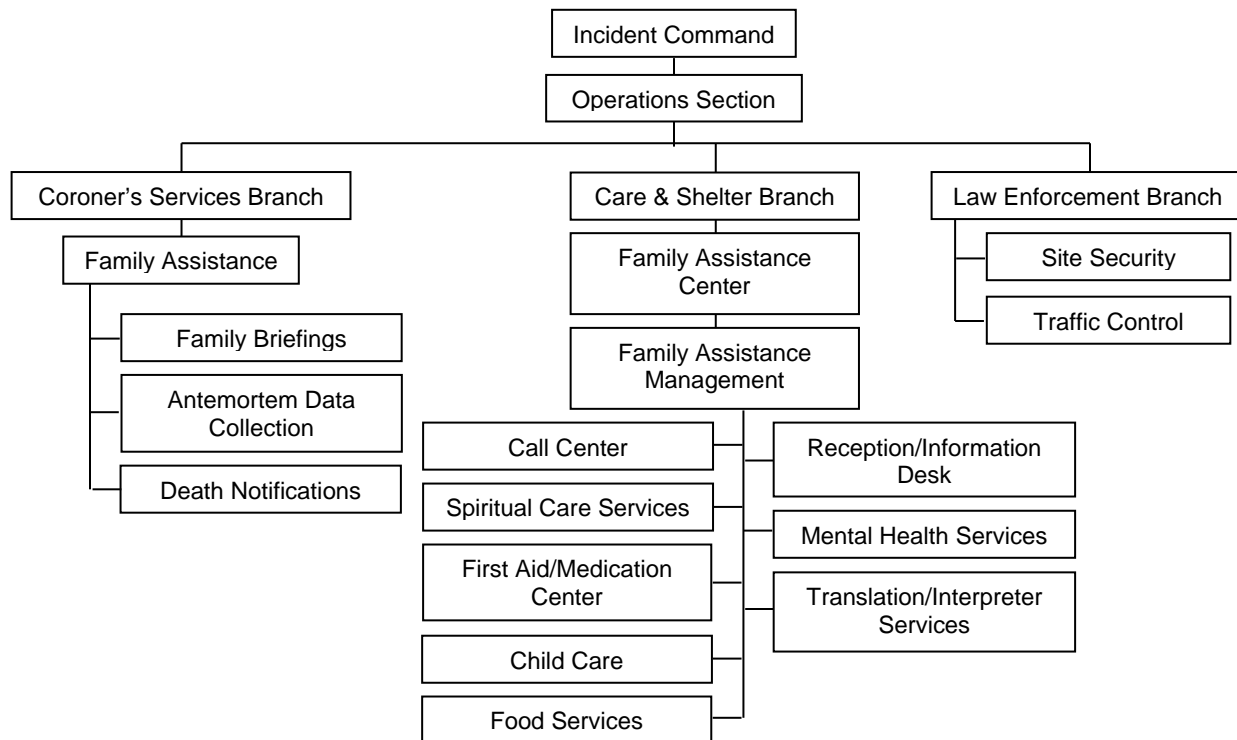
Human Remains Recovery Operations



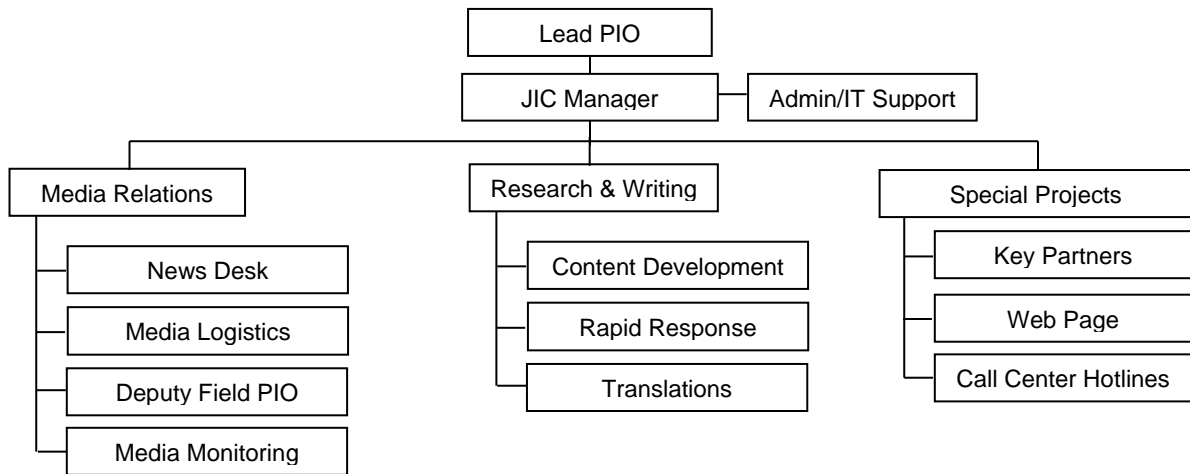
Field Organization for Mass Fatality Morgue Services



Field Organization for Mass Fatality Family Assistance Center (FAC)



Joint Information Center Organization



APPENDIX 5

MASS FATALITY INCIDENT FORMS

This appendix contains blank copies of several different forms that can, and should be utilized to assist in the management of the different aspects of a Mass Fatality Incident (MFI). This appendix contains the following forms.

- Chain of Custody
- Release of Human Remains
- Disaster Scene Death Investigation Record
- VIP/DMORT Incident Site Recovery Record
- Morgue Tracking Form
- Remains Release Authorization Form
- FAC Daily Sign-in Log
- FAC Staff Daily Registration
- FAC Daily Status Update Form

CHAIN OF CUSTODY

MRN: _____

Item Description: _____

Transfer 1	Received From:	Section #:	
I, _____ hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.			
Signed:		Date:	Time:
Transfer 2	Received From:	Section #:	
I, _____ hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.			
Signed:		Date:	Time:
Transfer 3	Received From:	Section #:	
I, _____ hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.			
Signed:		Date:	Time:
Transfer 4	Received From:	Section #:	
I, _____ hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.			
Signed:		Date:	Time:
Transfer 5	Received From:	Section #:	
I, _____ hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.			
Signed:		Date:	Time:

RELEASE OF HUMAN REMAINS

MRN: _____

Name of Deceased: _____

Date of Release: _____

Released To: _____
(Name of Person or Establishment)

Address: _____

Phone: _____

I/We certify that I/We represent all of the next of kin of the above, and do hereby accept custody of said Human Remains.

Signed: _____ Date: _____ Time: _____

(Print Name)

Signed: _____ Date: _____ Time: _____

(Print Name)

Witness: _____

(Print Name)

Released by: _____ Date: _____ Time: _____

(Print Name)

DISASTER SCENE DEATH INVESTIGATION RECORD

Date/Time: _____ Body Number: _____

Possible Name of Deceased: _____

Race: _____ Sex: _____ Approximate Age: _____ Photos Taken: Yes No

Physical Investigation

Clothing/Personal Effects: _____

Position and Location of Body: (Grid location, GPS, etc./Note type of surface the body is on, covering, etc.)

Rigor Mortis:	Liver:	Body Temperature:
Observations/Trauma: (NOTE MISSING PARTS)	Decomposition and Artifacts:	
	Identifying Marks: (i.e. scars, tattoo, etc)	

Comments/Summary: _____

Team Leader: _____

Recovery Team: _____

VIP/DMORT Program

Incident Site Recovery Record

Incident: _____
PM Case #

To be used in the field to document original findings. Please insert into the appropriate Victim Disaster Packet

Please document all information. A proper positive identification begins NOW with YOU. NOT all fields will be appropriate for all situations. Please complete all that are appropriate AND PUT A LINE OR N/A in the ones that you have no information for.

Date of Recovery: _____ Time / 24hr: _____
MM/DD/YYYY

Body Bag #: _____ GPS Location PM Place Body Found

Found In (Grid Number) _____

Condition of Remains: ☐ No Major Outward Damage ☐ Burning/Charring Present
☐ Water/Environmental Decay ☐ Obvious trauma ☐ Incomplete Remains

Position Found In: _____

Associated With Material: ☐ Vehicle Parts ☐ Personal Effects ☐ Unknown Material

Field Comments:

Do we have a presumptive identification? If so, who do you think this may be?

Please note in the field comments area

WHY you believe this is a presumptive ID.

_____ Last

_____ First

_____ (MM/DD/YYYY)

Number of Photo's taken in the Field:

Recovery Team Leader and Members: (please list everyone on the team)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Transported to Morgue By: _____

Time Received at Morgue: _____

Location of Remains at Morgue: _____

MORGUE TRACKING FORM

Morgue Case Number: _____ Scene Number: _____

Admitting Clerks Name: _____

Name of Tracker Assigned: _____

Station	Examination Indicated	Examiner's Signature	Date & Time of Examination
Photography	<input type="radio"/> Yes <input type="radio"/> No		
Radiology	<input type="radio"/> Yes <input type="radio"/> No		
Pathology & Personal Effects	<input type="radio"/> Yes <input type="radio"/> No		
Anthropology	<input type="radio"/> Yes <input type="radio"/> No		
Odontology	<input type="radio"/> Yes <input type="radio"/> No		
Fingerprint	<input type="radio"/> Yes <input type="radio"/> No		
DNA	<input type="radio"/> Yes <input type="radio"/> No		
Embalming	<input type="radio"/> Yes <input type="radio"/> No		

Comments: _____

In the event of co-mingling discovered within the morgue, detail which new case numbers were produced: _____

Name and Signature of Individual Describing Co-mingling:

Print Name

Signature

REMAINS RELEASE AUTHORIZATION FORM

Name of Deceased: _____

Please be advised that identified human tissue will be buried in an appropriate manner.

In the event in the additional tissues are recovered in the future and are identified as belonging to the above named deceased, I/We request the following (please check one of the boxes below):

☐ I/We do not wish to be notified. I/We are authorizing the Medical Examiner to dispose of said tissues by methods deemed appropriate by the Medical Examiner.

☐ I/We wish to be notified and will make a decision regarding disposition at that time.

_____	_____	_____
Name	Address	Telephone Number of Funeral Home

I/We certify that I/we have read and understand this release authorization. I/We further state I/we are all of the next of kin or represent all of the next of kin and am/are legally authorized and or charged with the responsibility of burial and or final disposition of above said deceased.

Signed: _____

Relationship to Deceased: _____

Print Name: _____

Date Signed: _____

Time: _____

Complete Address: _____

Telephone Number: _____

Victim Name

MI:

[illegible]

FAC STAFF DAILY REGISTRATION

Name:		Function:	
Address:			
City:		State:	Zip:
Phone #s:	()	()	
ID Badge #:			

[illegible]

FAC DAILY STATUS UPDATE FORM

FAC Daily Status Update		Date:	
Information	Information Source	Number in Last 24 Hrs	Number to Date
Number of families at FAC?	Reception/ Info Desk		
Number of calls to the call center/ number of calls answered/ number of calls not answered?	Call Center		
Types of calls?	Call Center		
Length of time of calls?	Call Center		
Number of families that have requested FAC assistance within the last 24 hours via the phone?	Call Center		
Number of family briefings?	ME/C		
Number of families at FAC that have requested support services for each service area?	Team Leaders		
Number of families at home that have been contacted by FAC representative within the last 24 hours for each service area?	Team Leaders		
Number of mass fatality response personnel that have received FAC assistance/Psychological First Aid in last 24 hours?	Team Leaders		
Faith communities represented by FAC families?	Faith Community		
Number of translation requests received and number of translation/interpreter services provided?	Translation/ Interpreter Team		
Number of antemortem data collection interviews?	ME/C		
Number of dental records, medical records and x-rays that have been requested/received?	ME/C		
Number of positive identifications?	ME/C		
Number of families notified of positive identification/ Number of disposition or remains request forms completed?	ME/C		
Number of families to which remains have been released?	ME/C		
Number of families using child care?	Child Care Center		
Number and ages of children receiving child care?	Child Care Center		
Number of people eating meals at the FAC?	Food Services Team		

APPENDIX 6

GUIDELINES FOR SELECTING A TEMPORARY MORGUE SITE

A temporary morgue site should be selected, organized, and put into operation if the number of dead exceeds the resources of the Coroner's office.

- ☐ Select a site that is as near as possible to the areas with the heavy (or heaviest) death toll.
- ☐ Temporary morgue site requirements:
 - Showers,
 - Hot and cold water,
 - Heat,
 - Electricity,
 - Drainage,
 - Ventilation,
 - Restrooms,
 - Parking areas,
 - Communications capabilities,
 - Rest areas,
 - Security (i.e., fencing and locking capabilities),
 - Operations can be removed from public view (to the extent possible), and
 - Sufficient space for separation of functions (i.e., handling remains, x-ray, autopsy, records maintenance, etc.).
- ☐ Attempt to identify all human remains.
- ☐ Record all helpful information in the Victim Identification Program (VIP).
- ☐ Receive, photograph, record, and secure personal effects.
- ☐ Determine if embalming is necessary.
- ☐ Request the assistance of the state Mortuary Response Team Liaison to coordinate temporary morgue site operations, if necessary.

APPENDIX 7

PERSONAL EFFECTS AND PROPERTY DISPOSITION

- ☐ Recover personal effects and property *concurrently* with recovery of remains.
- ☐ Plot the location of where personal effects and property were collected. Consider the following:
 - Property found on remains (e.g., wallets, jewelry, etc.) should stay with the recovered remains,
 - Property found close to remains should be tagged to identify its location in relationship to the remains, and
 - Photographs of personal effects should be taken prior to removal from the site.
- ☐ Place items in clear plastic bags for easier identification. Assign an identification (recovery) number for each bag; place the number on the bag and items.
- ☐ Place wet items in paper bags. Assign an identification (recovery) number for each bag; place the number on the bag and items.
- ☐ Designate a special, secure area for processing unidentified (as to ownership) personal effects.
- ☐ Use basic descriptions when recording items. For example, a ring should be described as “yellow in color with a clear stone”, not “gold band with diamond”.
- ☐ Release all identified personal effects to the next of kin or their representative.
- ☐ Generate and produce a receipt listing all items released to the next of kin. Ensure that the next of kin or representative signs a copy of the receipt.
- ☐ Maintain all unidentified personal effects under the control of the Coroner.
- ☐ Consult local legal counsel or the state attorney general on issues relating to the disposition of personal effects and property, if necessary.

APPENDIX 8

GLOSSARY OF TERMS & ACRONYMS

This appendix contains definitions of terms and acronyms used throughout the plan. Some of these terms may appear in other plans; they are included and defined here in the context of a mass casualty or mass fatality incident.

DEFINITION OF TERMS

A

Accountability: The process by which awareness is maintained of those individuals (victims and responders), equipment, etc. that are on-scene as well as those that have been on-scene and since left.

Acute Mass Fatality Incident: Incidents that are sudden and short-lived. Acute MFIs do not include deaths due to prolonged, non-acute incidents (such as pandemics). An acute MFI may result from a sudden, generally short-term emergency such as; an explosion, transportation accident, building collapse, or chemical exposure.

Altered Standards of Care: A shift in providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals.

Ante-mortem: Prior to death.

Assistant County Medical Examiner: Duly licensed physician, registered nurse, physician assistant, paramedic or emergency medical technician, in good standing, appointed by the Chief Medical Examiner for a term of three (3) years, to a position which possesses all of the duties and responsibilities given to C/MEs by state law, within a county-based jurisdiction.

C

Casualty: A person who is injured in a mass fatality incident but does not die.

Catastrophic Health Event: Events that are both regional in scope and necessitate regional resources (at minimum) to resolve. Regional Medical Response System (RMRS) resources would be involved.

Catastrophic Incident: As defined by the *National Response Framework (NRF)*, is any natural or manmade incident, including terrorism that results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions. A catastrophic incident could result in sustained nationwide impacts over a prolonged period of time; almost immediately exceeds resources normally available to state, local, and private-sector authorities in the impacted area; and significantly interrupts governmental operations and emergency services to such an extent that national security could be threatened.

Cause of Death: A formal, certified opinion by an attending physician or the medico-legal authority of the internal medical condition and/or external incident or chain of incidents that resulted in death.

Closed Decedent Population: The number of victims and their names are known. A commercial airline accident is one of the few examples of a closed population.

Coroner: A public officer whose primary function is to investigate by inquest any death thought to be of other than natural causes. Is trained and certified in the discipline of medicolegal death investigation, who is appointed by the county commission of that county in which he/she practices.

County Medical Examiner: Duly licensed physician, registered nurse, physician assistant, certified paramedic or certified emergency medical technician, in good standing, who is trained and certified in the discipline of medicolegal death investigation. The COME is appointed by the Chief Medical Examiner for a term of three (3) years to a position which possesses all of the duties and responsibilities given to medical examiners by state law, within a county-based jurisdiction, and may only be removed from office for cause.

D

Direct Reference: A DNA sample obtained from the deceased or their personal effects used for comparison with other DNA samples in laboratory identification procedures.

Disaster Mortuary Operational Response Teams (DMORT): Teams of forensic specialists who respond to mass fatality events through the National Disaster Medical System (NDMS). Teams are composed of private citizens, with specific expertise. DMORTs are directed by the NDMS in conjunction with a Regional Coordinator of the ten Federal Regions. Region V DMORT covers five states, including Ohio.

E

Emergency/Disaster Declarations: Official emergency declarations made by specified elected officials at the local, state, or federal level authorizing the use of equipment, supplies, personnel, and resources as may be necessary to cope with a disaster or emergency. Formal declarations are made when the incident requires more assets and resources than exist within the jurisdiction.

Emergency Public Information (EPI): Information that is disseminated primarily in anticipation of or during an emergency. In addition to providing situational information to the public, it frequently provides directive actions to be taken by the general public. During mass casualty / mass fatality incidents, it may include locations of family assistance centers, steps to take to protect oneself (in the case of a public health emergency), etc.

F

Family Assistance Center (FAC): The designated location/facility established to exchange accurate, timely information, render support services for victim family members of mass fatalities and friends who travel to the incident location.

Family Reference: A DNA sample taken from a biological relative (only one generation removed) or a spouse of the deceased used for comparison with other DNA samples in laboratory identification procedures. Also referred to as indirect references.

Fatality: A person who dies as a direct or indirect result of a mass fatality incident (interchangeable with victim, decedent).

Fatality Management: The process of locating, recovering, processing, identifying, and releasing for final disposition deceased victims of a mass fatality incident.

Final Disposition of Human Remains: The concluding arrangement for the remains of the decedent, a decision of the next of kin. Options include burial, entombment, cremation, or donation.

H

Human Remains: A deceased body or fragmented parts from a deceased body.

I

Incident Command System (ICS): A prescribed method of command, control, and coordination within the National Incident Management System to provide a common organizational structure designed to aid in the management of facilities, equipment, personnel, supplies, and information.

Incident Management Team (IMT): A scalable group of specially trained individuals who work closely in support of the locally-elected jurisdictional authority/officials to provide for the command, control, coordination, and support of the incident organization and available resources to address the needs of an incident.

Incident Morgue: The location where the medical examiner and law enforcement conducts medicolegal death investigations and identifies the remains, documents injuries, determines the cause and manner of death and collects forensic evidence for criminal and/or civil courts and law enforcement.

J

Just-in-Time Training: Instruction provided to capable individuals with general skills enabling them to perform task-specific functions immediately following the instruction.

M

Manner of Death: A classification of the fashion or circumstances that resulted in death (either: homicide, suicide, accidental, natural, or undetermined).

Mass Burial: A large plot of land used for burying multiple victims in partitioned, marked graves.

Mass Casualty Incident (MCI): An incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at that incident. Large scale emergencies affecting many individuals and divisions of the healthcare industry. For the purposes of this plan, a response to a MCI would go beyond the capabilities of any one (1) community. Numerous fire and Emergency Medical Services (EMS) units, as well as multiple hospitals would be involved. A major flash flood; large, long-track, devastating EF-4 tornado passing through population centers; large Class-I dam failure; commercial airplane crash, could be examples.

Mass Fatality Incident (MFI): Any incident that results in more fatalities than a local jurisdiction can adequately manage, whether natural or man-made, accidental or intentional. There is no minimum number of deaths for an incident to be considered a mass fatality incident because communities vary in size and resources. For the purposes of this plan, is an incident where more deaths occur than can be handled by Coroner /Medical Examiner (C/ME) resources throughout OHS Region 7.

Mass Grave: A common grave containing multiple, usually unidentified human corpses.

Mass Interment: Burial of large numbers of identified or unidentified bodies.

Medical Examiner: A public official who investigates by inquest any death not due to natural causes, and is a qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), and is usually an appointed position.

Medical Surge: An increase, usually significant and rapid, of patients at hospital facilities. The result of events that severely challenge or exceed the normal medical infrastructure of an affected community though the numbers and/or types of patients.

Medical Surge Response: The capability to rapidly expand the capacity of the existing healthcare system (i.e., the community's long-term care facilities, community health agencies, acute care facilities, alternate care facilities and public health departments) in order to provide triage and subsequent medical care. This includes providing definitive care to individuals at the appropriate clinical level of care, within sufficient time to achieve recovery and minimize medical complications. The capability applies to an event resulting in a number or type of patient that overwhelms the day-to-day acute-care medical capacity.

Medico-legal: Of or pertaining to law as affected by medical facts.

Missing Person: Those persons whose whereabouts are unknown to family or friends following an incident.

Morgue: The facility location where decedents undergo external and internal physical examinations.

Mortuary Affairs: A term synonymous with fatality management, generally referring to the provision of necessary care and disposition of missing and decedent persons, including their personal effects.

Mortuary Affairs Collection Points (MACP): Physical locations at or near the site or throughout a community where non-contaminated remains are collected, stored, and preserved before transported to the Incident Morgue or released to the Funeral Home of the family's choice. These are the types of facilities localities/regions should establish for a pandemic influenza event to manage fatalities.

Multiple Casualty Incident: Such incidents may involve several patients, but can be coordinated by a community's resources without taxing the countywide medical system (e.g., two [2] to three [3] fire departments, one [1] hospital). A large car accident could be an example.

N

National Incident Management System: The part of the National Response Framework that outlines how the government and private entities at all levels can work together to manage domestic incidents, regardless of their cause, size, location or complexity.

Next-of-Kin: Immediate family members including: parents, spouses, siblings, and children.

Non-Acute Mass Fatality Incident: MFIs that occur over an extended time period due to disease; or biological, chemical, or radiological contamination. Non-acute MFIs may result from a long-term emergency such as; an epidemic or pandemic, biological agent exposure, or radiation exposure.

Non-Governmental Organization: Independent organizations free from government control.

Non-Profit Organization: A business or enterprise that does not distribute its surplus funds to owners or shareholders, but instead uses them to help pursue its goals.

O

Ohio Mortuary Operations Response Teams (OMORT): Is a team of forensic specialists who respond to mass fatality events and is modeled after the Federal DMORT. These teams are composed of private citizens, with specific expertise, may work in the death care industry and includes; forensic pathologists, forensic odontologists, forensic anthropologist, funeral directors, x-ray technicians, DNR specialists, fingerprint and photography, data entry, and others.

Open Decedent Population: Neither the number of victims nor their names are known.

P

Patrons: Family members and close friends that visit and have access to the Family Assistance Center.

Personal Effects: Belongings of an individual including clothing, clothing accessories, jewelry, and other property on their person or otherwise in their possession.

Points of Distribution: Temporary locations at which commodities are distributed directly to disaster victims.

Postmortem: After death.

S

Situational Orphan: A child, due to circumstances of a MFI, that has been involuntarily separated or otherwise detached or displaced from their immediate family, relatives, or designated caregivers. The child may, or may not, have actually been orphaned as a result of the MFI.

Spontaneous Unaffiliated Volunteers: An individual, not associated with any recognized disaster response agency, who may or may not have special skills, knowledge, or experience, but who appears, unsolicited, at an incident to render assistance.

START Triage: A method that first responders use to effectively and efficiently evaluate all of the victims during a mass casualty incident. Used to prioritize care according to three conditions: breathing, circulation, and level of consciousness.

Survivor: Anyone who is exposed to or otherwise encounters a mass fatality incident that does not perish as a result of the incident.

I

Temporary Interment: A location where decedents are interred underground in individually marked spaces that may or may not become the final disposition location for some decedents.

Temporary Morgue: An ad hoc morgue operation established specifically to process and identify human remains resulting from a mass fatality incident. A permanent or semi-permanent structure near the incident site, which can be a tent or vehicle/trailer with a consistent 35-38°F temperature.

Transient Population: A population that is not permanent in an area (i.e., that does not live permanently in an area). Transient populations may not be aware of such things as transportation routes (especially detours), standard landmarks, local customs and culture, etc.

Triage: The process of sorting and providing care to multiple victims, according to the severity of their injuries or illnesses.

V

Victim: A person who dies as a result of a mass fatality incident (interchangeable with fatality, decedent).

Victim Identification Program: A disaster management computer software program designed to collect personal information of known and unknown individuals, and then conduct comparative analysis to suggest best probable matches or exclusions of ante- and postmortem information to aid in identification processes of unidentified individuals.

W

Walking Wounded: Patients who are conscious and breathing and usually have only relatively minor injuries; thus they are capable of walking.

DEFINITION OF ACRONYMS

AABB – American Association of Blood Banks

AAR – After Action Review

AFDIL – Armed Forces DNA Identification Laboratory

ALS – Advanced Life Support

ARC – American Red Cross

BLS – Basic Life Support

CBIRF – Chemical, Biological Incident Response Force

CBRNE – Chemical, Biological, Radiological, Nuclear, Explosive

CDC – Centers for Disease Control and Prevention

CIA – Catastrophic Incident Annex

CMA – Columbus Medical Association

C/ME – Coroner / Medical Examiner

CO₂ – Carbon Dioxide

COHDIMS – Coalition Healthcare Disaster Information Management System

COOP – Continuity of Operations Plan

COTS – Central Ohio Trauma System

COVID – Corona Virus Disease
CPG – Comprehensive Preparedness Guide
DAS – Department of Administrative Services
DMAT – Disaster Medical Assistance Team
DMORT – Disaster Mortuary Operational Response Team
DNA – Deoxyribonucleic Acid
DOD – Department of Defense
DOJ – Department of Justice
DPMUs – Disaster Portable Morgue Units
DRMUs – Disaster Response Medical Units
DVP – Disaster Victim Packet
EDRS – Electronic Death Registration System
EMA – Emergency Management Agency
EMAC – Emergency Management Assistance Compact
EMS – Emergency Medical Services
EOC – Emergency Operations Center
EOD – Emergency Ordinance Disposal
EOP – Emergency Operations Plan
EPI – Emergency Public Information
ER – Emergency Room
ERS – Emergency Response System
ERT – Evidence Response Team
ESAR-VHP – Emerg. System for Advance Registration of Vol. Health Professionals
ESF – Emergency Support Function
FAC – Family Assistance Center
FBI – Federal Bureau of Investigation
FEMA – Federal Emergency Management Agency
FOUO – For Official Use Only
FSRT – Fatality Search and Recovery Team
GPS – Global Positioning System
HIL – Healthcare Incident Liaison
HIPAA – Health Insurance Portability and Accountability Act
HSEEP – Homeland Security Exercise and Evaluation Program
HSPD – Homeland Security Presidential Directive

IAP – Incident Action Plan
IC – Incident Commander
ICP – Incident Command Post
ICS – Incident Command System
ILS – Intermediate Life Support
IMAC – Intrastate Mutual Assistance Compact
IMATs – Incident Management Assistance Teams
IMTs – Incident Management Teams
IP – Improvement Plan
IRC – Information Resource Center
JCEMA – Jackson County Emergency Management Agency
JIC – Joint Information Center
JIS – Joint Information System
JTF-CS – Joint Task Force – Civil Support
LEADS – Law Enforcement Agencies' Data System
LHD – Local Health Departments
LRN – Laboratory Response Network
MACP – Mortuary Affairs Collection Point
MACS – Multi-Agency Coordination System
MCI – Mass Casualty Incident
MFI – Mass Fatality Incident
MFP – Mass Fatality Plan
MMRS – Metropolitan Medical Response System
MOU – Memorandum of Understanding
MRC – Medical Reserve Corp
NCIC – National Crime Information Center
NDMS – National Disaster Medical System
NGOs – Non-Governmental Organizations
NIMS – National Incident Management System
NNRT – National Nurse Response Team
NRF – National Response Framework
NFR-CIA – National Response Framework-Catastrophic Incident Annex
NTSB – National Transportation Safety Board
OAFME – Office of the Armed Forces Medical Examiner

OBEFD – Ohio Board of Embalmers and Funeral Directors
OCEM – Office of Chief Medical Examiner
ODAS – Ohio Department of Administrative Services
ODH – Ohio Department of Health
ODMH/AS – Ohio Department of Mental Health and Addiction Services
ODPS – Ohio Department of Public Safety
OEMA – Ohio Emergency Management Agency
OEMS – Ohio Division of Emergency Medical Services
OFCA – Ohio Fire Chief's Association
OFDA – Ohio Funeral Directors Association
OFDA-MRT – Ohio Funeral Directors Association-Mortuary Response Team
OHA – Ohio Hospital Association
OHNG – Adjutant General's Department, Ohio National Guard
OHS – Ohio Homeland Security
OHTRAC – Ohio Track
OIC – Officer in Charge
OMCP – Ohio Medical Coordination Plan
OMORT – Ohio Mortuary Operational Response Team
OMRC – Ohio Medical Reserve Corp
OPMU – Ohio Portable Morgue Unit
ORC – Ohio Revised Code
OSCA – Ohio State Coroners/Medical Examiners Association
OSHA – Occupational Safety and Health Administration
OSHP – Ohio State Highway Patrol
OSU – Ohio State University
OVOAD – Ohio Volunteer Organizations Active in Disaster
PIA – Principal Investigating Agency
PIO – Public Information Officer
POC – Point of Contact
POD – Points of Distribution
PPE – Personal Protective Equipment
RHC – Regional Healthcare Coordinators
RMRS – Regional Medical Response System
ROC – Regional Operations Center

RTAS – Real Time Activity Status
SALT – Sort-Assess-Lifesaving Interventions-Treatment and/or Transport
SARS – Severe Acute Respiratory Syndrome
SEOC – State Emergency Operations Center
SEOHC – Southeast Central Ohio Healthcare Coalition
SEOP – State Emergency Operations Plan
SME – Subject Matter Expert
SNS – Strategic National Stockpile
SO – Safety Officer
SOCC – Surge Operations Call Center
SOG – Standard Operating Guidelines
START – Simple Triage and Rapid Treatment
TENS – Telephone Emergency Notification System
THIRA-SPR – Threat & Hazard Identification & Risk Assessment-Stakeholder Preparedness Review
TTX – Table Top Exercise
UC – Unified Command
USAR – Urban Search and Rescue
USC – United States Code
US DHS – United States Department of Homeland Security
US DOD – United States Department of Defense
US DOJ – United States Department of Justice
US HHS – United States Department of Health and Human Services
VAMC – Veteran Affairs Medical Center
VIC – Victim Identification Center
VIP – Victim Identification Program
VOAD – Voluntary Organizations Active in Disaster
VRC – Volunteer Reception Centers
WHO – World Health Organization
WMD – Weapon of Mass Destruction

OHS Region 7 Mass Casualty / Mass Fatality Plan
Approval and Implementation

 Athens County Emergency Management Agency, Director	8/15/23 Date
 Gallia County Emergency Management Agency, Director	8/29/2023 Date
 Hocking County Emergency Management Agency, Director	8/15/23 Date
 Jackson County Emergency Management Agency, Director	7/24/2023 Date
 Lawrence County Emergency Management Agency, Director	7/26/2023 Date
 Meigs County Emergency Management Agency, Director	8-22-23 Date
 Perry County Emergency Management Agency, Director	7-25-23 Date
 Pike County Emergency Management Agency, Director	7-20-23 Date
 Ross County Emergency Management Agency, Director	07/25/23 Date
 Scioto County Emergency Management Agency, Director	8-28-2023 Date
 Vinton County Emergency Management Agency, Director	7-26-2023 Date