

# **State of New Hampshire Naturally Occurring Disease Event Mass Fatality Management Plan**

**July 14, 2008**

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Abbreviations Used in this Document

AHHR	All Health Hazards Region
ARNP	Advanced Registered Nurse Practitioner
CDC	U.S. Centers for Disease Control and prevention
COOP	Continuity of Operations Plan
DBHRT	Disaster Behavioral Health Response Team
DHHS	NH Department of Health and Human Services
DMORT	Federal Disaster Mortuary Operational Response Team
DOC	NH Department of Corrections
DOT	NH Department of Transportation
DVRA	NH Division of Vital Records Administration
EOC	State Emergency Operations Center
ESF-8	Emergency Support Function Health and Medical
GPS	Global Positioning System
HSEM	NH Homeland Security and Emergency Management
ICC	DHHS Incident Command Center
MACE	Regional Multi-Agency Coordination Entities
NCHS	National Center for Health Statistics
NOK	Next of Kin
OCME	Office of Chief Medical Examiner
PIO	Public Information Office
PPE	Personal Protective Equipment
RSA	Revised Statute Annotated
SAMHSA	U. S. Substance Abuse and Mental Health Services Administration

## I. INTRODUCTION

### **A. Purpose**

The purpose of this plan is to provide guidance to State agencies, local governments, All Health Hazard Region (AHHR) planners, and hospitals to prepare for a mass fatality event. State and federal assistance will be requested when numbers of deceased exceed local capabilities.

### **B. Scope**

The objective of the New Hampshire Naturally Occurring Disease Event Mass Fatality Plan is to ensure timely processing of a large number of fatalities during widespread naturally occurring disease outbreaks. A multi-case, multi-site fatality incident includes public health emergencies, such as a pandemic influenza. This plan is intended to assist localities with the management of this type of fatality incident.

Mass fatality incidents that are the result of a single occurrence, such as a plane crash, building collapse, fire, hurricanes, earthquakes, or tornados or are the result of terrorism, such as a biological, chemical or radiological event, fall under the jurisdiction of the Office of Chief Medical Examiner (OCME) (RSA 611-B). These incidents require resources separate from those used in a pandemic influenza situation. The OCME Mass Fatality Plan details procedures that should be implemented in events that fall under the jurisdiction of the OCME. That plan includes discussions of the Family Assistance Center, scene documentation and recovery, and the temporary morgue.

The main goals of OCME are the following:

- To make positive identification of the decedents
- To establish cause and manner of death
- To release the remains to the families in a timely manner

Any death in the State that is not due to entirely natural causes, including deaths that occur in hospitals, falls under the jurisdiction of the OCME. OCME staff are charged with determining cause and manner of these deaths. Only OCME staff can certify non-natural deaths.

### **C. Assumptions**

The following assumptions have been made in drafting this plan:

- There may be limited or no mutual aid between New Hampshire communities, counties, and the Federal Disaster Mortuary Operational Response Team (DMORT).
- An adequate supply of vaccine or post-infection treatments may not be widely available at the onset of a public health emergency.

- Planners should assume that funeral homes and crematoria will be at, if not over, capacity.
- The presence of a public health emergency may only become apparent days after its arrival.
- This plan uses a population estimate of 1,300,000 residents in the State of New Hampshire.
- AHHR planners will assess local funeral home and crematoria capacity in the region bi-annually using the assessment tool in Appendix 4 and submit data to the NH DHHS ESF-8 Coordinator
- AHHR planners will encourage funeral homes and crematoria in the region to create COOP plans

#### **D. Capacity**

The current, normal functioning capacity of private funeral homes and crematoria are described below. During a naturally occurring disease mass fatality event, crematoria may be expected to surge their body processing up to three times their current capacity. Short-term capacity of mortuary services depends on multiple factors, including but not limited to the availability of cemetery space and personnel, type of handling (cremation or embalming), and availability of staff at mortuary facilities. AHHRs should assess their local capacity bi-annually using the assessment tool in Appendix 4. These data will be collected and compiled by the NH Department of Health and Human Services Emergency Support Function Health and Medical (ESF-8) Coordinator in order to summarize the current capacity of private funeral homes and crematoria in NH.

The following data were compiled using death certificates completed by funeral home directors and the Funeral Board (2005/2006):

- Monthly average of funeral home body processing in New Hampshire: 719
- Yearly total of funeral home body processing in New Hampshire: 8632
- Number of Funeral Homes in NH: 88
- Number of Crematoria in NH: 14

Funeral homes and crematoria may have to hold and/or process up to three times more bodies than normal capacity. Limited embalming and storage supplies during the peak impact of the mass fatality event may also change the way bodies are managed. In addition, crematoria and funeral home absenteeism may be a complicating factor adding to the demand on local funeral homes and crematoria for processing. Funeral homes and crematoria in NH are encouraged to create continuity of operations plans (COOP) to plan for a naturally occurring disease mass fatality event. Rules or laws pertaining to the deceased may need to be amended or suspended to expedite processing in the interest of public health.

## II. Operation Plans

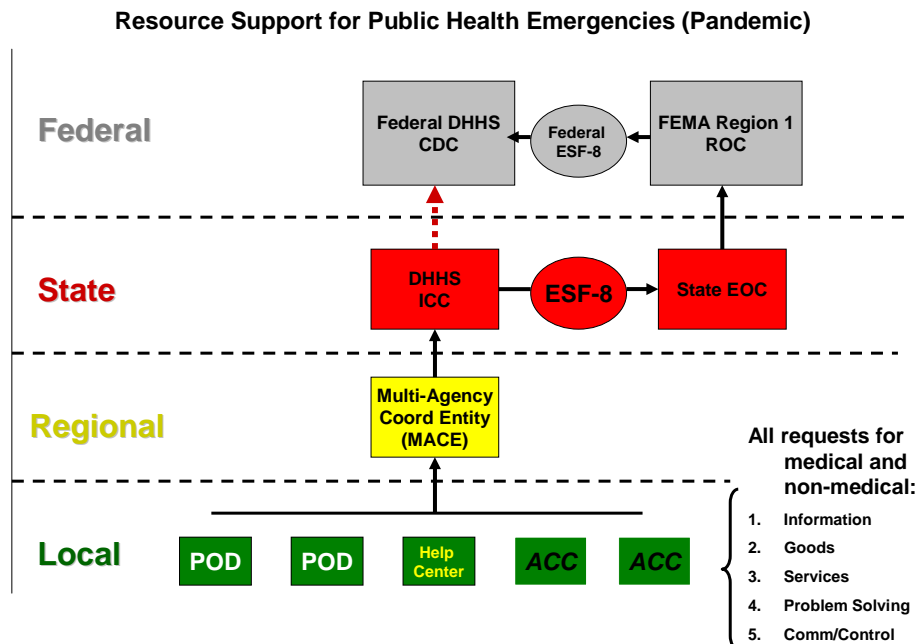
### A. Cultural and Religious Sensitivity

During a mass fatality event every effort should be made to determine if the deceased came from a cultural or religious community for which certain customs and traditions should be observed in handling the body and making final arrangements. If no relative is available to advise in the final disposition of the body, assistance from local funeral home directors and cultural or religious leaders should be solicited to help determine if any customs should be considered regarding the deceased, and if so determined, to assist in observing those customs and rituals.

### B. Roles and Responsibilities

The OCME, the AHHR and DHHS will utilize the Incident Command Structure established by the Department of Health and Human Services and at the NH Department of Safety the Division of Homeland Security and Emergency Management (HSEM) to coordinate efforts.

Coordination of all health-related emergencies will be between the State Emergency Operations Center (EOC) and the DHHS Incident Command Center (ICC), the DHHS ICC and the AHHR's Multi-Agency Command Entities (MACE), and from the MACE to local authorities. (See the diagram below).



\*Hospitals and long-term care facilities work in collaboration with the Help Centers, ACCs, and PODS on the local level.

The role of the State EOC is to coordinate the distribution of resources as requested, by communities and state agencies. For an event that includes mass fatalities, the EOC will perform the following functions:

- Coordinate with the ICC on any public health implications regarding the deceased
- Request state and federal resources, as applicable

The role of the DHHS ICC is to perform the following functions:

- Provide technical guidance for the prevention of the spread of illness
- Provide information to AHHRs regarding expected deaths, resource allocation, and surveillance
- Request resources for the MACE from the EOC
- Coordinate information between NH Division of Vital Records Administration and the MACEs

The role of the AHHR is to:

- Designate the location in the AHHR for a refrigerated trailer
- Designate the entity responsible for the refrigerated trailer
- If needed, coordinate transportation of the deceased to funeral homes, crematoria, or refrigerated storage when deaths occur in the home or at the ACC
- Coordinate with Town Clerks to act as a local resource for retrieving information regarding the location of deceased from the state's web-based death registration system
- Maintain a list of the Town Clerks in the AHHR

The role of the MACE is to:

- Request information and resources from the ICC
- Maintain communication with each town in the AHHR
- Coordinate local funeral home resources and assess the AHHR's need for refrigerated storage
- Coordinate with hospitals when morgue resources are exceeded

The role of the hospital is to:

- Follow normal procedures for handling the deceased until morgue capacity is exceeded
- Implement emergency plan for the handling of excess bodies, when applicable
- Coordinate with the local MACE when emergency morgue resources are exceeded

The Role of OCME

- To investigate all deaths as designated by statute (RSA 611B) (see Appendix 7)
- To investigate deaths when the deceased is unidentified or are unidentifiable

## The Role of Vital Records

- Coordinate the parties (funeral directors, medical examiner staff, certifying physicians, and ARNPs) who provide real-time data entry into the death certificate database
- Coordinate with local town clerks and others who may be recruited to assist with providing real-time data entry into the death certificate database
- Conduct queries of the death certificate database and provide reports to the EOC. Potential fields of interest include: date of death, gender, age, method of disposition, place of disposition, and location.

## **C. Declaration of a State of Emergency**

During an emergency, it is likely that the Governor will declare a state of emergency. This declaration is authorized by state statute (RSA I-4: 45), which gives authority to the Governor to alter typical policy for the purposes of managing the incident and mitigating any public health threat.

## **D. Behavioral Health**

HSEM has developed a Disaster Behavioral Health Response Plan to provide an effective, organized system to manage the consequences of emergencies and disasters which impact consumers, staff, and area residents. The response may include immediate crisis intervention, short term and long-term support for emotional needs, community networking, assessment of the scope of disaster and support of first responders. Because a mass fatality event is an unplanned, disruptive event, response and interventions will emphasize the utilization of local resources first such as community mental health services and agencies within the affected area.

This Plan is designed to guide the behavioral health planning, intervention and response efforts relative to disasters of any type, which would include mass fatality events. Disaster behavioral health response will be led by HSEM and coordinated with other agencies including the Department of Health and Human Services- Bureau of Behavioral Health, the Division of Public Health Services, the American Red Cross and, in federally declared disasters, the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

The DHHS PIO in collaboration with HSEM and the Disaster Behavioral Health Response Coordinator will write and disseminate public information messages regarding stress management coping strategies and the occurrence of death at home versus death in a medical facility. (See also the DBHRT Response Plan in the Appendix of the Public Health Emergency Preparedness and Response Plan)

## **E. Pronouncing, Certifying, and Registering Deaths**

### Pronouncing Deaths

Pronouncing death is to declare that death has occurred. Fields 14 – 31 on the New Hampshire Certificate of Death are to be completed by the person pronouncing the death.

According to State of New Hampshire statute 290:1-b, deaths can be pronounced by Registered Nurses if it is an anticipated death that occurs in a hospital, a nursing home, a private home served by a home health care provider licensed under RSA 151, an assisted living residence as defined in RSA 161-J: 2, II, or a hospice. The registered nurse attending at the last sickness may pronounce the death and release the body to the funeral director, next-of-kin, or designated agent after verifying the fact of death and completing the death record by hand or other approved electronic process. When a contagious disease is known to be present at the time of death, that fact shall be indicated on the death record.

### Certifying Deaths

Certifying deaths is to complete the official death certificate with the cause of death and a signature. Fields 32 – 49 on the New Hampshire Certificate of Death are to be completed by the person certifying the death. Physicians and Advanced Registered Nurse Practitioners (ARNPs) are responsible for completing the death certificates for their patients who die from entirely natural causes, using their best clinical judgment as to the cause of death. This remains true regardless of whether the patient is in a clinical setting or at home, when the death appears to be natural to the person who responds to the scene of the death. It is legal and acceptable for a physician or ARNP to pronounce a death without seeing the body when the death appears to be due to natural causes (RSA 5-C: 62).

RNs, ARNPs, and physicians should be encouraged to complete their portion/s of the death certificate in a timely manner if they do not have access to the Internet or if their clinical duties hinder their ability to enter information via the web-based registration system.

The MACE will facilitate the process of pronouncing and certifying deaths when the treating RN, MD, or ARNP are not available by enlisting other local clinicians or requesting assistance from the ICC. Under a State of Emergency or a Declaration of a Public Health Incident the Governor may authorize the Commissioner of DHHS to deputize others to certify deaths as appropriate.

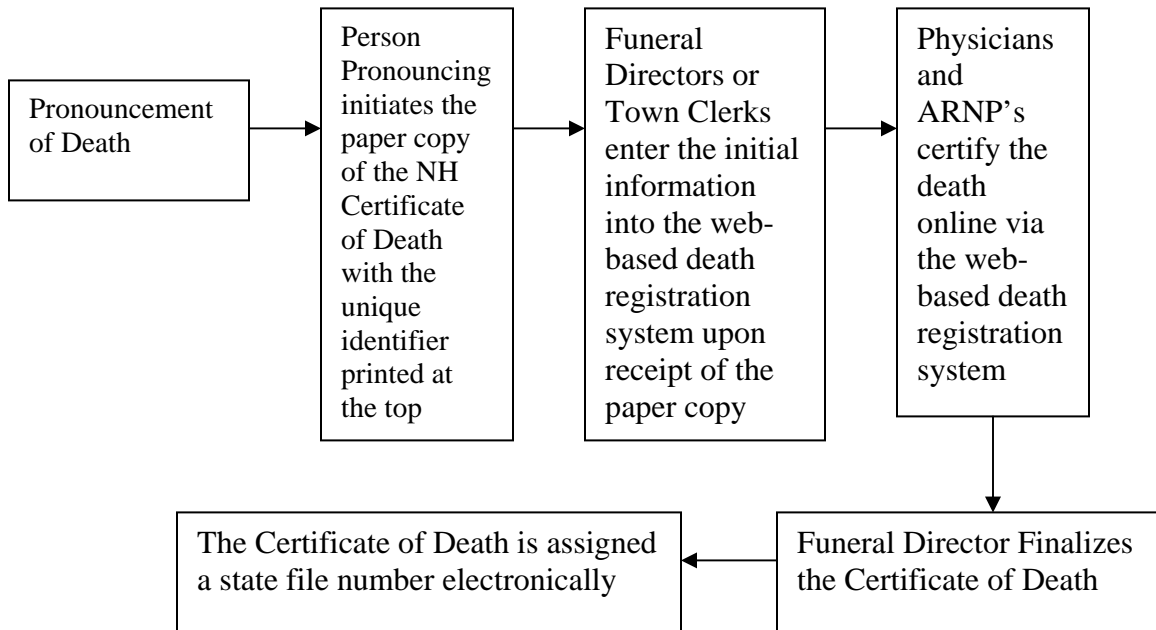
### Registration

In the event that web-based registration of death certificates becomes a problem for practitioners and funeral home directors, town clerks have access to the registration system and may be able to help by entering information from paper death certificates. Vital Records can also facilitate just in time training for more assistance if needed. Timely entering of death certificates will provide a resource for body tracking and situational awareness for state leadership, clinicians, and incident command.

NH will participate in the *Advancing Strategies to Improve Influenza Surveillance* pilot project, for the project period 7/1/08 to 6/30/10. The main objective is for NH DHHS to collaborate with the NH Department of State's Division of Vital Records Administration (DVRA) to ensure that 100% of death data, including fact of death and basic demographic information, is transmitted to the National Center for Health Statistics

(NCHS) within 5 days of death, and the cause of death within 10 days of death. DVRA will be responsible for capturing and reporting death data to NCHS. In addition, DHHS will monitor pneumonia & influenza (P&I) deaths at least weekly and provide reports of incidence, distribution and basic epidemiologic characteristics of P&I deaths. DHHS will also continue to monitor all influenza surveillance systems for increased morbidity and mortality compared to previous influenza seasons, and provide reports at least weekly.

### The New Hampshire Death Registration Process



### F. Home Deaths

When a death occurs at a home or in a non-clinical setting, it is expected that a funeral home will remove the body from the premises. Deaths must be pronounced before funeral homes can transport bodies out of the home.

The body must be appropriately labeled by the responding funeral home. Identification tags will be distributed to funeral homes to be used in a naturally occurring and biological mass fatality event. Duplicate tags should be completed for each decedent. One tag should be attached to the body and the second tag should be attached to the body bag. The following information will be requested if known on each tag:

- Name
- Address
- DOB
- Date of death
- Sex

- Race
- Location of death
- Next of Kin (NOK) name/address/phone number
- Funeral Home
- Religious affiliation

When a body is found at home and cannot be identified, the local police or funeral home (if they have been called by the police or any other entity) will contact the MACE. The MACE will contact the ICC and the ICC will contact the OCME in order to investigate the death. An unidentified body is under the jurisdiction of the OCME and would be investigated by the medical examiner.

### **G. Deaths in Healthcare Settings**

When a death occurs in a hospital, nursing home, rehabilitation center, or other healthcare setting the standard practice for death management should be followed. The same tag system as outlined in the Home Deaths section above should also be followed. If problems with pronouncement, certification, storage or transportation of bodies occur, a representative of the institution will contact the MACE for assistance.

### **H. Personal Effects**

When a death occurs at home, the personal effects should be left in the home. Healthcare settings and funeral homes should follow their normal procedures. When a death occurs in an ACC and/or a body is temporarily stored or interred, the ACC should make arrangements to secure personal effects.

### **I. Infection Control**

Special infection control measures may be required for the handling of persons who died as a result of a biological incident. Some incidents may require decontamination of human remains prior to handling. Standard precautions should be used when handling bodies unless otherwise directed by DHHS through the MACE. Please see Appendix 3 for more information on contamination control and handling of the deceased.

### **J. Storage During a Mass Fatality Incident**

Bodies will be transported and processed by local funeral homes and crematories. Memoranda of Understanding should be in place for local funeral homes, so that when storage space available in one funeral home is exhausted, another funeral home would assume storage when available. Should the volume of storage overwhelm capacity in a region, the MACE will request a refrigerated trailer from the ICC. Rental contracts have been established by the NH Department of Administrative Services for 19 standard refrigerated trailers (40 feet long). If needed, each of the AHHRs will be provided with a refrigerated trailer in a statewide mass fatality incident.

Refrigerated trailers will be driven to the regions by cabs owned by the State of NH Department of Transportation (DOT). DOT will be notified through the State EOC, and DOT will provide drivers. It will be the responsibility of DOT to schedule and assign drivers.

AHHR planners will determine where their allocated refrigerated trailer will be placed during the mass fatality incident, and which personnel from which agency will be responsible for the trailer.

The refrigerated trailers will be equipped with ramps and shelving for storage of bodies. The NH Department of Corrections (DOC) is a potential resource for building ramps and shelving as requested by the State EOC during an emergency. Building specifications for the pallets are provided in Appendix 6. Using these building specifications, a 40-foot long trailer can hold 20 bodies.

AHHR planners will provide a hotline number or contact number for families to call, when necessary, in order to arrange to identify remains held in refrigerated storage. AHHR planners should coordinate with Town Clerks to act as a local resource for retrieving information regarding the location of deceased from the web-based death registration system. The web-based death registration system can be searched using many fields including name of deceased, date of death, and place of death.

#### **K. Temporary Interment**

Temporary interment or burial of bodies is an extreme measure reserved for the circumstance when hospital and funeral home morgues are at capacity, and when other interim measures, such as refrigerated trucks, are unavailable or at capacity. Cremation or burial using established systems and cemeteries should always be the first option. In the event of the need for temporary interment, identifying information about the person will be buried with the body, and the Division of Vital Records Administration, NH Department of State, will keep a record of where each body is buried using Global Positioning System (GPS) coordinates. Several fields currently on the Certificate of Death may be used for this purpose (See Identification and Tracking of Bodies).

The decision to temporarily inter bodies would be made by the Governor in accordance with RSA 21-P: 37. Under a declared state of emergency the Commissioner of Health and Human Services has the authority to temporarily inter bodies in accordance with RSA 21-P: 54. Local and State authorities will coordinate efforts if assistance is needed from the State (land, personnel, etc.).

The State has identified several state-owned pieces of land that would be appropriate for temporary interment. Workers and equipment from the Department of Transportation will be used to prepare the site(s) for temporary interment. The ICC will request assistance from funeral home directors and religious leaders regarding proper handling and giving due respect to the deceased. Personal Protective Equipment (PPE) for workers at such sites would be at the recommendation of DHHS. Request for PPE will be made through the MACE to the ICC.

#### **L. Security**

Once the situation has been determined that it is not a crime, security will need to be maintained to prevent desecration of remains, potential scavengers, and improper

handling of remains. The AHHR fatality plan should assign the responsibility for security to an appropriate local entity to be assigned to the site of the refrigerated trailers and any local interment site. A single entry access will be maintained to discourage unauthorized access. Entry will be limited to State and Federal personnel, AHHR authorities, and funeral homes. Family members should call the AHHR designated hotline to arrange to identify the remains of relatives being temporarily held or who have been temporarily interred and arrange to remove for burial or cremation.

**M. Identification and Tracking of Bodies**

Bodies will be tracked using the web-based death registration system (see below). In the event that the system is unavailable, a tracking log should be used by the entity designated by the MACE. An example of a tracking log is given below:

Tracking Log				
Name, DOB	Cold Storage Facility	Storage Location Identification	Interment Facility	Date
	-	-	-	

When bodies are temporarily interred, Vital Records will record the locations of bodies interred in the death registration system. If the web-based registration system is unavailable, a tracking log will be kept. A record example is given below:

Interment Tracking Log		
Name, DOB	Interment Row GPS Coordinates	Date of Interment
Smith, Joe DOB 5/23/61	Universal Transverse Mercator (UTM)	01/01/07

The web-based death registration system will be used when filling out the death certificate for a deceased that is going to be placed in cold storage or temporary interment; the following fields can be used to track the location of the body through Vital Records:

- Field 18. Method of Disposition: Check *Other* and write in the type of storage (cold storage or temporary interment)
- Field 19b. Place of Disposition: Free Text the location of the body
- Field 19c. Location: Free Text City/Town Name

These fields can be updated if the deceased is moved to a different location.

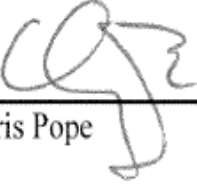
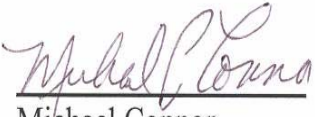

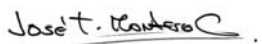
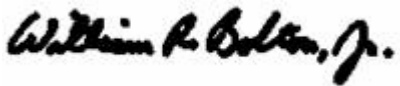
**N. Moving Bodies to other States**

When a death occurs in N.H. a death certificate must be issued. Transportation to another State will be coordinated through funeral homes and burial societies per routine procedures.

**O. Moving Bodies to other Countries**

Returning a body to another country involves understanding the process specific to that country and the relevant country should be consulted. Since Canada borders New Hampshire, help with returning the body of a Canadian citizen to Canada may be found with the Canadian Operations Centre of Foreign Affairs and International Trade (<http://www.voyage.gc.ca/main/sos/emergencies-en.asp>). For deaths of foreigners to other countries notify the nearest consulate of the corresponding country.

Signatories to NH Naturally Occurring Disease Event Mass Fatality Plan

<u>Signature</u>	<u>Title &amp; Agency</u>	<u>Date</u>
 Chris Pope	Director, Homeland Security & Emergency Management Department of Safety	<u>8/29/2008</u>
 Michael Connor	Director, Division of Plant and Property Management Department of Administrative Services	<u>8/29/2008</u>
 Michael Pillsbury	Assistant Dir of Operations, Department of Transportation	<u>8/8/2008</u>
 Jose Montero, M.D.	Director, Division of Public Health Services Department of Health and Human Services	<u>8/12/2008</u>
 William R. Bolton, Jr	Director, Division of Vital Records Administration Department of State	<u>8/5/2008</u>

## Document Review

Version and Nature of Change	Revision Date

APPENDICES

**APPENDIX 1: New Hampshire Body Tag**

Death Certificate #: \_\_\_\_\_  
(if/when known)

Decedent's name:

\_\_\_\_\_

Decedent's address:

\_\_\_\_\_

DOB (if unknown, estimate approximate age) \_\_\_\_\_

Date of death (if unknown, estimate): \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Location of Death: \_\_\_\_\_

Next of Kin Name/address/phone number:

\_\_\_\_\_

\_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

FUNERAL HOME:

\_\_\_\_\_

Comments:

\_\_\_\_\_

## APPENDIX 2: Pandemic Influenza

### Fatality Assumptions in an Influenza Pandemic

Below is the list of expected fatalities in an influenza pandemic, stratified by most likely and maximum scenarios for each of the 19 All Health Hazards Regions. Using population data with statewide hospital data, the estimated most-likely and maximum number of fatalities during an influenza pandemic were calculated using CDC’s FluSurge2.0 software (see Table 1). It is important to note that these numbers serve only as estimates of potential impact, and they are not indications of how or when individuals will die. The disease incidence is estimated to be approximately 22.5% with an 12-week duration of pandemic, 4% rate of hospitalization, and mortality rates at 1% (for the most likely scenario) and 2% (for the maximal scenario). Attack, hospitalization and mortality rates used in the calculations were determined by consensus of regional medical surge planners at the New England Pandemic Influenza/Avian Influenza Regional Meeting in August 2006.

Table A1. Estimated Numbers of Deaths by AHHR for the Most-Likely Scenario and the Maximum Scenario

<b>AHHR Region</b>	<b>Death rate (likely)<sup>a</sup></b>	<b>Death rate (maximum)<sup>b</sup></b>
<b>Bristol-Franklin</b>	<b>78</b>	<b>156</b>
<b>Claremont- (Sullivan)</b>	<b>96</b>	<b>191</b>
<b>Concord</b>	<b>294</b>	<b>589</b>
<b>Conway</b>	<b>43</b>	<b>87</b>
<b>Dover</b>	<b>158</b>	<b>316</b>
<b>Exeter</b>	<b>229</b>	<b>459</b>
<b>Great North</b>	<b>76</b>	<b>151</b>
<b>Keene</b>	<b>147</b>	<b>294</b>
<b>Laconia-Meredith</b>	<b>122</b>	<b>245</b>
<b>Lebanon-Hanover</b>	<b>102</b>	<b>203</b>
<b>Lisbon (N. Grafton)</b>	<b>49</b>	<b>98</b>
<b>Manchester</b>	<b>414</b>	<b>828</b>
<b>Nashua</b>	<b>468</b>	<b>935</b>
<b>Peterborough</b>	<b>85</b>	<b>170</b>
<b>Plymouth</b>	<b>42</b>	<b>84</b>
<b>Portsmouth</b>	<b>82</b>	<b>163</b>
<b>Rochester</b>	<b>110</b>	<b>219</b>
<b>Southeastern</b>	<b>304</b>	<b>608</b>
<b>Southern Carroll</b>	<b>49</b>	<b>98</b>
<b>Totals</b>	<b>2947</b>	<b>5895</b>

<sup>a</sup> Most Likely Scenario calculated using a 1% death rate. Estimates are calculated using NH’s age demographic data, number of non-ICU hospital beds, number of ICU beds, and number of ventilators.

<sup>b</sup> Maximum scenario calculated with a 2% death rate.

Funeral homes and crematoria should take the following mitigation steps in preparation for an influenza pandemic:

- Keep all seasonal influenza vaccinations for staff up to date.
- Keep adequate supplies on hand to deal with an unexpected influx of bodies.
- Maintain communications with the Office of the State Medical Examiner to ensure information and emergency status is current.

### APPENDIX 3: Contamination Control Measures

***Handlers of the deceased should ALWAYS use standard precautions as a minimum level of protection, unless higher levels of protection are warranted.***

- Handlers may include volunteers and/or other individuals involved in search and recovery operations, transport of bodies, body identification and disposition. See the job action sheet in the appendix.

***Specific precautions for transporting & moving bodies, or other superficial handling:***

- Wear gloves
- Wear boots, if available
- Wash hands with soap & water after handling bodies
- Avoid wiping face or mouth with hands
- Wash & disinfect all equipment, clothing, and vehicles used
- Masks are optional
- If body has been decomposing for several days, allow time for air circulation & release of gases that have built up before handling
- Decontaminate surface of body bag before transporting
- Family members viewing bodies should be issued disposable gloves and gowns during the viewing

***When an airborne agent is involved***

*(These procedures may change according to CDC guidance)*

- Consider alterations or discontinuations of embalming practices
  - Direct burial without embalming
  - Cremation without embalming

## APPENDIX 4: Annual Funeral Home and Crematoria Local Assessment

Date

Dear,

If you attended the 107<sup>th</sup> Annual NHFDA Meeting on January 20<sup>th</sup> 2007 in Meredith, you may recall hearing about the ongoing preparations being made for a localized response to a mass fatality event here in New Hampshire.

Currently, the All Health Hazards Regions (AHHRs) are trying to involve all of the funeral homes in this process by determining just how prepared we are when something happens. Nationally, the focus appears to be the Avian Flu, but I assure you, we are trying to be prepared for any mass fatality event that may happen here in New Hampshire.

One of the steps in this process is to come up with an approximate inventory of the equipment and other funeral resources that are routinely on hand, as well as gathering a geographical idea of where these resources are located throughout the State. This has become part of the planning process in New Hampshire, and this information will be collected bi-annually.

The easiest way to do this is with the enclosed survey. Recently, you may have filled out a similar survey and while it may seem repetitive, this survey is an extremely valuable tool for us to update the information specific to New Hampshire annually.

We ask you to please take a moment to complete this survey and fax it to me at XXX-XXXX .

Please understand that this information will be kept confidential and will only be used to better prepare us in New Hampshire for whatever may come in the future.

I thank you very much for your time.

Signature

Name of Funeral Home: \_\_\_\_\_

Towns / Area of Service \_\_\_\_\_

1. What is the realistic storage capacity for remains at your funeral home?
2. Do you have access to additional, appropriate storage?  Yes  No  
("Appropriate" meaning able to be secured and information as possible refrigeration – for example, tombs, out buildings, refrigerated trailers)
  - a) If you answered "yes," what type? \_\_\_\_\_
  - b) What is the capacity? \_\_\_\_\_
3. Does your firm have a crematory?  Yes  No
  - a) If you answered "yes," what is the capacity? \_\_\_\_\_
  - b) If you answered "yes," how many cremations can be performed daily?
  - c) If you answered "no," is there a crematory available for your use in your area?  Yes  No
  - d) If you answered "yes," what is the capacity? \_\_\_\_\_  Do not know
4. Approximately how many "typical" embalmings could you perform with the quantity of embalming chemicals that you routinely have in stock? \_\_\_\_\_
5. How many body bags do you routinely have on hand that could be available for immediate use? Standard: \_\_\_\_\_ Heavy Duty: \_\_\_\_\_
6. What Type(s) and Quantities of PPE do you typically have on hand for immediate use? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. How many vehicles do you have available for immediate use?
  - a) Hearses \_\_\_\_\_
  - b) Vans \_\_\_\_\_

## **APPENDIX 5: Mass Fatality Management Plan Development Checklist**

### Preparedness Phase

#### Cultural and Religious Sensitivity:

- Plan to assist in observing cultural and religious customs and rituals

#### Current Capacity:

- Assess the local capacity using the survey in Appendix 4
- Mail the funeral homes and crematoria the cover letter and the assessment tool in Appendix 4 and follow up with non-responders via telephone
- Assess the local capacity bi-annually
- Submit data to DHHS ESF-8 Coordinator

#### Temporary Interment / Storage during a Mass Fatality Incident:

- Designate the location in the AHHR for the refrigerated trailer

#### Security:

- Assign an entity to provide physical security and controlled access to the areas of temporary storage of bodies. Security also ensures the security of all personnel, equipment, and storage

#### Identification and Tracking of Bodies:

- Coordinate with Town Clerks in the AHHR to plan for data entry into the death certificate database
  - Attempt to have Town Clerks identify a back up person in the town office to be trained on entering death certificates into the death certificate database

#### Encourage funeral homes and crematoria to take the following mitigation steps in preparation for influenza pandemic:

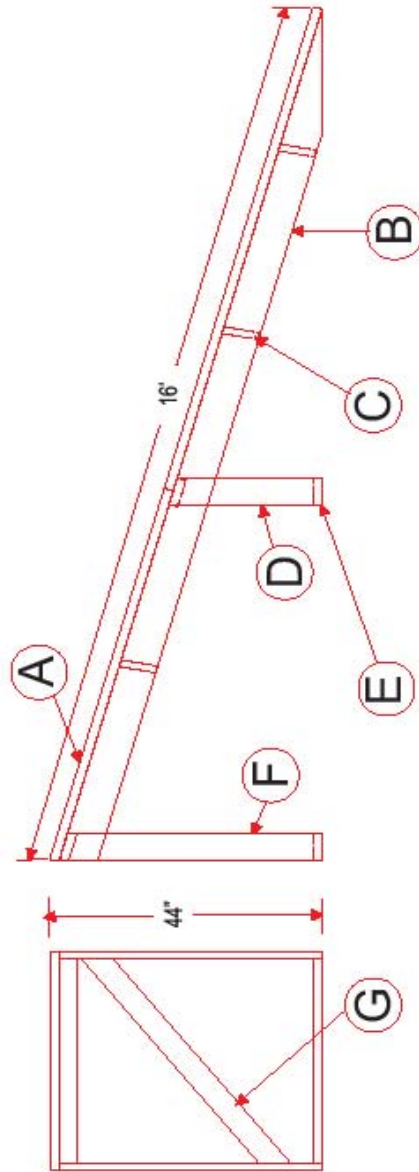
- Keep all Seasonal Influenza vaccinations for staff up-to-date
- Keep a surplus of supplies on hand to deal with an unexpected influx of bodies

### Response Phase

- Plan for fulfilling the roles and responsibilities of the MACE and Local Authorities in a Natural or Biological Mass Fatality Event as outlined in the State of New Hampshire Natural and Biological Event Mass Fatality Management Plan

**APPENDIX 6: Refrigerated Trailer Shelving and Ramp**

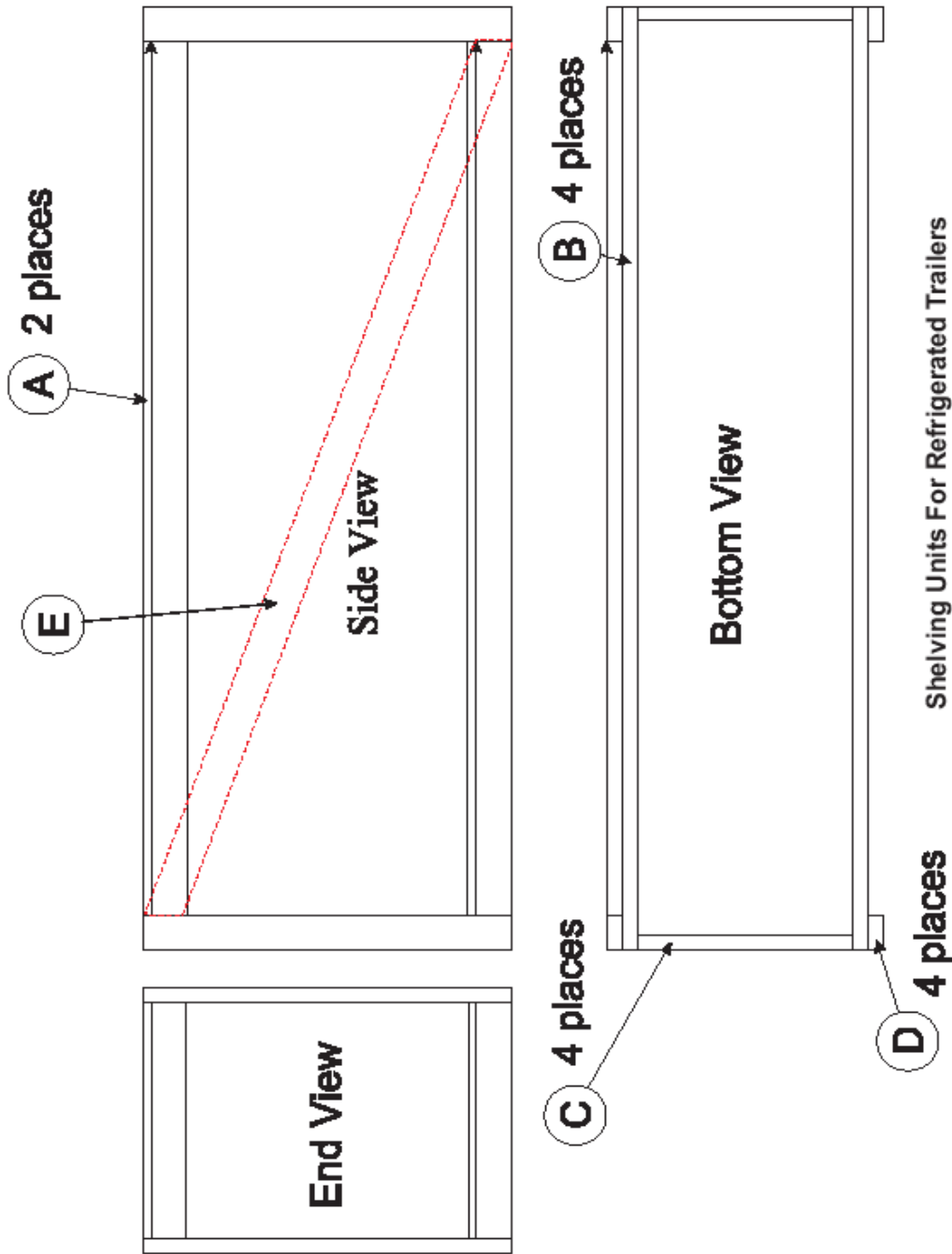
Refrigerated Trailer Ramp



# Refrigerated Trailer Ramp

## Material List

Item	Qty.	Description
A	2	3/4 x 4 x 8 CDX Plywood
B	2	2 x 6 x 16'
C	3	2 x 4 x 46 1/2"
D	2	2 x 4 x 32 1/4"
E	4	2 x 4 x 45"
F	2	2 x 4 x 43 1/2 "
G	1	2 x 4 x 67 1/2



## Shelving Units For Refrigerated Trailers

Each Unit consists of the following				Qty.
A	Shelf	24" x 96"	3/4" A/C Plywood	2
B	Frame side	2" x 4" x 96",	Framing Stock	4
C	Frame end	2" x 4" x 21"	Framing Stock	4
D	Leg	2" x 4" x 36"	Framing Stock	4
E	Brace	2" x 4" x 96"	Framing Stock	1

12 shelving units required per trailer

### Materials Required per trailer:

(12) Sheets 3/4 x 48 x 96 A/C Plywood

(96) 2 x 4 x 96 Framing Stock

**APPENDIX 7: Definition of Deaths under the Jurisdiction of the OCME**

**TITLE LIX  
PROCEEDINGS IN CRIMINAL CASES  
CHAPTER 611-B  
OFFICE OF THE CHIEF MEDICAL EXAMINER  
Section 611-B:11**

**611-B:11 Oath; Duty to Investigate in Medico-Legal Case. –**

I. Each medical examiner shall, before entering upon the duties of the office, take an oath of office.

II. A medical examiner shall make investigations in medico-legal cases. A medico-legal case exists when death is pronounced or remains are found indicating that a human has died and that death is known or suspected to have resulted from:

(a) Any death known or suspected to have occurred during or as a result of any criminal act regardless of the time interval between incident and death and regardless of whether criminal violence appears to have been the immediate cause of death or a contributory factor thereto.

(b) Any death by suicide regardless of the time interval between the incident and death.

(c) Any death due to accidental or unintentional injury regardless of the time interval between the incident and death and regardless of whether such injury appears to have been the immediate cause of death or a contributory factor thereto.

(d) Deaths associated with fire or explosion.

(e) Deaths associated with firearms or other mortal weapons.

(f) Any death which occurs in or associated with any public or private conveyance, including but not limited to any motor vehicle, recreational vehicle, bicycle, aircraft, watercraft, motorcycle, bus, train, or the like.

(g) Abortion or the complications thereof if the abortion was known or suspected to have been performed by an unlicensed practitioner.

(h) Poison, illicit drug use, or an overdose of any drug or medication.

(i) Disease, injury, or exposure to a toxic agent resulting from or occurring during the course of employment.

(j) Disease or agent which constitutes a public health hazard or environmental hazard.

(k) Sudden unexpected death when in apparent good health of a person under the age of 60 years.

(l) Death of a person whose medical care has not been regularly followed by a physician.

(m) Death occurring in legal custody, including any death that occurs in any prison or penal institution.

(n) Death associated with diagnostic or therapeutic procedures, including intraoperative and perioperative deaths.

(o) Death in which a body is to be cremated in the state of New Hampshire or buried at sea regardless of the jurisdiction in which the death occurred.

(p) Death occurring less than 24 hours after admission to a health care facility or hospital, except when the decedent was known to have been terminally ill from natural

disease and the death is imminent and expected.

(q) Death of a child under the age of 18 years unless the child is known to be terminally ill from natural disease or congenital anomaly and the death is expected.

(r) The death of any child from any cause when such death occurs at a day care facility, or when the child is in foster care, or when the child is in the custody of or being investigated by the department of health and human services.

(s) Fetal deaths that result from intrauterine trauma when the fetus has attained 20 weeks gestation or 350 grams weight.

(t) Death known to have been improperly certified, including but not limited to any remains brought into the state of New Hampshire without proper certification.

(u) Death of any unidentified person regardless of cause and manner.

(v) Discovery of buried remains which are known or thought to be human and which are uncovered other than by an exhumation order.

(w) The discovery of decomposed remains, including partially or completely skeletonized remains.

(x) Suspicious or unusual circumstances surrounding a presumed natural death.

**Source.** 2007, 324:1, eff. Sept. 14, 2007.

## APPENDIX 8: AHHR Regional Mass Fatality Plan Template

### [Name of AHHR/Region] Mass Fatality Plan

#### **Purpose**

The purpose of this plan is to outline the preparedness plans and response capabilities for this region to prepare for and respond to a mass fatality event.

#### **Scope**

The scope of this plan includes mass fatality events that are from naturally occurring disease events and are not events for which the Office of the Chief Medical Examiner would assume jurisdiction. This plan covers the geographical area of the region.

#### **Concept of Operations**

The fundamental assumption in this plan is that local capability to handle the number of deceased is exceeded. When this occurs, much of the response will be coordinated with the State *Naturally Occurring Disease Event Mass Fatality Management Plan*. The regional public health Multi Agency Coordinating Entity (MACE) will be the primary coordinating entity with the State.

#### **Capacity**

The [entity or position of person responsible] will bi-annually assess the capacity of the local hospital/s and funeral homes. Record of this capacity will be kept with this plan. A sample survey and letter can be found [in the State plan or attached as an appendix]. In addition to an annual survey, updates should be made whenever AHHR planners become aware of significant events within the region, such as a funeral home opening or closing.

#### **Temporary Storage**

When the region reaches [XX%] capacity during this type of event, the [entity or person responsible] will notify the Department of Health and Human Services (DHHS) Incident Command Center (ICC) that the region is nearing capacity and request a refrigerated trailer.

The refrigerated trailer will be placed at [name/address of location where trailer will be placed].

The personnel from [agency/organization] will be responsible for the trailer.

#### **Temporary Interment**

If refrigerator trailer capacity is also exceeded, more refrigerated trailers may be requested from the State. If refrigerated trailer capacity is exceeded and resources are exhausted, the Governor may determine that temporary interment should be implemented. The State will coordinate this effort and supply land, resources, and personnel. Bodies may need to be moved out of the region to temporary interment sites.

The [entity or position of person responsible] will coordinate these efforts with the State ICC.

**Security and Tracking of Bodies**

Responsibility for security for the refrigerated trailers and any local interment site is assigned to [local agency/organization]. A single entry access will be maintained to discourage unauthorized access. Entry will be limited to State and Federal personnel, AHHR authorities, and funeral homes. Family members should call the AHHR designated hotline to arrange to identify the remains of relatives being temporarily held or who have been temporarily interred and arrange to remove for burial or cremation.

Bodies will be tracked using the web-based death registration system of the State Division of Vital Records Administration (<http://www.sos.nh.gov/vitalrecords/>). In the event that timely web-based registration of death certificates becomes a problem for authorized healthcare practitioners and funeral home directors, town clerks have access to the registration system and may be able to help by entering information from paper death certificates. In the event that the system is unavailable, a tracking log should be used by the [entity designated by the MACE]. An example of a tracking log is given below:

Tracking Log				
Name, DOB	Cold Storage Facility	Storage Location Identification	Interment Facility	Date
	-	-	-	

When bodies are temporarily interred, Vital Records will record the locations of bodies interred in the death registration system. If the web-based registration system is unavailable, a tracking log will be kept. A record example is given below:

Interment Tracking Log		
Name, DOB	Interment Row GPS Coordinates	Date of Interment
Smith, Joe DOB 5/23/61	Universal Transverse Mercator (UTM)	01/01/07

The web-based death registration system will be used when filling out the death certificate for a body that is going to be placed in cold storage or temporary interment; the following fields can be used to track the location of the body through Vital Records:

- Field 18. Method of Disposition: Check *Other* and write in the type of storage (cold storage or temporary interment)
- Field 19b. Place of Disposition: Free Text the location of the body
- Field 19c. Location: Free Text City/Town Name

These fields can be updated if the deceased is moved to a different location.

**Religious and Cultural Communities Sensitivity**

During a mass fatality event every effort should be made to determine if the deceased came from a cultural or religious community for which certain customs and traditions should be observed in handling the body and making final arrangements. If no relative is available to advise in the final disposition of the body, assistance from local funeral home directors and religious leaders should be solicited to help determine if any customs should be considered regarding the deceased, and if so determined, to assist in observing those customs and rituals.

Religious and Cultural Communities in our Region Contact Information:

[List Organization Name, Contact Person, Phone, Email or attach as appendix]

**Behavioral Health**

Support for Counseling and Behavioral Health needs may be requested of the State Disaster Behavioral Health Team by contacting Homeland Security and Emergency Management at 800-852-3792.