Fatality Management Planning Guide

HOSPITALS

IMFC/AmericaReady

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FATALITY MANAGEMENT: YOUR GUIDE TO PLANNING

Welcome to the planning guide for fatality management. In this document, you will find all the necessary tools to develop and/or update your fatality management plan.

This guide is designed with a basic set of planning elements and a planning template that every fatality management plan should include. Each planning element includes a short description and, in most cases, a sample section that can be used in your plan development. The rest of the planning will be up to your planning team and the individual needs of your facility.

A planning template is attached at the end of the guide for your use. Each template contains the elements that are critical to your particular planning efforts. The remaining planning elements found in this guide are for educational purposes and to increase the level of understanding of fatality management planning from a community perspective.

The primary objectives to developing a fatality management plan includes the following but is not limited to:

- To ready your facility for managing a mass fatalities incident
- To identify decedent operational areas, the stakeholders and organizations responsible for these operational areas, and develop a plan for providing and for coordinating operational activities
- To specify the command and control structure, who will activate the plan, and criteria for levels of activation
- To provide logistics information that enables readiness and scalability
    - Supplies and equipment
    - Staffing requirements
    - Facility requirements
- To provide information on infection and other health and safety threats; fatality management information systems, pandemic influenza considerations, security requirements; family, cultural and religious considerations; and staff and volunteer management
- To describe how the plan will be exercised, updated and maintained

INTEROPERABLE PLANNING

Fatality management plans cannot be developed without considerations for other existing plans from emergency management, public health, hospitals, and the like. Every department, agency, organization or facility with a role in emergency planning will also have a seat at the planning table for fatality management.

Your fatality management plan should describe the relationship to other emergency plans. Begin by identifying other existing plans. Determine how the fatality management plan relates to the other emergency plans. Then consider creating an organizational chart to illustrate how the plans relate to each other.

Plan Response Time and Managing Expectations

A fatality management plan addresses mass fatalities incidents that occur both with and without warning and during on-duty or off-duty hours. When determining plan performance expectations or expected response time, determine what operations for which you want to specify response time and the many organizations involved in those operations. Some of the organizations may already have specified response times in their existing plans and protocols for their area of responsibility.

HOSPITAL PLANNING

In addition to all the basic planning elements, this guide contains items that are specific to fatality management planning in a hospital setting. Inclusion of the basic elements and coordinating with external fatality management planning efforts will help to ensure that hospital fatality management plans are consistent with external plans.

In a mass fatalities Incident, hospitals will likely be alerted and notified about the incident by either the on-scene incident command or the medical examiner. This early warning enables the hospitals to prepare for multiple patients, begin the process of standing up any alternate care centers or request additional anticipated resources.

The hospitals are responsible for the following:

- Triage, treatment, and support non-fatal casualties at their facility
- Dissemination of information to victims' families in collaboration with a community Family Assistance Center
- Storage of remains, if appropriate

- Work closely with the local Emergency Medical Services, Emergency Management Agency and the medical examiner to help track patients and fatalities

If any part of the mass fatalities infrastructure—remains recovery, Victim Identification Center, family assistance, public information, and the vital records system—is not prepared and able to carry out its critical function, the entire fatality management infrastructure will be negatively impacted.

HOSPITAL MASS FATALITIES INCIDENT PLANNING TEAM

The team is responsible for initial organization and plan development. Consider 1: How the list below might be expanded or organized so that specific steps are included, and 2: How the team might organize the tasks.

1. Initial organization, fact-finding, resource evaluation (including staff)
    a. Which staff will need to be involved?
    b. What are the resources for gathering information?
    c. What supplies, equipment and staffing are on hand at this time that will be used during a response to a mass fatalities incident? What supplies, equipment, and staffing are needed?
2. Coordination with community partners
    a. Who will be involved?
    b. What is the best method to communicate with community partners?
3. Fatality management plan development
    a. Who is responsible?
    b. What is the timeline?
    c. Who will the mass fatalities plan/annex be shared with?
4. Develop procedures for:
    a. Decedent identification and tracking
        - What are the key elements of a tracking system?
        - What is the procedure for next of kin notification?
    b. Decedent storage
        - What will you include in a decedent storage procedure/SOP?
    c. Decedent transportation
        - How will remains be transported?
        - How will communications for transportation be coordinated?
    d. Personal belongings preparation

- Identified with next of kin
- Identified without next of kin (or abandoned)
- Unidentified decedent

e. Death certificate processing
   - Is there need for an expedited process?

f. Body preparation
   - Sheeting or wrapping
   - Decontamination, if needed
   - Identifying documentation
   - Other documentation

g. Other procedures that need to be developed?

5. Assessing current morgue capacity

6. Options for surge capacity

h. In-house
i. In the community
j. Commercially available secondary systems

7. Coordination of staff training on mass fatality incidents

a. Who is responsible?
b. Task: write a training schedule for staff

8. Coordination of exercises for mass fatality incidents

HOSPITAL PLANNING QUESTIONS

Planning is all about preparing for an outcome to a given situation. A disaster plan is designed to help us know the ***how***, ***who***, ***what***, ***when***, and ***where*** if we should have to respond. Plans are supposed to provide the answers on how we will respond, who will respond, what will be needed to respond, when will certain activities take place, and where will get the resources we need to respond. Fatality management planning has its own set of questions that also help further refine your plan. Utilize these questions and this information in this guide to help ensure your plan contains all of the necessary information your facility needs to respond to a mass fatalities incident.

1. What are the management priorities of your organization for handling remains? What key assumptions are these priorities based upon?
2. Does your organization have a written fatality management plan in place? If so, who has the authority to activate these plans and/or procedures, and have you trained to the plan?

3. Do you have staff and resources identified that will be dedicated to mass fatalities incident management?
4. What are the possible bottlenecks in the procedures for processing remains? Have any solutions been developed and/or implemented to mitigate these issues?
5. What is the capacity of your morgue? Do you have alternate on-site and off-site surge morgue capacity? Do you have memoranda of understanding in place (if applicable)?
6. Do you have staff and resources identified that will be dedicated to surge morgue management?
7. To what extent can technology assist with the processing of remains?
8. What legal hurdles, if any, does your organization or jurisdiction face when executing your fatality management plan? How will your organization and jurisdiction deal with them to ensure that the processing of remains is not delayed or otherwise stalled by legal matters?
9. What reputation management issues could arise if your facility does not adequately manage a mass fatalities incident? Do you have a public Information Plan in place at your facility that can be used in a mass fatalities incident? If so, does that plan have pre-scripted messages for handling a mass fatalities incident?

FATALITY MANAGEMENT PLANNING ELEMENTS

These elements coincide with sections of the Hospital Fatality Management Plan Template.

INTRODUCTION

Description: A common introduction should be developed for all fatality management plans that convey a shared message. Additional information should be tailored to fit each individual plan according to the needs of that department, agency, organization, or facility.

Introductions should include basic information as to the definition of a "Mass fatalities Incident" or MFI. It is recommended that all plans in the SE Minnesota region use shared terminology and definitions to avoid confusion.

PLAN MAINTENANCE AND DISTRIBUTION

Description: All fatality management plans should include a detailed section regarding how the plan should be maintained, how it should be distributed, and when these activities should take place. Annual reviews are recommended with periodic updates for resource and contact information.

Hospital plan maintenance should include:

- A schedule for plan review and updates
- A description of who is responsible in-house for plan review and updates
- A list of stakeholders that should be included in the update process
- A description of the approval process for updates

PURPOSE AND SCOPE

Description: A common message for the purpose and scope should be developed for each fatality management plan. Additional information should be tailored to fit each jurisdiction.

Purpose

The fatality management plan provides an overview of how identification and statutory services will be established in the event of a mass fatalities incident.

The fatality management plan provides a framework in support of the ME/Coroner efforts during mass fatalities incidents. The ME/ Coroner assumes the lead role in coordinating the activities of all public and private agencies engaged in a mass fatalities incident.

Scope

An effective response to a Mass Fatality incident will require coordination of not only the critical field response, but of the many expected missions in support of those specialized activities.

This plan assumes that the hospital may be without major Federal assistance for up to 72 hours.

This plan:

- Describes the activation process by which a hospital response and resources are engaged in a mass fatalities incident
- Is designed to work in concert with the activated Community Fatality Management Plan
- Does not supersede existing hospital administrative rules or County laws

AUTHORITIES AND REFERENCES

All fatality management plans should include all relevant local, state, and federal authorities and references as determined by the department, agency, organization, or facility and other key stakeholders. The section should include brief information for each authority listed.

SITUATION AND ASSUMPTIONS

Situations and assumptions should be tailored to fit each jurisdiction. Unique planning challenges exist in a number of counties that may require more detailed information.

CONCEPT OF OPERATIONS

The fatality management plan should include a Concept of Operations or ConOps that is similar in format and structure. Details should vary based on jurisdictional need and capability. The ConOps is a brief overview of how fatality management operations will flow.

All fatality management plans policies and procedures should be integrated to coordinate with surrounding departments, agencies and organizations plans.

PLAN ACTIVATION NOTIFICATIONS

Include notification actions for when the plan is activated.

INCIDENT MANAGEMENT

Describe how incident management occurs.

MORGUE SURGE

Each fatality management plan should describe morgue surge options, which should consider the following:

- Storage of Remains
- Contaminated Remains

Storage of Remains: remains, prior to transfer to the Coroner/Medical Examiner or selected funeral home/mortuary, should be placed in secure storage in [insert room number and or location description]. Special Note: Morgue facilities for storing remains should be capable of sustaining a temperature of 1.1-4.4 degrees Celsius (34-40 degrees Fahrenheit). If the proper temperature is not attainable, the Coroner/Medical Examiner should be promptly informed and an alternative storage venue should be identified. If a funeral home/mortuary has been selected by the family or Coroner/Medical Examiner, coordination with the funeral home/mortuary will be beneficial to expedite a resolution to the storage temperature problem. Other considerations for a functional hospital morgue include:

1. Integrated back-up electrical power and HVAC
2. Close proximity to transportation staging area that offers privacy from public view
3. Access to communications resources (e.g. telephone, fax, computer/internet)
4. Ability to be secured for limited/authorized access
5. Access to hand washing facilities
6. Access to PPE
7. Non-porous flooring
8. Adequate ventilation
9. Call local Emergency Management Agency when facility capacity is exceeded

Hazardous Material Decontamination: In the event that the deceased remains are contaminated either due to the inability to effectively decontaminate or as the result of a decision to preserve forensic evidence, careful attention to safety must be maintained. If decontamination is to be undertaken, the hospital's, or community HazMat Team, current

decontamination procedures should be followed. In the event that successful decontamination is compromised (e.g. off-gassing of cyanide), further consultation from appropriate resources may be appropriate such as the [Insert name of community designated Haz-Mat Decon Response Team and contact number], and Poison Control Center.

RELEASE OF REMAINS

Describe the process for release of remains.

MULTIAGENCY COORDINATION

A mass fatalities response often requires the support of several other departments, agencies, organizations or facilities. Each plan should include a section for multiagency coordination or outside support. This section should outline ***what*** steps are needed to request or notify that support (and under what circumstances it can be requested or notified), ***who*** is responsible for those requests or notifications, and ***how*** that support will be integrated into your overall response.]

RESOURCE COORDINATION

Mass fatalities response operations are very resource intensive events. Mass fatalities incidents can be either man-made or natural events. In the case of man-made events, financial claims for reimbursement will or can be made against an entity that is deemed responsible for the incident. Regardless of the cause, it is necessary to maintain detailed records of costs and expenditures in the event reimbursement is possible.

The plan should include a list of the basic resource requirements necessary to meet a minimum response in a mass fatalities incident (based on your own unique trigger or number of deaths that defines a mass fatalities incident in your facility.) The resource requirements list can be added as a checklist to ease an annual inventory and update process and should include all of those items needed to meet every phase of the response from plan activation, mobilization or resources, operations, and demobilization. The process for doing an annual update or inventory should also be documented.

In addition to the resource requirements list, the process for coordinating resources should be included in the plan. Any resource that is acquired or shared through outside sources should be thoroughly documented according to ***what*** resources may be need, ***where*** the resource can be acquired, ***who*** can make the request, what the ***resource request process*** is, ***how*** the resource will be physically obtained and returned (if necessary).

CHAIN OF CUSTODY

Tracking decedents or maintaining a chain of custody in the hospital setting is an important piece of the hospital fatality management plan. While it is understood that most patients triaged as "red" or "expectant" will be at hospitals, it can be anticipated that some such patients will present to clinics in disaster situations. As such, it is important that clinics have mechanisms in place to support the successful tracking of decedents.

Develop a Decedent Tracking Log. Ensure that this form is utilized and maintained properly during a disaster.

Develop a process for patient information to be utilized for the "matching" process, whereby unidentified decedents are recognized as other definitive identifying information becomes available.

Develop an address or locator process to quickly identify where a decedent is being stored (such as Exam Room 1D). This can also be monitored on the Decedent Tracking Log if the decedent needs to be moved from one decedent storage area to another within the facility.

Planners should explore ways to ensure as many decedents as possible are directed to mortuaries. Key considerations include:

- Contact mortuary/ME/Coroner to discuss methods to expedite decedent release.
- Ensure that all necessary documentation is completed on the part of the healthcare facility.
- For scenarios that call for physicians to sign death certificates (e.g. pandemic), coordinate just-in-time training for physicians regarding the signing of death certificates. Consider the activation of the "Physician in Charge" death certificate signing method, if practiced and part of facility policy.
- Advise admissions staff to collect decedent processing information from patients as part of the admissions process, to include preferences regarding mortuaries, burial/cremation, and religious/cultural practices as appropriate.

If a hospital's capacity to manage fatalities has been overwhelmed AND a Victim Identification Center has been activated, the following should be considered prior to transporting decedents:

- ALL who interface with the deceased should record official personal identification information (first, middle, last name and suffix; race/ethnicity, color of eyes, hair, height, and weight; home address, city, state, zip and telephone number; location of

death and place found; place of employment and employer's address; date of birth, social security number and age; and next of kin—or witness—name, contact number and address).

- To ensure proper identification of the deceased, consider implementing standardized methodology for collecting samples of deceased such as a right thumbprint, DNA sample (e.g., saliva swab or blood stain card), and a facial photograph. In the case of decomposed bodies, this may also include assistance from the ME/Coroner for identification—anthropological markers, dental impressions, and, if possible, fingerprints, etc.
    - Although these identification samples may not need to be processed, those in authority are able to substantiate the identification of the decedent at a later time should individuals question the ME/C about a decedent's identity.
- Healthcare facilities may want to consider designating a single physician, familiar with patients' records, as responsible for expeditiously signing death certificates.
- Consider pre-identifying "collection points" for the deceased to centralize processing and hold remains at the lowest appropriate local level. Have an authorized person certify deaths en masse and batch process death certificates of identified decedents to improve efficiency.
- At the designated collection point, trained personnel should sort bodies by cause and manner of death (identified pandemic influenza cases vs. ME/Coroner cases) to ease subsequent processing (victim identification and issuing a death certificate).
    - Attended deaths will have a known identity and may have a signed death certificate. Unattended deaths may require the ME/Coroner to further process remains to determine identification, issue the death certificate, track personal effects, and notify next of kin.
- Establish a uniform method for numbering and tracking decedents, such as the state abbreviation, zip code, and a case number (with name if identified).
- When moving, storing, and/or releasing remains and personal effects, keep detailed records like that of a chain-of–evidence for each individual decedent and personal effects bag.

VOLUNTEERS & CREDENTIALING

Describe the process for volunteer management and credentialing.

PSYCHOLOGICAL FIRST AID

The hospital should plan for the mental health of staff. Describe in this section the plan for staff behavioral health support.

FAMILY ASSISTANCE CENTER

Hospitals should have a plan to provide for family assistance during disasters. ***A Family Assistance Center (FAC) is generally a community-based operation, but the hospital plan should include family assistance functions and include procedures for integrating activities into the community FAC operations.*** The purpose of a **Family Assistance Center (FAC)** is to provide a safe and private place, protected from the media, for families of deceased, missing or injured survivors to grieve and/or wait for information regarding their loved ones and the status of rescue or recovery activities. This is often the location where families will be informed about the positive identification of their loved one(s).

Key activities provided by various agencies include:

- Providing privacy and support services to grieving families
- Security from media and curiosity seekers
- Facilitating information exchange between ME offices, local officials and the families in order to assist in identification of victims
- Providing death notification, to facilitate the processing of death certificates and release of remains
- Providing information about recovery efforts

DEMOBILIZATION

The plan should include a documented process for how response operations will be discontinued and demobilized once the response phase has been completed. Be sure to include ***who*** has the authority to deactivate operations (and under what circumstances), ***what*** notifications need to be made, and all other steps that need to be taken to ensure that day-to-day operations can resume as normal.]

APPENDIX C (IN TEMPLATE) POLICIES

There may be special situations in which specific policies may need to be included in your planning. These policies should only be used as guidance in creating your own policies that meet the needs of your hospital.

TRANSPORTATION

Planning for the transportation of remains from the hospital should be done in coordination with the medical examiner. Other considerations for the transportation of remains from the hospital include coordination with funeral homes, emergency management, and transport companies that would be supporting the activity. All transportation activities to and from the facility should be documented in the plan.

PUBLIC INFORMATION

A trained and experienced public information officer (PIO) from the hospital is an integral member of the Joint Information Center (JIC) staff for a mass fatalities incident. The local EMA will work with the medical examiner or medical examiner representative and representatives from the incident site, Victim Identification Center and Family Assistance Center for news conferences and interviews as requested by the Joint Information Center (JIC).

When requested, medical examiner/coroner's office will provide information to the JIC to coordinate the release of information to the media and public. All media requests should be funneled through the JIC. If information is requested by the media from the ME staff-staff should not release information. They should let their supervisors know, who will, in turn notify the JIC.

DATA/INFORMATION MANAGEMENT

Vital Records:

It is critical that death certificates be processed accurately.

1) Death certificates issued according to procedures normally in place and as directed by the ME

2) The administrative or judicial issuance of death certificates in situations in which there is an absence of positive physical forensic scientific identification is a responsibility of the ME in conjunction with local legal and public health authorities. (Presumption of death from absence, MN statue **576.141)**

3) When circumstances suggest that a death has occurred although a dead body cannot be produced to confirm the fact of death, a death record shall not be registered until a court has adjudicated the fact of death. (**144.221 sub 3)**

TRAINING AND EXERCISES

Multi-year Training and Exercise Plans should include information and guidance for exercise and training recommendations for all personnel and other key stakeholders involved with the fatality management plan.

Exercises provide training and practice for emergency events that test readiness, evaluate the fatality management plan, and provide detailed feedback for your facility. Even though exercises can be costly and time consuming, they are the best way to test a plan prior to an actual mass fatalities incident.

In the multi-year training and exercise plan, present a strategy for training and exercises, including:

- The functions and/or parts of the plan that you will exercise.
- The type of exercises.
- How you will evaluate the exercises.
- A time frame within which each exercise will be done

Information and guidance for developing a fatality management training and exercise plan should be integrated with existing policies and procedures and coordinated with the departments, agencies, organizations, or other facilities that would support your response to a mass fatalities incident. This plan should be established to keep staff up-to-date and orient new employees to the Plan. Remember to train with those departments, agencies, organizations, or other facilities that support your fatality management plan.

HOSPITAL PLANNING CHECKLIST

In addition to the planning elements described in this guide, this checklist contains items that should be included on a hospital fatality management plan.

Additional Hospital Planning Elements	
1. General Plan Requirements	Completed
• Integrate with other pertinent protocols in facility's comprehensive Emergency Operations Plan, including activation of hospital incident command system (ICS)	
• Identify back-up measures for key components wherever appropriate	
• Assign responsibilities and formal process for review and update of plan, including incorporation of after action report results (utilize AARs for exercise and live events)	
• Develop staff training including plan overview, specific roles and responsibilities, utilization of mass fatality equipment, and knowledge of primary/surge morgue areas	
• Identify points of contact for information on fatality management resources 1. Medical Examiner 2. Funeral Directors 3. Cultural and Faith-based community contacts 4. Vendors that support surge plans (e.g., refrigerated trucks)	
• Uses standard terminology in common and consistent plain English language and emphasize its use by staff during a fatality management plan activation	
2. Activation	Completed
• Define criteria and authority for decision to activate the plan	
• Define the plan for communication and coordination with the Coroner/Medical Examiner, SEMN Healthcare Multi-Agency Coordination Center and the operational area Incident Command Center (e.g., EMS DOC or EOC)	
• Identify and/or reference Crisis Communication/Public Information Plan	
3. Incident Management	Completed
• Identify the lead person to implement the hospital's Fatality Management Plan	
• Develop or adopt hospital specific Job Action Sheets for Fatality Management positions under an ICS structure (HICS) (Refer to Appendix B for an example Job Action Sheet.)	
4. Communication	Completed
• Assign responsibility for maintaining communication with the Hospital Command Center to receive mortality estimates in order for Logistics to anticipate and provide needed administrative and morgue equipment	
• Define the process for communications with local government point of contact (Liaison Officer or designee)	
• Define the process for contacting County Emergency Medical Services (EMS) – Departmental Operations Center (DOC) and/or facilities (Liaison Officer or designee)	
• Define the process for contacting the Medical Examiner (i.e., case reporting, status	

updates) during an activation	
5. Morgue Surge	Completed
• Identify current morgue capacity: number and location (May also be labeled Primary Morgue)	
• Identify surge capacity morgue: number and locations (May also be labeled Secondary, Surge, or Temporary Morgue)	
• Consider identification of a tiered level with triggers to prompt activation of a surge morgue. This may be the result of the number of decedents (escalation and de-escalation), new resources available, the viability of the current location, etc.	
6. Staff Training and Exercises	Completed
• Develop staff training to include plan overview, specific roles and responsibilities, utilization of equipment, supplies, notification, decedent tracking, and secondary or surge morgue areas	
• Conduct and track staff training on plan overview, specific roles and responsibilities, utilization of equipment, supplies, notification, decedent tracking, and secondary or surge morgue areas	
• Assign responsibilities and formal review process, including incorporation of after action report results and updates	
• Incorporate fatality management plan into exercise program, including specific objectives in future exercises	
7. Resources	Completed
• Identify a list of mental/behavioral health, community and faith-based resources to provide counseling to personnel during a mass fatalities incident	
• Identify Personal Protective Equipment (PPE) needed	
• Identify local/city/county/regional caches	
8. Tracking and Next of Kin Notification	Completed
• Develop a process to identify decedent (such as DNA swabs, photos and/or fingerprints) and attach hard copy to the outside of the body bag.	
• Develop a process to track decedents	
• Describe the process for assignment of staff members to conduct and track family/responsible party notification.	
• Develop and/or follow standard operating procedures to identify, protect decedent personal property, including transfer to next-of-kin, Medical Examiner, law enforcement, or funeral director.	
• Develop and/or follow standard operating procedures to maintain integrity and chain-of-custody of decedent personal property if identified as potential evidence.	
9. Recovery, Reverting to Daily Morgue Plans	Completed
• Develop criteria and responsibilities for closing temporary or surge morgue site and reverting to primary morgue	
• Define process to address staff stress and debriefing	
• Identify plan to restock supplies and equipment	

EXAMPLE DECENDENT MANAGEMENT POLICY/PROCEDURE

Policy

It is the policy of the hospital to appropriately prepare, store and arrange for the disposition of a patient's body and belongings after a patient has expired and has been declared deceased by a licensed physician. In all cases, the body of the deceased will be treated in a manner that maintains dignity and respect with every effort made to assist in the arrangement of disposition consistent with the cultural and religious wishes of the deceased and/or family.

Procedure

1. *Personal Protection: Any persons handling remains (e.g. hospital staff, Medical Examiner, funeral home staff), if the patient died of or was recently exposed to an infectious disease, shall be notified. As a general rule, all personnel who remains should take protective precautions including:*
    - *Wear disposable long-sleeved cuffed gown (should be waterproof if exposure to body fluids is anticipated)*
    - *Wear non-sterile gloves covering the cuffs of the long-sleeve gown;*
    - *Wear a surgical mask capable of filtering respiratory particulate if handling the body immediately after death*
    - *Wear surgical cap and face shield if exposure to body fluids is anticipated;*
    - *Wear water-proof shoe-covers if exposure to body fluids is anticipated;*
    - *Maintain proper hand washing*

1. Personal Belongings: As a general rule, jewelry, wallets, purses and other valuable should not accompany the body to the hospital morgue. Jewelry or other valuables should be labeled with the patient's full name, address, telephone number, and hospital record number. Jewelry or other patient valuables may be given to a spouse or next of kin as documented in the patient record, unless the death has been determined to be a Medical Examiner case. If next of kin are not available, the inventoried items should be sent to a secured storage location or accompany the patient to the morgue. Any jewelry that remains on the body or is sent to the secured location should also be clearly documented in the patient record.
2. Location of Death: Document location death occurred (e.g. In-patient unit, ancillary department, OR, PACU, Labor and Delivery). Each location may require attention to procedures and notifications trees that are sensitive to the needs of that location. (Insert list of procedures and reference here)

3. Medical Examiner/Coroner Case: Incidents of reportable deaths should be communicated to the Medical Examiner/Coroner's Office. Cases that may result in Medical Examiner jurisdictions are those that may have impact on the public interest. Such cases generally include:
   - Violent deaths, which include homicide, suicide, or accidental death resulting from physical, mechanical, thermal, electrical, or radiation injury
   - Deaths related to disease thought to be virulent or contagious, with may constitute a public health hazard
   - Persons who die suddenly when in apparent good health
   - Suspicious circumstances
   - Unknown or obscure causes
   - Unclaimed/unidentified remains

The Medical Examiner/Coroner may take jurisdiction over an apparent natural death if the death was unexpected and no medical cause can be determined; if the deceased was not under the care of a physician for any disease, which could reasonably be expected to cause death; and if death might be due to a public health hazard. In the event that the Medical Examiner retains custody of the case for further investigation and/or autopsy, the following should be noted:

1. Any material removed from the body (e.g. knives, bullets, personal effects) should be considered as forensic evidence and preserved to maintain a chain of custody. Such items should be wrapped, labeled with patient's full name, address, telephone number and hospital record number and placed next to the body but NOT in the shroud

2. The body should not be cleansed prior to transfer to the hospital morgue

3. A hospital staff member must be present at all times when family/significant others view the decedent

4. All indwelling tubes, needle, catheters, etc. are to be left in place. Exceptions may be made in neonatal and/or pediatric cases when tubes/lines are judged to be non-essential to the autopsy. For permission to remove non-disposable items or any other questionable tubes, lines or needles, the County Medical Examiner should be contacted. In the case of a hospital autopsy, the pathologist on-call should be contacted