

Charles County COVID-19

Incident Action Plan



Operational Period

From
4/23/20
8:00

To
4/25/20
8:00



INCIDENT OBJECTIVES (ICS 202)

1. Incident Name Charles County COVID-19	2. Operational Period	Date From: 4/23/20	Date To: 4/25/20				
		Time From: 8:00	Time To: 8:00				
3. Objectives							
<p>A. Ensure the safety and overall health and well-being, including mental health of the residents, county employees, and responders, throughout this incident.</p> <p>B. Conduct surveillance of COVID-19 cases in collaboration with the health department, hospital, physicians, and other health care providers.</p> <p>C. Maintain timely, accurate and uniform communications with residents, employees and first responders as well as partners in the tri-County and National Capital Region and the state of Maryland.</p> <p>D. Prepare for and handle the human reaction crisis contingencies in long terms.</p> <p>E. Prepare for long term order maintenance.</p> <p>F. Prepare for and sustain our communities' hierarchy of needs throughout this incident.</p> <p>G. Determine trigger points for Continuity of Operations for all agencies, including government, public safety, schools, hospital, and other critical infrastructure systems.</p> <p>H. Ensure all practical steps to "Slow the Spread" of transmission of COVID-19.</p>							
4. Operational Period Command Emphasis							
<p>Use the recommended PPE on all calls, take all the necessary precautions. PPE recommendations need to be followed 100% especially in nursing homes, and areas with groups of non-ambulatory patients.</p>							
General Situational Awareness							
<p>"The New High Five! Elbow bumps help prevent the spread of COVID-19 and still make you feel good!"</p>							
5. Site Safety Plan Required? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Approved Site Safety Plan(s) Located at:							
6. Attachments (check if attached) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <input checked="" type="checkbox"/> ICS 203 <input type="checkbox"/> ICS 207 <input type="checkbox"/> ICS 204 <input checked="" type="checkbox"/> ICS 208 <input type="checkbox"/> ICS 205 <input type="checkbox"/> Map/Chart <input checked="" type="checkbox"/> ICS 205A <input type="checkbox"/> Weather <input type="checkbox"/> ICS 206 <input type="checkbox"/> Forcast/Tides/Currents </td> <td style="width: 50%; padding: 5px;"> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </td> </tr> <tr> <td colspan="2" style="text-align: right; padding: 5px;"> ICS 214 <hr/><hr/><hr/><hr/> </td> </tr> </table>				<input checked="" type="checkbox"/> ICS 203 <input type="checkbox"/> ICS 207 <input type="checkbox"/> ICS 204 <input checked="" type="checkbox"/> ICS 208 <input type="checkbox"/> ICS 205 <input type="checkbox"/> Map/Chart <input checked="" type="checkbox"/> ICS 205A <input type="checkbox"/> Weather <input type="checkbox"/> ICS 206 <input type="checkbox"/> Forcast/Tides/Currents	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	ICS 214 <hr/> <hr/> <hr/> <hr/>	
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ICS 214 <hr/> <hr/> <hr/> <hr/>							
7. Prepared by: Name: <u>Joe Hoffmaster</u> Position/Title: <u>PSC</u> Signature: _____							
8. Approved by Incident Commander: Name: <u>Michelle Lilly</u> Signature: _____							
ICS 202	IAP Page <u>2</u>	Date/Time: <u>April 21, 2020 @15:00</u>					

ORGANIZATION ASSIGNMENT LIST (ICS 203)

1. Incident Name Charles County COVID-19		2. Operational Period Date From: 4/23/20 Date to: 4/25/20 Time From: 8:00 Time to: 8:00		
3. Incident Commander and Staff		7. Operations Section		
UC	Dr. Howard Haft	Chief		
UC	Michelle Lilly	Deputy		
Deputy	Melanie Gardiner			
Deputy	Tony Rose			
Safety Officer	John Filer	a. Branch I	Public Health	
Public Information Office	Jennifer Harris	Branch Director	Ranston Harvey	
Intell Officer	Jason Stoddard	Deputy	Mary Lilly	
4. Agency Representative		DSS		
		Liaison Officer	Tom Brown	Robbie Jones
Agency	Name	Hospital	Bill Grimes	John Filer
Intell officer Deputy	Mike Meiser	Nursing Homes	Tiffany Brown	
Lifestyles	Sandy Washington	Health Care Providers	Melanie Gardiner	
Public Schools	Mike Meiser	Rehab Centers	Eddie Kratzer	
		Assisted Living	Rosalinda Horton	
		Funeral Services	Cataria Patterson	
		b. Branch II	Public Safety	
		Branch Director	Mark Kaufmann Jr.	
		Deputy	Scott Herbert	D J Mills
		DES EMS	Steve Finch	
		Vol EMS	Andrew Spalding	Mitchell Lewis
		Vol Fire	Scott Herbert	
		Logistics	Scott Herbert	
5. Planning Section		c. Branch III	Law Enforcement	
Chief	Joe Hoffmaster	Branch Director	Chris Schmidt	
Deputy	Bill Smith	Deputy	Cari Baker	
Resource Unit		La Plata Police	Chris Becker	
Situation Unit	need to fill	MD State Police	Thomas Quade	
Documentation Unit	need to fill	DNR	Catherine Meddelin	
Demobilization Unit		MdTA	Brian Lawrence	
Human Resources				
Technical Specialists	(name / specialty)	d. Branch IV	Infrastructure	
		Branch Director		
		Deputy		
		SMECO	Jennifer Raley	
		Grocery		
6. Logistics Section		Propane		
Chief	Nick Ellis	Natural Gas		
Deputy	Lori Cherry			
Support Branch				
Donations	Ed Tucker			
Supply Unit				
Facilities Unit	Nick Ellis	10. Finance Section		
Ground Support Unit		Chief	Jennifer Adams	
Service Branch		Deputy		
Service Branch Dir.		Time Unit		
Communications Unit		Procurement Unit		
Medical Unit		Comp/Claims Unit		
Security Unit		Cost Unit		
Food Unit				
9. Prepared by: Name: Joe Hoffmaster		Position/Title: PSC Signature _____		
ICS 203	IAP Page 3	Date/Time: April 22, 2020 @ 15:00		

ORGANIZATION ASSIGNMENT LIST (ICS 203)

1. Incident Name Charles County COVID-19		2. Operational Period Date From: 4/23/20 Date to: 4/25/20 Time From: 8:00 Time to: 8:00		
3. Incident Commander and Staff		7. Operations Section		
UC	Dr. Howard Haft	Chief		
UC	Michelle Lilly	Deputy		
Deputy	Melanie Gardiner			
Deputy	Tony Rose			
Safety Officer	John Filer	a. Branch V	Governance	
Public Information Office	Jennifer Harris	Donna Fuqua		
Intell Officer	Jason Stoddard			
4. Agency Representative		Charles County Govern.	Michele Lilly	
Agency	Name	Town of LaPlata	Chris Becker	
Intell officer Deputy	Mike Meiser	Town of Indian Head	Ryan Hicks	
Lifestyles	Sandy Washington			
CC Public Schools	Michael Meiser			
		b. Branch VI	Business	
		Branch Director	Darre'll Brown	
		Deputy	Marcia Keeth	
		Economic Development	Darre'll Brown	
		Chamber of Commerce	Bonnie Grady	
5. Planning Section		c. Branch VII	Peer Support	
Chief	Joe Hoffmaster	Branch Director		
Deputy	Bill Smith	Deputy		
Resource Unit		CISM		
Situation Unit	need to fill			
Documentation Unit	need to fill			
Demobilization Unit				
Human Resources				
Technical Specialists	(name / specialty)	d. Branch VIII		
		Branch Director		
		Deputy		
6. Logistics Section				
Chief	Nick Ellis			
Deputy	Lori Cherry	e. Branch IX		
Support Branch				
Donations	Ed Tucker			
Supply Unit				
Facilities Unit	Nick Ellis	10. Finance Section		
Ground Support Unit		Chief	Jen Adams	
Service Branch		Deputy	need to fill	
Service Branch Dir.		Time Unit		
Communications Unit		Procurement Unit		
Medical Unit		Comp/Claims Unit		
Security Unit		Cost Unit		
Food Unit				
9. Prepared by: Name: Joe Hoffmaster		Position/Title: PSC	Signature _____	
ICS 203	IAP Page 4	Date/Time:	April 22, 2020 @ 15:00	

COMMUNICATIONS LIST (ICS 205A)

1. Incident Name Charles County	2. Operational Period: COVID-19	Date From: Time From:	4/23/20 8:00	Date to: Time to:	4/25/2020 8:00
3. Basic Local Communications Information:					
Name - Last	Name-First	Representing	Email	Phone	
Adams	Jennifer	DES FSC	AdamsJen@Charlescountymd.gov		
Baker	Cari	CCSO	bakerce@ccso.us		
Becker	Chris	La Plata Police	cbecker@townoflaplata.org		
Brown	Darrell	Business Director Econ Dev	Brownd@charlescountymd.gov		
Cress	Lauri	Charles Regional Medical Center	lauri.cress@umm.edu		
Ellis	Nick	DES- Logistics	DESLogistics@charlescountymd.gov		
Filer	John	DES- Liaison	FilerJ@charlescountymd.gov		
Finch	Stephen	DES	FinchS@charlescountymd.gov		
Fuqua	Donna	PIO	Fuquad@CharlesCountyMD.gov		
Harris	Jennifer	PIO	HarrisJ@CharlesCountyMD.gov		
Hoffmaster	Joe	Planning Section	DESPlanning@charlescountymd.gov HoffmasJ@CharlesCountyMD.gov		
Kaufmann	Mark Jr	PS Branch Dir. Vol Fire Chief	markeng1trk@hotmail.com		
Konschak	Matt	NSWC IHD	matthew.konschak@navy.mil		
Lilly	Michelle	CCDES Director, Unified Command	LillyM@charlescountymd.gov		
Lilly	Mary	C C Dept. of Health	Mary.Lilly@maryland.gov		
Lowry	Susan	MDH	suzan.lowry@maryland.gov		
Mills	D.J.	Vol Fire- Special Operations Chief	djm31_9@hotmail.com		
O'Malley Simpson	Katie	CCBOE PIO	Komalley@ccboe.com		
Proctor	Destiny	DES	proctord@charlescountymd.gov		
Quade	Thomas	MSP	Thomas.Quade@maryland.gov		
Rose	Tony	DES Deputy Director, Unified	RoseT@charlescountymd.gov		
Russell	Cindy	DSS	cindy.russell@maryland.gov		
Schmidt	Louis Chris III	CCSO	schmidtlo@ccso.us		
Seaman	Kevin	CCEMS	seamank@charescountymd.gov		
Smith	Bill	CCVFA/CCAEMS	Smithb@ccvfireems.org		
Spalding	Andrew	Volunteer EMS Chief	chiefems@ccvfireems.org		
6. Prepared by: Name: <u>Joe Hoffmaster</u> Title: <u>PSC</u> Signature: _____					
ICS 205A	IAP Page <u>5</u>	Date/Time: <u>April 22, 2020</u> @ <u>15:00</u>			

COMMUNICATIONS LIST (ICS 205A)

1. Incident Name Charles County	2. Operational Period: COVID-19	Date From: Time From:	4/23/20 8:00	Date to: Time to:	4/25/2020 8:00
3. Basic Local Communications Information:					
Name - Last	Name-First	Representing	Email	Phone	
Stoddard	Jason	Intell	jstoddard@ccboe.com		
Ranston	Harvey	CCDOH	Ranston.harvey@maryland.gov		
Laschatt	Lisa	CCDOH	lisa.laschatt@maryland.gov		
Meiser	Michael	CCPS	mlmeiser@ccboe.com		
EOC- CC		CCEOCC	DESEOC@charlescountymd.gov		
Cherry	Lori	LOGS- Deputy	Cherry@charlescountymd.gov		
Herbert	Scott	PS LOGS	sherbert@hvdems.org		
Haft	Howard	CCDH	Howard.haft@maryland.gov		
Raley	Jennifer	SMECO	Jennifer.Raley@SMECO.Coop		
Farr	Courtney	SMECO	Courtney.Farr@SMECO.Coop		
Law	Natasha	SMECO	Natsha.Law@SMECO.Coop		
Teleconference #			1-872-240-3212		
Tucker	Ed	Donations	DESDonations@Charlescountymd.gov Etucker@Charlescountymd.gov		
Barnes	Raena	DH-Liaison	raena.barnes@maryland.gov		
Wolf	Theresa	PH-DSS	Therese.Wolf@maryland.gov		
Higgins	David	Safety Officer-Assistant	HigginsD@charlescountymd.gov		
Jones	Robbie	HD-Liaison	JonesRob@Charlescountymd.gov		
Hicks	Ryan	Indian Head	ryan@townofindianhead.org		
Lewis	Mitchell	Volunteer EMS Chief, Assistant	mlewis@WaldorfVFD.com		
Mott	Robert (Bob)	VEIP Manager Document Facil.	capt302a@gmail.com		
Rands	Ray	VEIP Manager	raymond.rands@maryland.gov		
Edge	Bill	CCSO-Safety			

SAFETY MESSAGE/PLAN (ICS 208)

1. Incident Name Charles County COVID-19	2. Operational Period	Date From: 4/23/20	Date To: 4/25/20
		Time From: 8:00	Time To: 8:00
3. Safety Message/Expanded Safety Message, Safety Plan, Site Safety Plan: <p style="margin: 0;">"The New High Five! Elbow bumps help prevent the spread of COVID-19 and still make you feel good!"</p> <p>1. Total identified PUI's transported as of 4/22: Total # of patients testing positive :</p> <p>2. PPE stockpiles remain stable with an estimated supply range of 10+ days based on current call volumes.</p> <p>3. Revision to EMSOP Special Order 2020-01 Version 4.0 has been completed and disseminated to staff.</p> <p>4. As this is a rapidly changing landscape, leaders should review any changes with their personnel each morning.</p> <p>5. Speical Order 2020-04 Version 1.0 was released today. New guidelines for personnel at the beginning of their shift, end of their shift and at the station.</p> <p>6. Personnel who report having a fever, sore throat, cough or other respiratory related symptoms should stay at home and self-isolate until they are symptom free for a period of 72 hours.</p> <p>7. The County's Peer Support Team has been activated and will make weekly wellness checks with our County's first responders. We are working through the logisitcs but will provide an email address and phone number to contact the team. Will disseminate when we have the contact information.</p> <p>8. Please remember that PPE caches are for EVERYONE. We are all in this TOGETHER so there is NO career and volunteer PPE caches.</p> <p>9. Under the approval of the EOC and to keep congruent with the CDC and Governor Hogan's reccomendations, Safety has approved the use of simple face masks (commercial or crafted) in the public arena. Per SOP, N95's are to be used for all patient contacts with reuse guidelines in place per the CDC recomendations.</p> <p>10. Two new videos posted on You Tube: PPE Best Practices - https://youtu.be/mY4rvyJDxDk and Peer Support Services - https://youtu.be/jZD1EOon7Sw</p>			
Site Safety Plan(s) Located At: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
5. Prepared by: Name: <u>John Filer</u> Title: <u>Safety Officer</u> Signature: _____			
ICS 208	IAP Page _____	Date/Time: <u>April 22, 2020</u> @ <u>15:00</u>	

ACTIVITY LOG (ICS 214)

ACTIVITY LOG (ICS 214)

A photograph of a woman and a man wearing face masks, elbow bumping. The woman is on the left, wearing a white lace-sleeved top and a white mask. The man is on the right, wearing a tan blazer and a blue mask. They are in an office setting with a window in the background.

The New High Five!

Elbow bumps help prevent the spread of COVID-19 and still make you feel good.



PUBLIC HEALTH BRANCH BRIEFING COVID-19 PANDEMIC RESPONSE

April 22, 2020

GENERAL REPORTING INFORMATION

INFECTIOUS DISEASE

CASE COUNT—CHARLES COUNTY

As of 4/22/2020, total case count for Charles County is 427.

- *The line list with confirmed case counts for Charles County is continuously updated as lab reports are received from MDH, hospitals, and commercial laboratories.*
- *Contact tracing efforts are continuous with a focus on healthcare workers, EMS, and police.*

CALL CENTER UPDATE

- Operation time: 0800 to 2200.
- The numbers to call remain the same: 301.609.6717 or 301.609.6777
- Volume for new system is approximately 60 call per day.

MEDIA, SOCIAL MEDIA AND WEBSITE

- Currently staffing a disclosure statement with MDH in reference to Baltimore.

PARTNER/STAKEHOLDER OUTREACH

ALL-PARTNER

- The all-partner call will be held Thursday, April 23 at 4 p.m.

LTC/AL

- The Long-Term Care and Assisted Living call will be held, Thursday, April 23 at 3 p.m.

GENERAL PREPAREDNESS

Suggested pushing out CCDOH's Vital Documents Reference Guide to the LTCs, ALs and other agencies, as well as the general public. This will be handled as an add-on to information that will be shared on grief counseling.

EPI SURVEILLANCE PROFILE FOR STATE

Case Investigation, Surveillance, and Infectious Disease Response (D, Blythe)

1) **Latest case counts** – total: 14775 (61754)

2) **New cases:** 582

a) **Age distribution:**

- i) under 18 years - 2 %
- ii) in 18-64 age range 74%
- iii) in 65+ age range 24%

b) **Geographic distribution:**

- i) National Capital 53%

- ii) Baltimore Metro area 41%
- iii) Eastern Shore 3%
- iv) Southern 2%
- v) Western 1%
- c) Of cases, 54% female; 46% male
- d) Hospitalizations 167 new; total 3325
- e) Deaths -- Total 631 (47 in Last 24hrs)
- f) Release from isolation – 981
- g) Greatest number of cases have been in 50-59 age range; greatest number of confirmed deaths have been 80+

CONFIDENTIAL – (INFORMATION BELOW IS FOR CORE PLANNING GROUP ONLY)

RESOURCE DISTRIBUTION

- 1 order filled 4/20/2020
- 2 orders turned back to EOC – incomplete information and PPE supplies onhand had not been updated.
- Nurse liaisons will be also assessing LTC/AL needs and encouraging them to enter proper PPE requests and encourage pick up.

VOLUNTEERS

MARYLAND MEDICAL RESERVE CORPS

- 1 responder accepted into unit 04/21/2020

TESTING

VEIP TESTING SITE UPDATE

- Tested to Date as of 4/21/20 (TTD): 367
- VEIP site testing underway 96 appointments/out of 100 were in CRISP prior to beginning testing this morning. (89 Tests were conducted. Reasons for numbers not tested: Hospitalization, tested prior to VIEP appointment, one had car trouble, one had other testing arranged, and one no show.)
- For VIEP testing on 4/23/20, 96 appointments are already scheduled in CRISP.

EPIDEMIOLOGY AND SURVEILLANCE

Charles County

- As of 4/22 at 900 am, total case count for Charles County was 427 cases.
- There have been 28 deaths associated with COVID-19 (6.6%). Majority of deaths are associated with outbreaks in skilled nursing facilities.
- Average age of fatalities: 75 years
- Number of negative lab results: 1911
- Positivity Rate: 18%
- Recovered and released from isolation: 85
- Partially recovered with improved symptoms: 25
- 98 or 23% required hospitalization

- 263 (61.6%) Female; 164 (38.4%) Male
- 20% Healthcare Workers
- 2% First Responders: EMS, Fire, Law Enforcement
- 33% have underlying health conditions
- Age range of positive COVID-19 cases: 6 months-100 years

Age Distribution for Charles County cases:

- Under 18 years: 1.4%
- 18-64 years: 75.6%
- 65+ years: 23%

ESSENCE data for urgent care utilization at Patient First in Waldorf had no data warnings or alerts for Tuesday, April 21st. Patient volume was 28 patients. All were discharged to home for self-care. 5 presented with ILI or COVID-19 like symptoms on Tuesday, 4/21. Diagnoses included acute sinusitis, allergic rhinitis, acute bronchitis, and unspecified pneumonia. There was 1 case with a CDC Classifier tag for Pneumonia.

Surveillance of EMS call data and alerts

The epidemiologist monitors the Charles County DES First Watch trigger alerts. The number of daily trigger alerts for COVID-19 cases or COVID-19 persons under investigation was 21 on 4/21. Discussions with Robbie Jones from EMS reveal data issues with the alert system. The decrease in COVID-19 PUI alerts does not indicate a decrease in call volume. The epidemiologist has also noticed potential COVID-19 PUI that came as regular trigger alerts. Robbie said that they have to fix each tablet in order to fix the problem and have more accurate data.

- 4/18: 18
- 4/19: 23
- 4/20: 19
- 4/21: 21

Racial breakdown

Racial breakdown: The data is now being captured in the MDH line lists of confirmed cases in REDCap. Data was accessed on 4/22 at 9:00 am. Please be cognizant that data may differ from numbers pulled later in the morning since new positive lab results are being received by the health department and entered into NEDSS throughout the work day. This explains any discrepancies in the total count or denominator being used to calculate each data measure.

Total: 427 cases on 4/22 at 900 am MDH line list assessed through REDCap:

Data on race and ethnicity changes daily as case investigations are completed and more information on demographics is updated in the electronic reporting disease system. Additionally, when there is an influx of new cases in electronic reporting disease system, data on race and ethnicity may not be available immediately for new cases since race information is not typically captured on a lab report and must be obtained during the investigation.

Case counts with less than 7 cases should not be shared publicly. This data is confidential.

Race Breakdown:

- Asian: 9 (2.1%)
- Black/African American: 201 (47.1%)
- White: 102 (23.9%)
- Other: 18 (4.2%)
- Two or more races: 2 (0.5%)
- Data not available: 95 (22.2%)

Ethnicity Breakdown:

- Hispanic 10 (2.4%)
- Non-Hispanic 311 (72.8%)
- Declined to answer 39 (9.1%)
- Data not available 67 (15.7%)

Epidemiologist note: Please use caution when drawing any conclusions regarding race or ethnicity. There is still a percentage where race data is not available, and information regarding this missing population cannot be assumed. Additionally, it should be noted that the greatest number of cases (58%) are the Waldorf zip codes of 20601, 20602, and 20603. Over half of the county population lives in those zip codes. Additionally, those zip codes have a very diverse population with minority populations comprising the majority of the zip code level population and with African Americans being the largest racial group in those zip codes.

Zip Code breakdown

Zip Code level data was also analyzed using the MDH line lists of confirmed cases in REDCap. Data was accessed on 4/22 at 9:00 am with 427 cases as the total count at that moment in time. Data for all zip code with a case count greater than 7 has been included in the attached GIS map. (Zip code level data with counts less than 7 cases cannot be shared publicly and must remain confidential.)

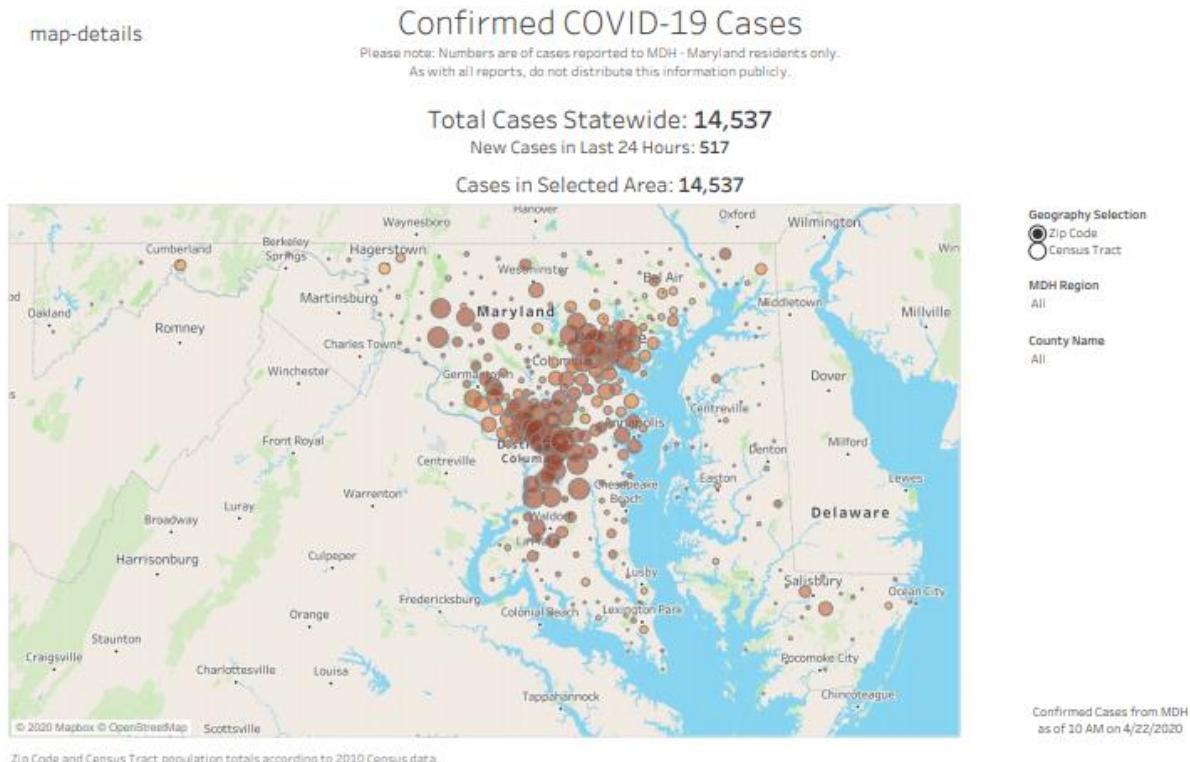
Confirmed cases by zip code:

Zip code:	4/20	4/21	4/22	Change from 4/21 to 4/22
20601	52	54	55	+1
20602	71	73	76	+3
20603	99	100	116	+16
20607	9	9	9	0
20611	1	1	1	0
20613	15	15	15	0
20616	7	7	9	+2
20622	2	2	2	0
20632	2	2	2	0
20637	12	12	12	0
20640	15	15	15	0
20646	43	46	49	+3
20658	1	1	1	0
20662	4	4	5	+1
20664	4	4	4	0

20675	3	3	3	0
20677	3	3	4	+1
20693	1	1	1	0
20695	26	27	27	0

ADDITIONAL INFORMATION: *This includes the following:*

- **Heat map of COVID cases in Maryland by zip code – provided through the Chesapeake Regional Information System for our Patients (CRISP)**



• Heat Map of Southern Maryland

map-details

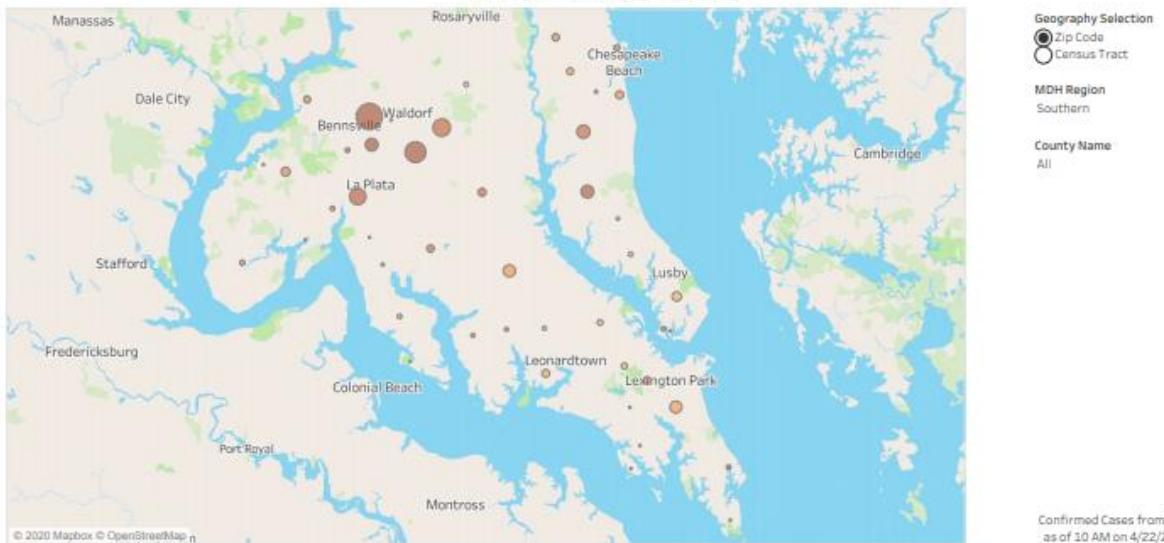
Confirmed COVID-19 Cases

Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Cases in Selected Area: 645



Zip Code and Census Tract population totals according to 2010 Census data.

• Heat Map of Charles County

map-details

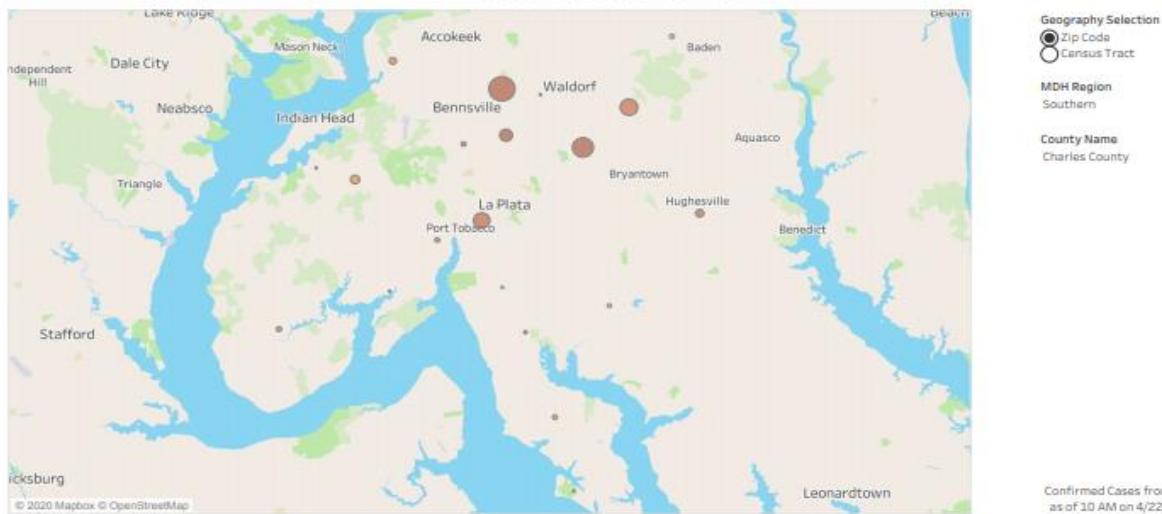
Confirmed COVID-19 Cases

Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Cases in Selected Area: 405



Zip Code and Census Tract population totals according to 2010 Census data.

- Maryland Case Map

Confirmed COVID-19 Cases

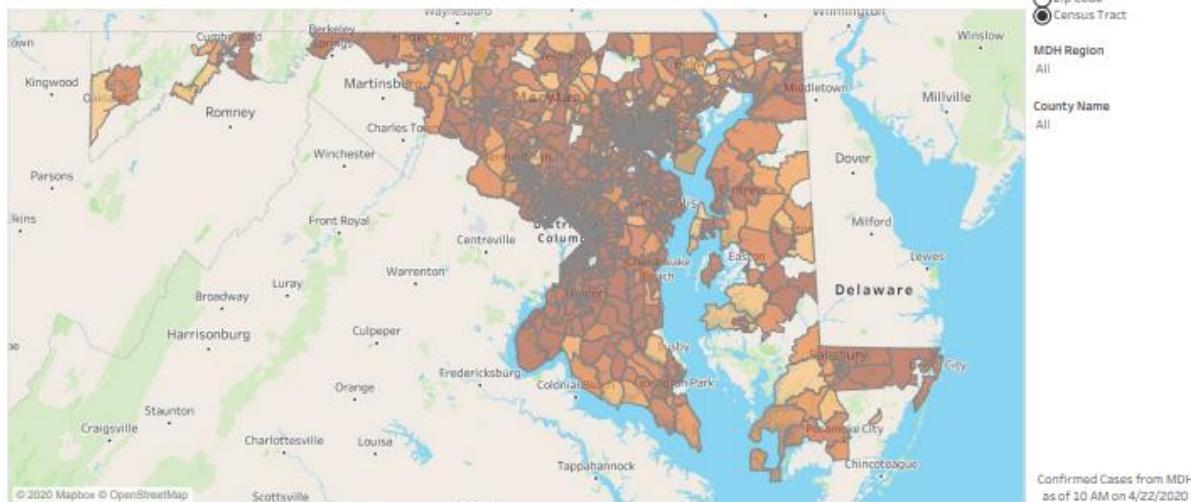
Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Cases in Selected Area: 14,537

Cases in Selected Area that are unable to be geocoded: 1,602



Zip Code and Census Tract population totals according to 2010 Census data.

- Southern Maryland Case Map

Confirmed COVID-19 Cases

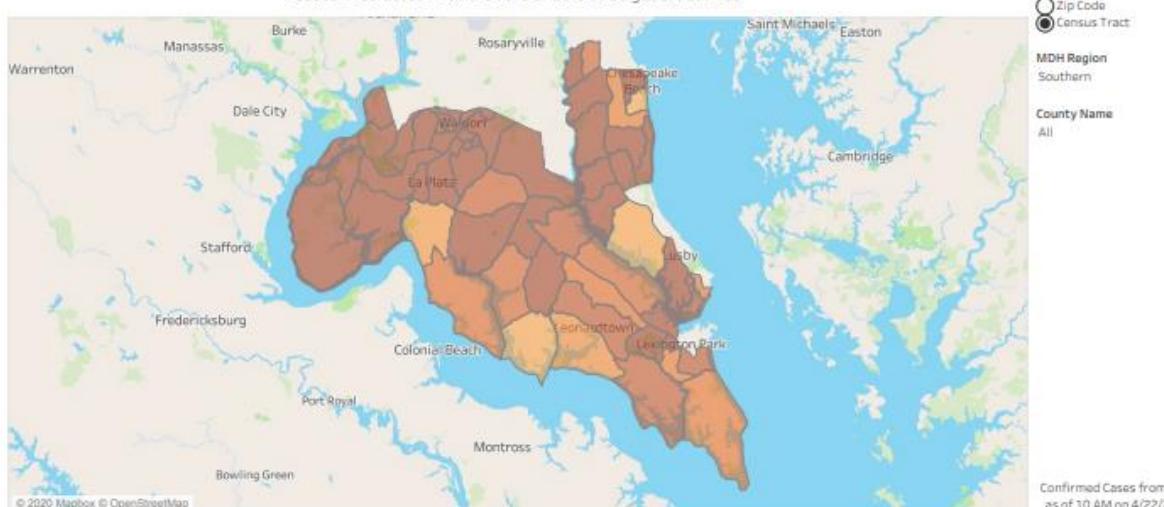
Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Cases in Selected Area: 645

Cases in Selected Area that are unable to be geocoded: 108



Zip Code and Census Tract population totals according to 2010 Census data.

- Charles County Case Map

Confirmed COVID-19 Cases

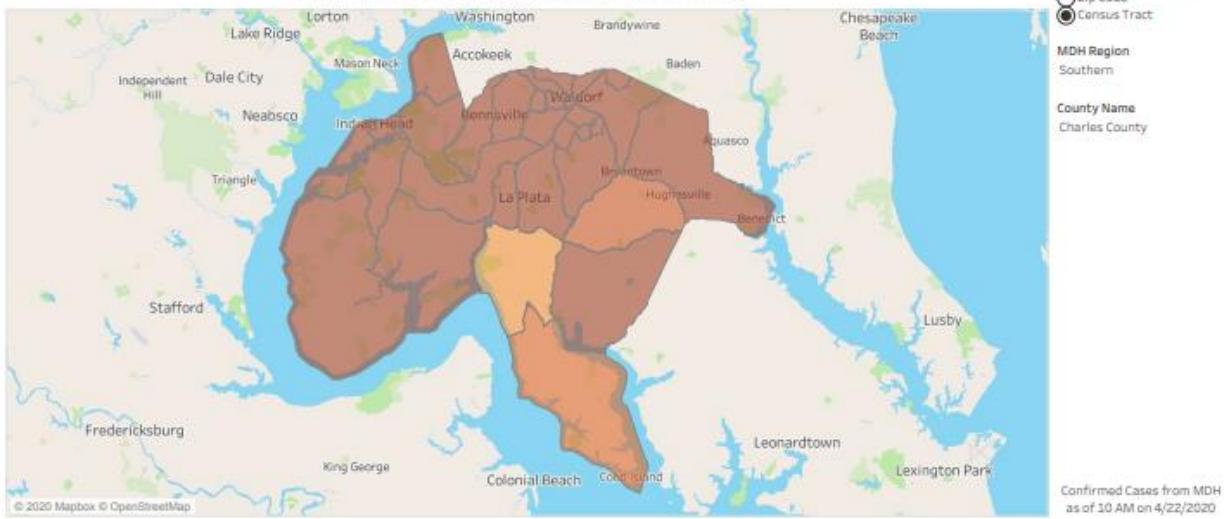
Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Cases in Selected Area: 405

Cases in Selected Area that are unable to be geocoded: 60



Zip Code and Census Tract population totals according to 2010 Census data.

- Gender, Age, Region (Fatalities)

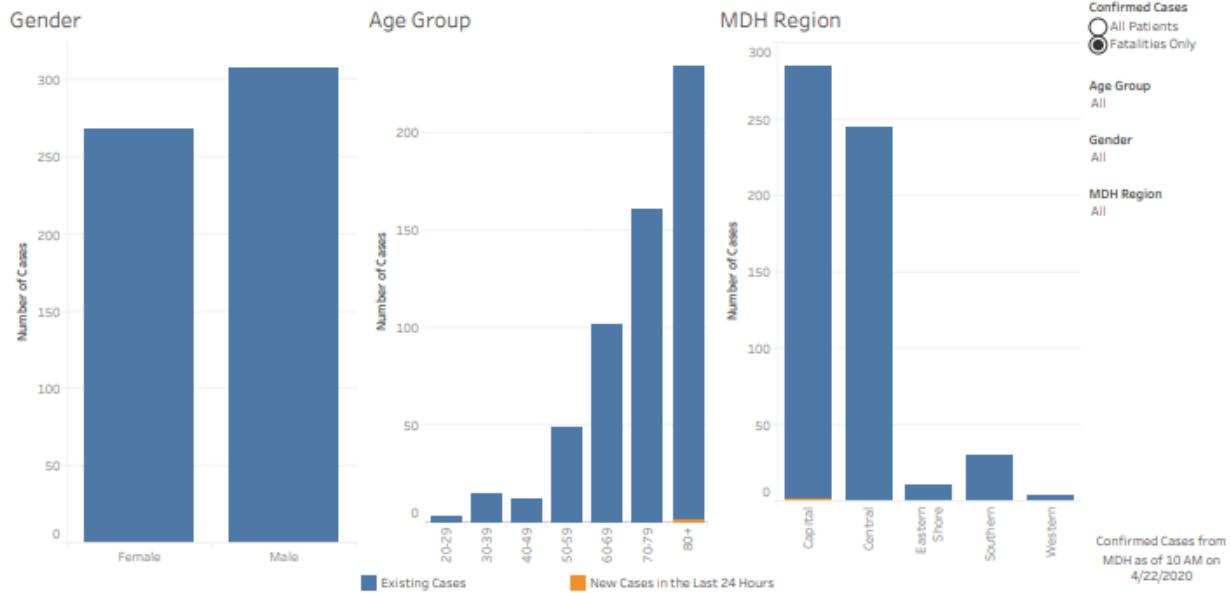
Confirmed COVID-19 Cases

Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Number of Cases for Selected Area/Demographics: 576



- **Gender, Age, Region (All)**

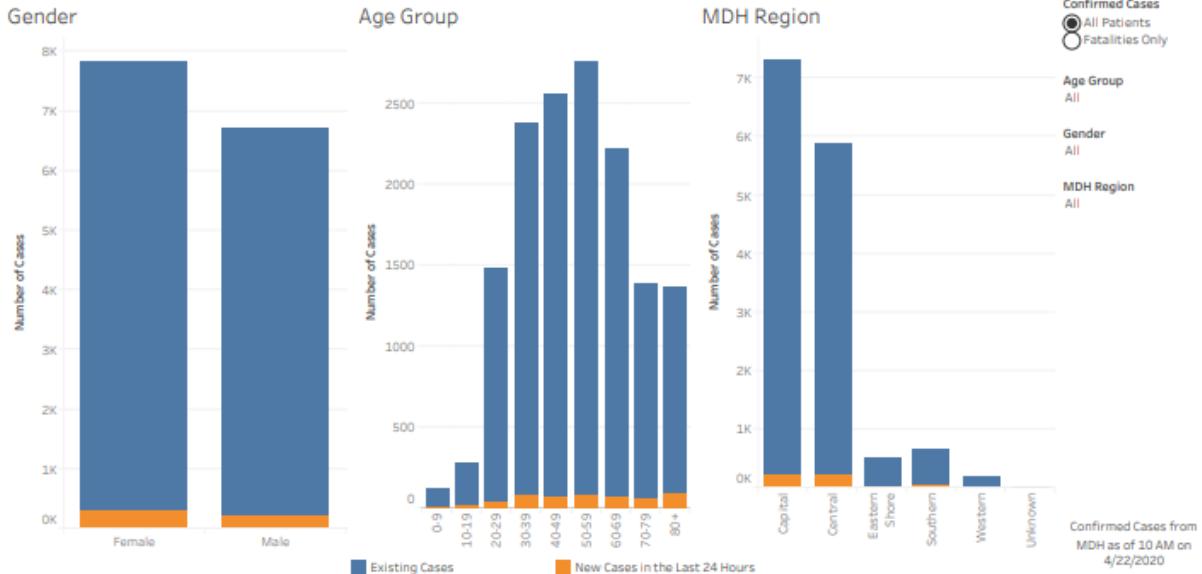
Confirmed COVID-19 Cases

Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Number of Cases for Selected Area/Demographics: 14,537



- **Southern Maryland Gender, Age, Region (Fatalities)**

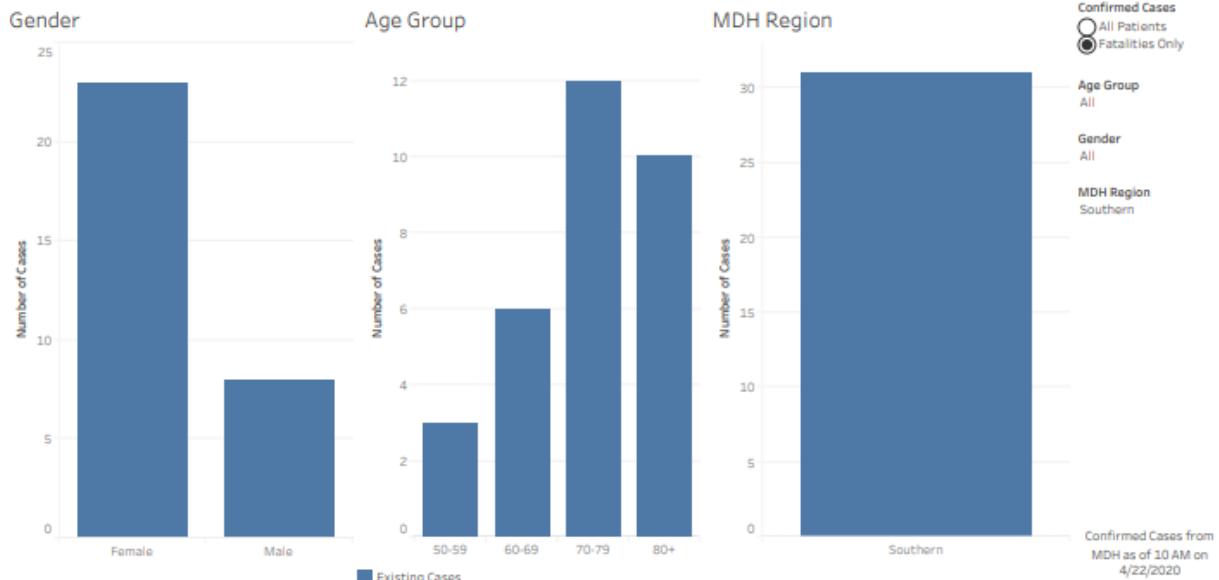
Confirmed COVID-19 Cases

Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Number of Cases for Selected Area/Demographics: 31



Southern Maryland Gender, Age, Region (All)

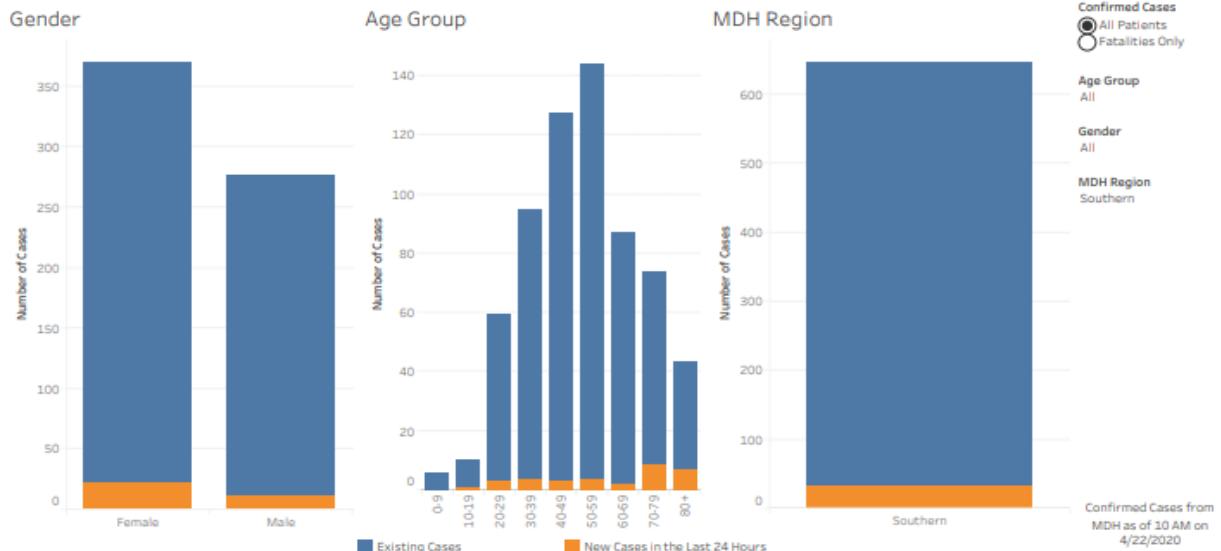
Confirmed COVID-19 Cases

Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Number of Cases for Selected Area/Demographics: 645



- **Statewide Cases by Date**

Confirmed COVID-19 Cases

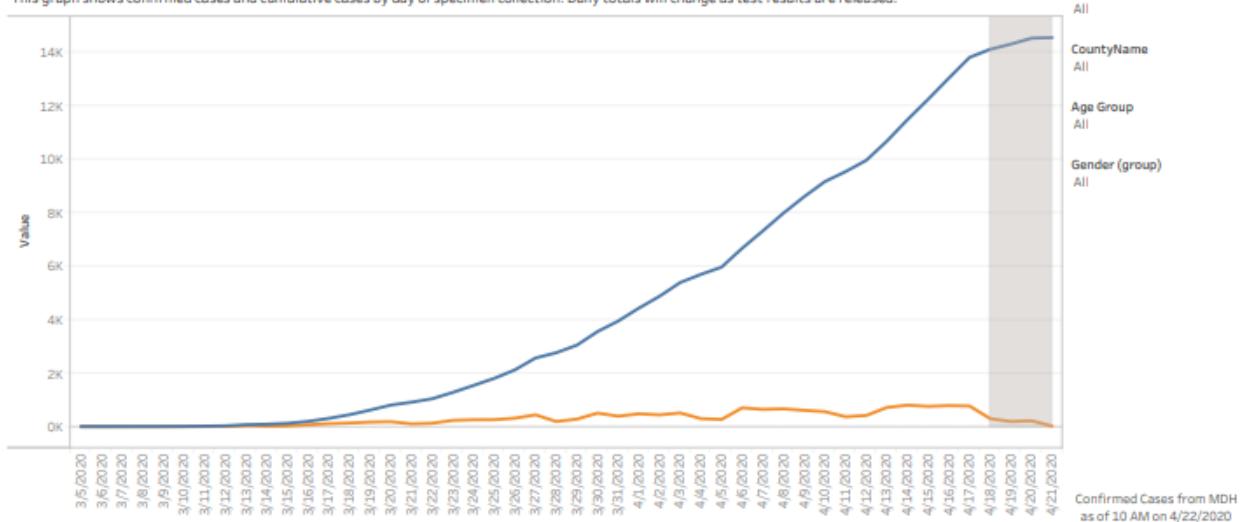
Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Number of Cases for Selected Area/Demographics: 14,537

This graph shows confirmed cases and cumulative cases by day of specimen collection. Daily totals will change as test results are released.



Date shown is the sample collection date, not the date when the test result was confirmed. Daily totals may change as pending tests are reported. Test Result Pending dates are greyed out in the chart.

- **Southern Maryland Cases by Date**

Confirmed COVID-19 Cases

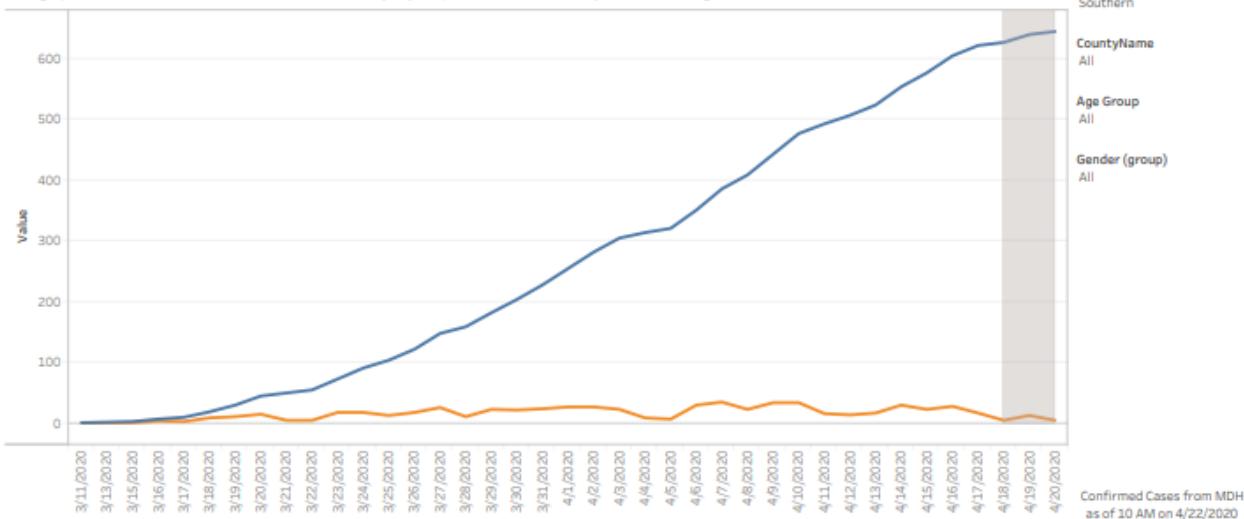
Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Number of Cases for Selected Area/Demographics: 645

This graph shows confirmed cases and cumulative cases by day of specimen collection. Daily totals will change as test results are released.



Date shown is the sample collection date, not the date when the test result was confirmed. Daily totals may change as pending tests are reported. Test Result Pending dates are greyed out in the chart

- **Charles County Cases by Date**

Confirmed COVID-19 Cases

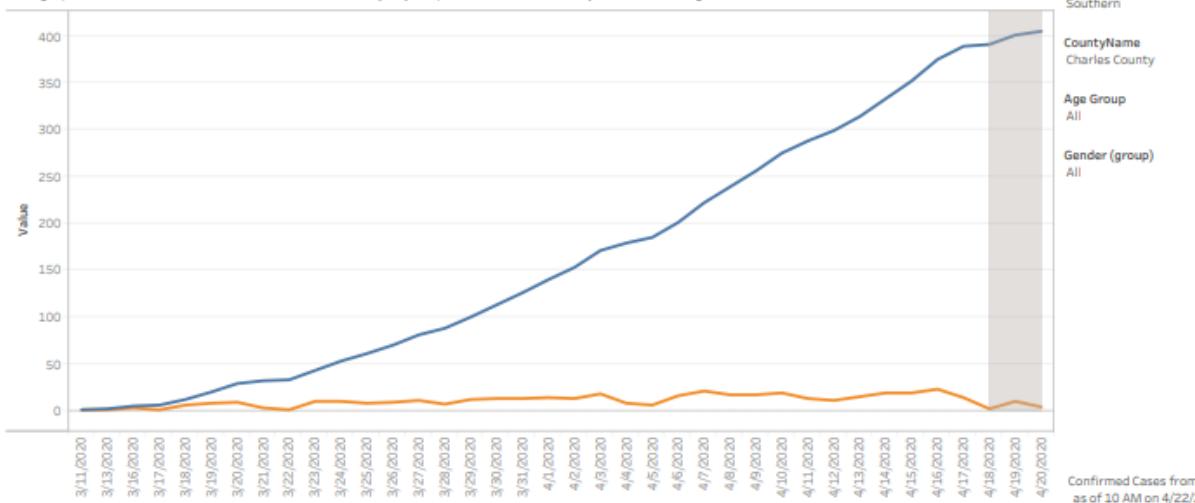
Please note: Numbers are of cases reported to MDH - Maryland residents only.
As with all reports, do not distribute this information publicly.

Total Cases Statewide: 14,537

New Cases in Last 24 Hours: 517

Number of Cases for Selected Area/Demographics: 405

This graph shows confirmed cases and cumulative cases by day of specimen collection. Daily totals will change as test results are released.



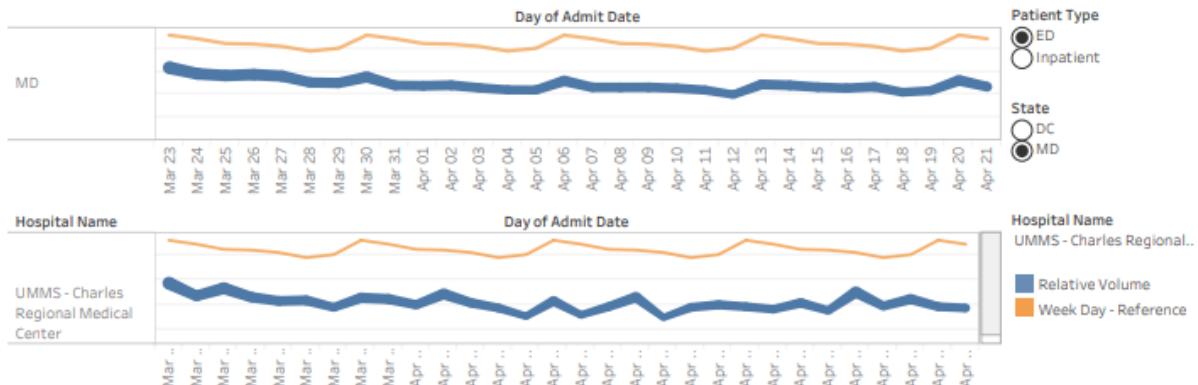
Date shown is the sample collection date, not the date when the test result was confirmed. Daily totals may change as pending tests are reported. Test Result Pending dates are greyed out in the chart

• Hospital Volume Trends ED

Hospital Volume Trend Lines

These volume data are derived from real-time Admission/Discharge/Transfer feeds sent to CRISP. The thickness of the line is a measure of volume. These volume counts are imprecise for reasons such as differences in how feeds are implemented among hospitals. However, the trendlines provide utility in understanding directional volume change over time.

The orange reference line shows the statewide average relative volume by the day of the week, using all ADT data from January 1, 2020 to February 29, 2020.

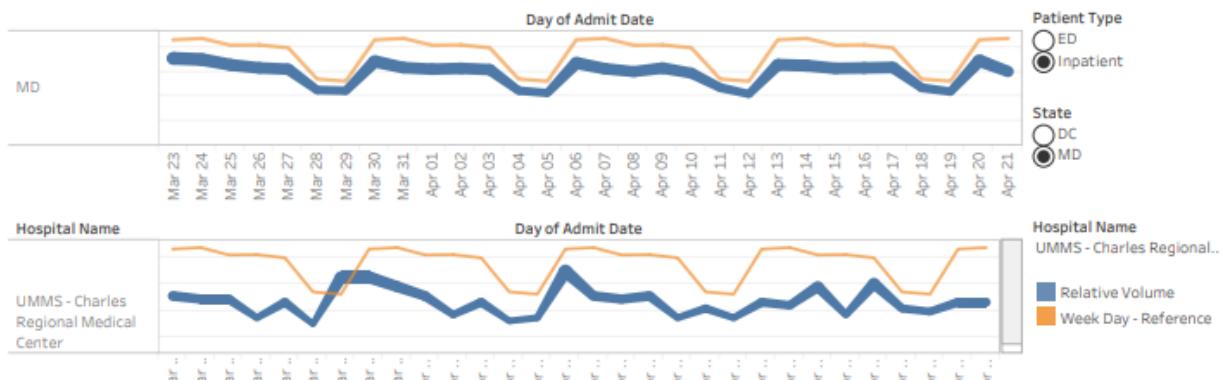


• Hospital Volume Trends Inpatient

Hospital Volume Trend Lines

These volume data are derived from real-time Admission/Discharge/Transfer feeds sent to CRISP. The thickness of the line is a measure of volume. These volume counts are imprecise for reasons such as differences in how feeds are implemented among hospitals. However, the trendlines provide utility in understanding directional volume change over time.

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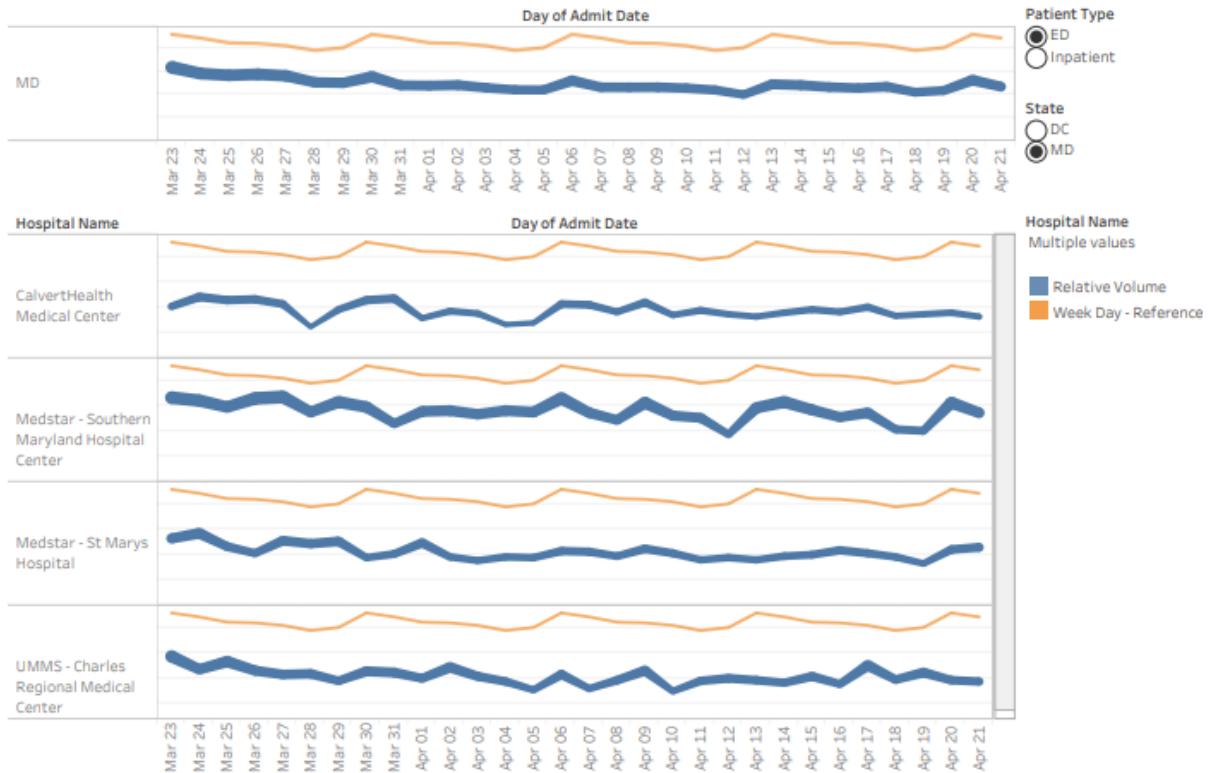


- **Regional Hospital Volume Trends ED**

Hospital Volume Trend Lines

These volume data are derived from real-time Admission/Discharge/Transfer feeds sent to CRISP. The thickness of the line is a measure of volume. These volume counts are imprecise for reasons such as differences in how feeds are implemented among hospitals. However, the trendlines provide utility in understanding directional volume change over time.

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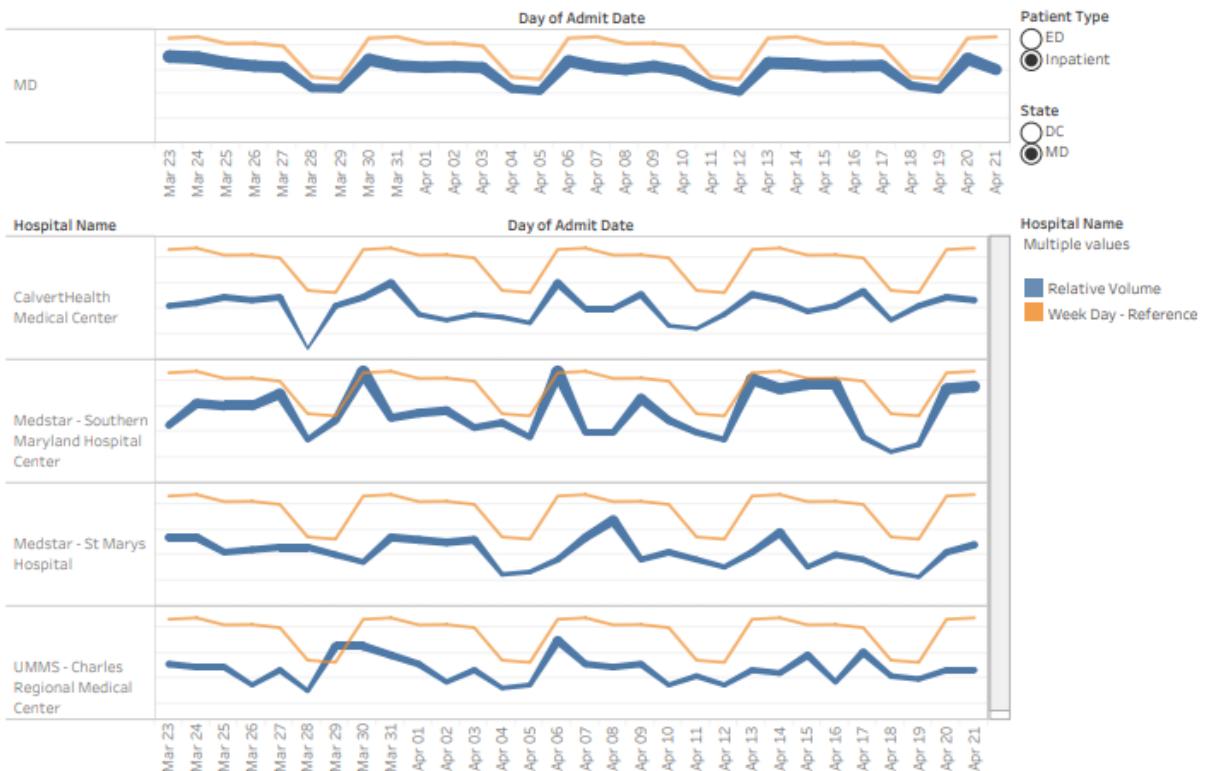


- **Regional Hospital Volume Trends Inpatient**

Hospital Volume Trend Lines

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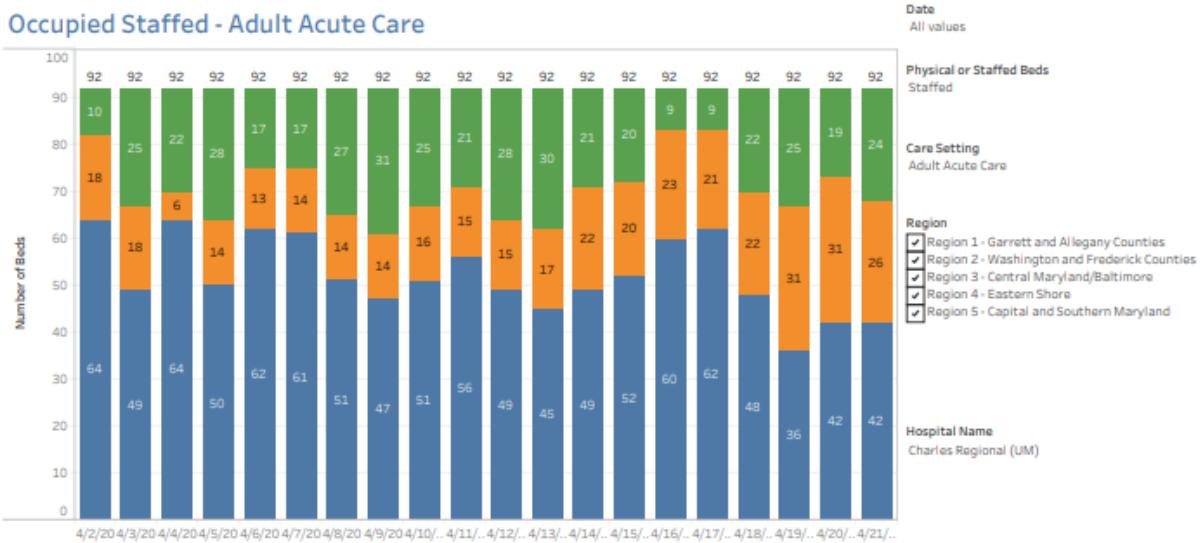


• Maryland Occupied Staff Acute Care

MIEMSS Facility Resources Emergency Database (FRED)

Data as of 4/21/2020

Occupied Staffed - Adult Acute Care



Occupied Staffed by Hospital - Adult Acute Care

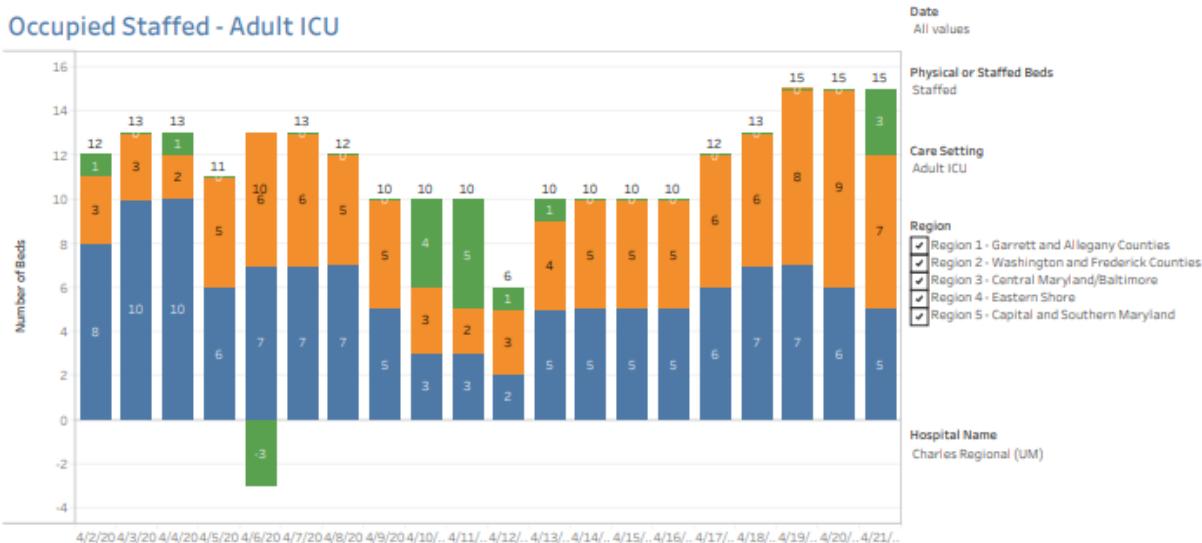


• Maryland Occupied Staff ICU

MIEMSS Facility Resources Emergency Database (FRED)

Data as of 4/21/2020

Occupied Staffed - Adult ICU



Occupied Staffed by Hospital - Adult ICU



- **Regional Occupied Staffed Beds Acute Care**

MIEMSS Facility Resources Emergency Database (FRED)

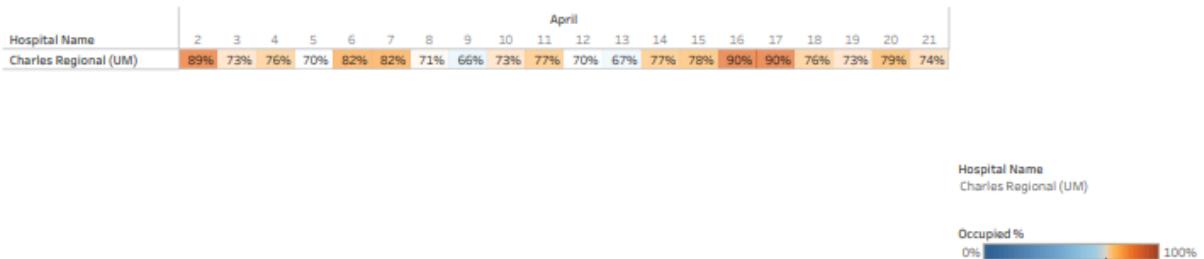
Data as of 4/21/2020

The data in this report is self-reported daily by hospitals to Maryland Institute for Emergency Medical Services Systems (MIEMSS). The data in this report reflect point in time counts. Please note data is presented as reported and is not edited or validated by CRISP.

Occupied Staffed Beds - Adult Acute Care



Occupied Staffed Beds - Adult Acute Care by Hospital



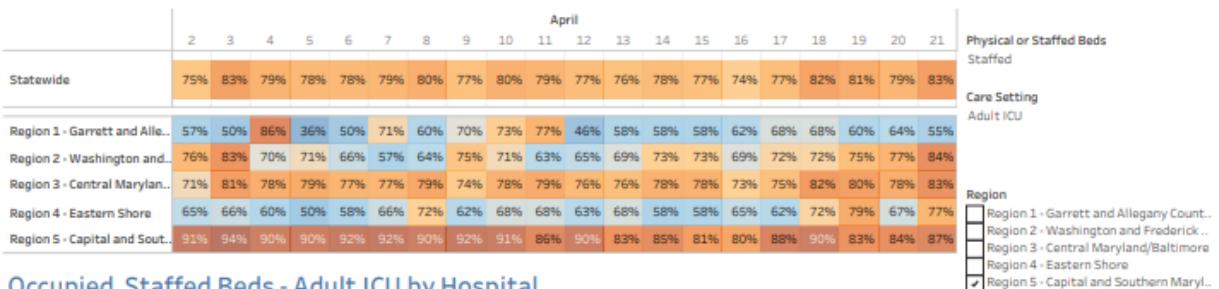
- **Maryland Occupied Staffed Beds ICU**

MIEMSS Facility Resources Emergency Database (FRED)

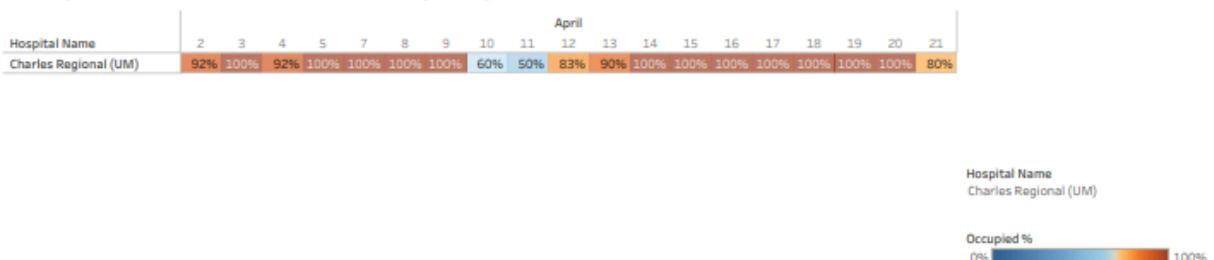
Data as of 4/21/2020

The data in this report is self-reported daily by hospitals to Maryland Institute for Emergency Medical Services Systems (MIEMSS). The data in this report reflect point in time counts. Please note data is presented as reported and is not edited or validated by CRISP.

Occupied Staffed Beds - Adult ICU



Occupied Staffed Beds - Adult ICU by Hospital



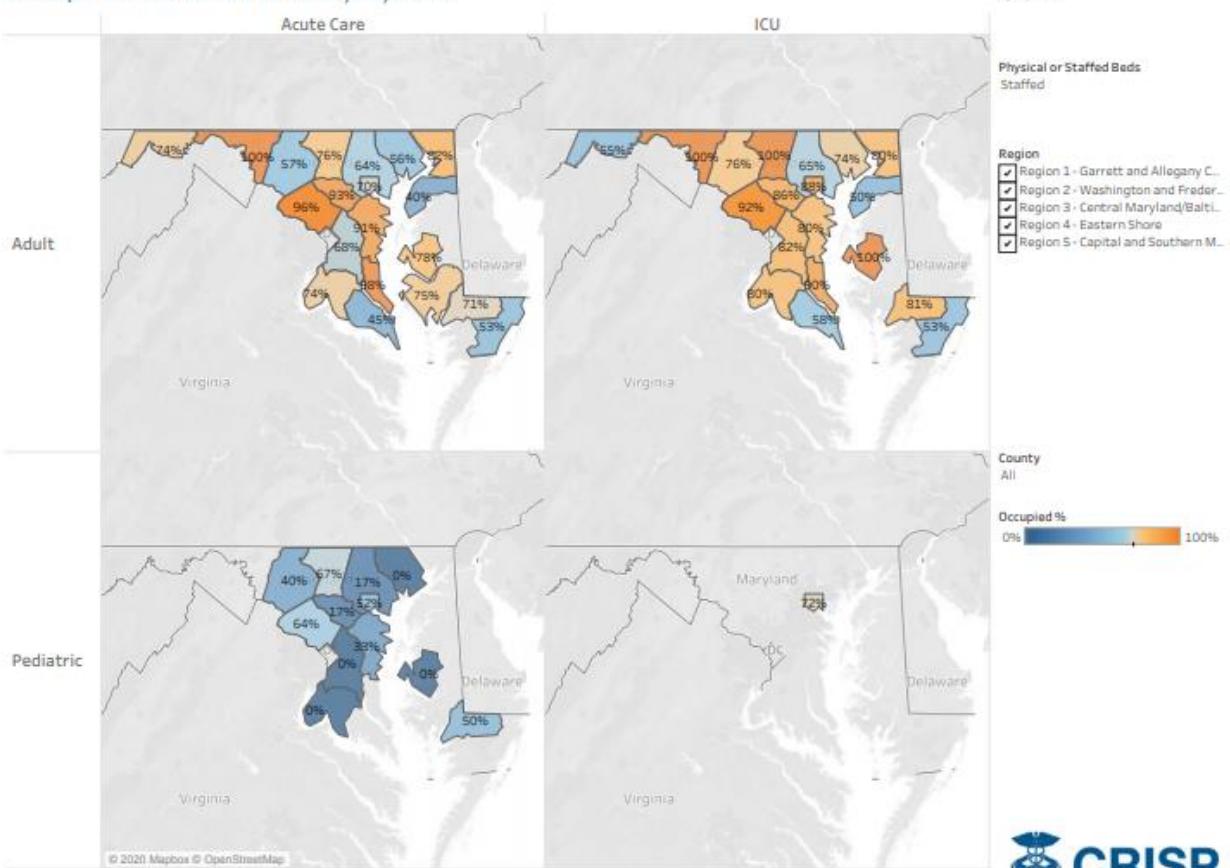
- Maryland Occupied Staffed Beds

MIEMSS Facility Resources Emergency Database (FRED)

Data as of 4/21/2020

The data in this report is self-reported daily by hospitals to Maryland Institute for Emergency Medical Services Systems (MIEMSS). The data in this report reflect point in time counts. Please note data is presented as reported and is not audited or validated by CRISP.

Occupied Staffed Beds - on 4/21/2020



Sources: CRISP, 2020. CRISP MIEMSS FRED SmartSheet Download.

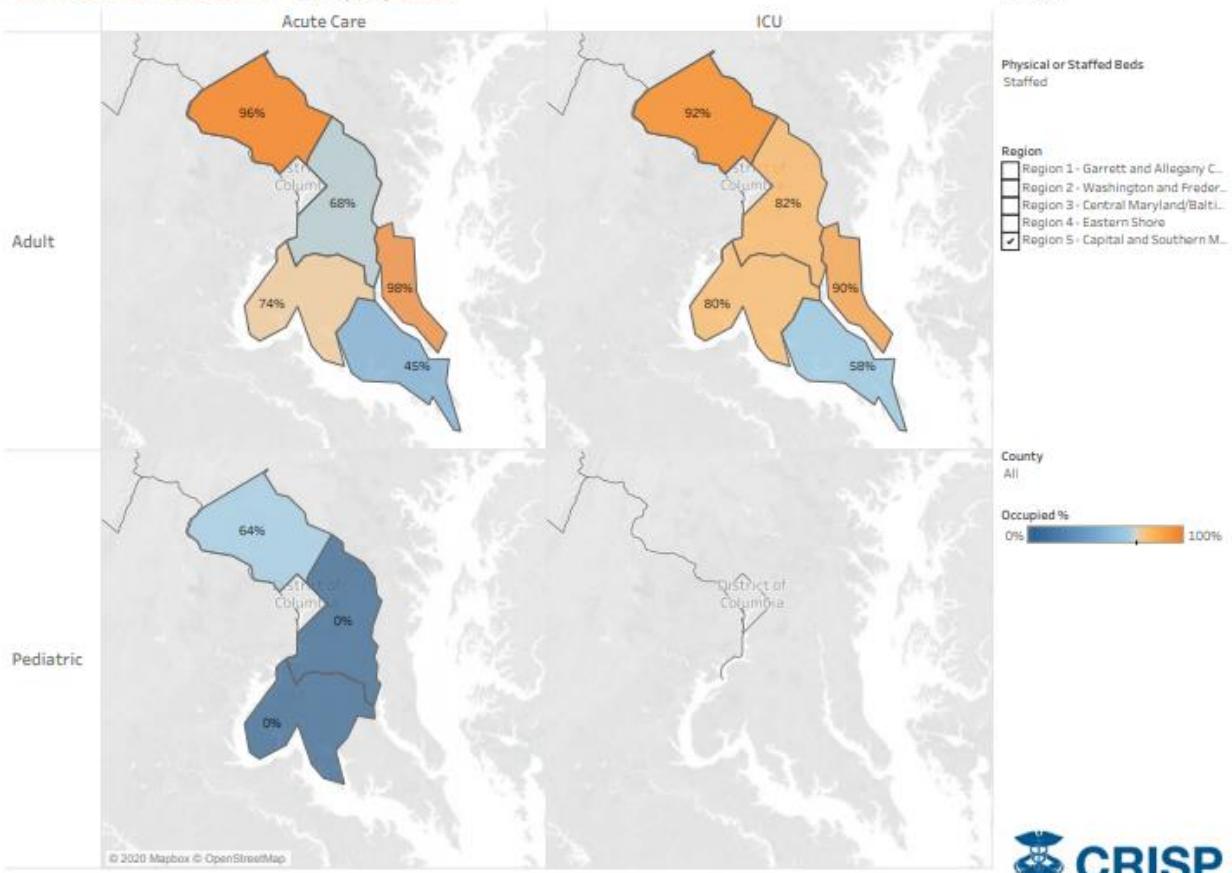


- Maryland Occupied Staffed Beds Regional

MIEMSS Facility Resources Emergency Database (FRED)

Data as of 4/21/2020

Occupied Staffed Beds - on 4/21/2020



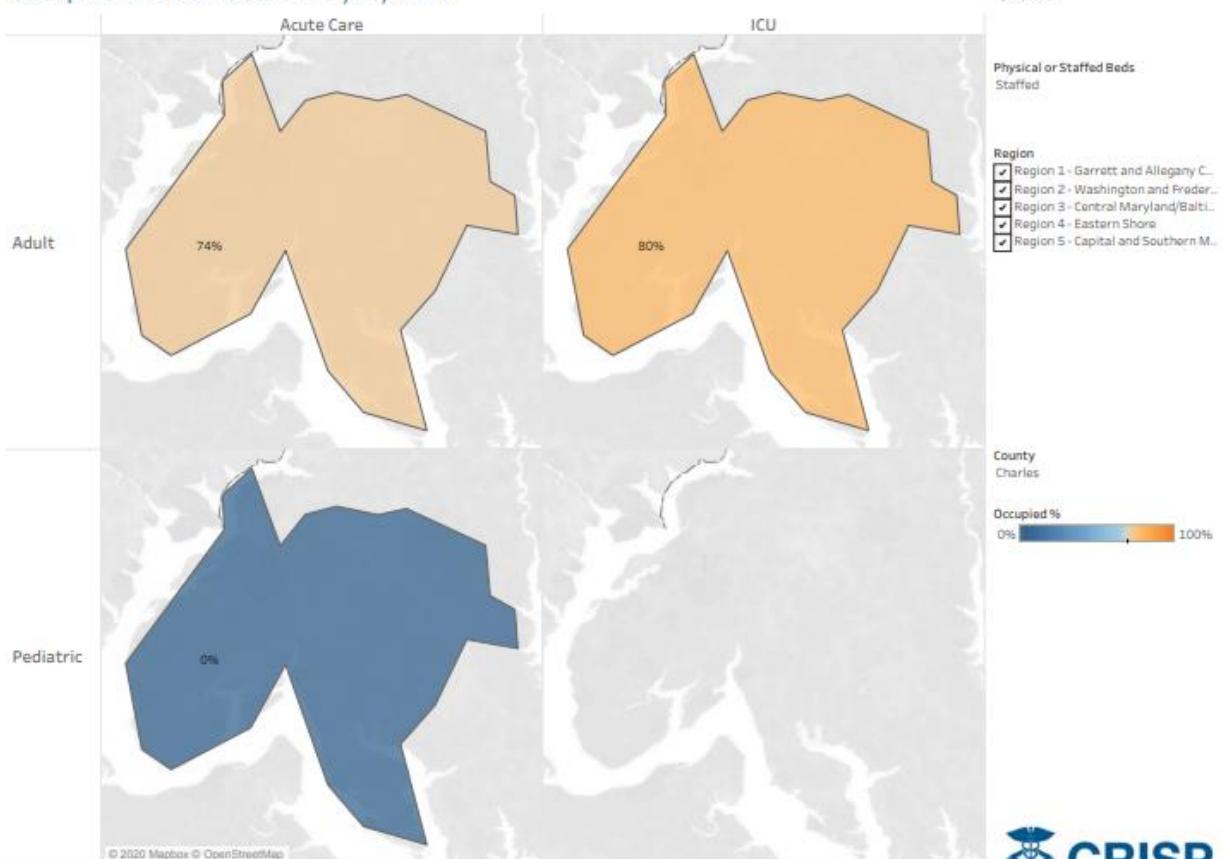
- Maryland Occupied Staffed Beds Charles County

Miemss Facility Resources Emergency Database (FRED)

Data as of 4/21/2020

The data in this report is self-reported daily by hospitals to Maryland Institute for Emergency Medical Services Systems (MIEMSS). The data in this report reflect point in time counts. Please note data is presented as reported and is not edited or validated by CRISP.

Occupied Staffed Beds - on 4/21/2020



Source: CRISP, 2020. CRISP MIEMSS FRED SmartSheet Download.



• Statewide Capacity Overview

MIEMSS Facility Resources Emergency Database (FRED)

Data as of 4/21/2020

The data in this report is self-reported daily by hospitals to Maryland Institute for Emergency Medical Services Systems (MIEMSS). The data in this report reflect point in time counts. Please note data is presented as reported and is not edited or validated by CRISP.

Statewide Capacity Overview

Available Acute Care and ICU Staffed Beds (Adult):

1,743

(1743/7223) = 24%

Ventilators Available:

1,325

(1325/2001) = 66%

Patients in the Emergency Department:

611

(611/2168) = 28%

Change from day before:

-158 beds

Change from day before:

+69 vents

Change from day before:

-38 patients

Hospitalized Confirmed COVID-19 Patients

Staffed Acute Care Beds Occupied by COVID-19 Patients:

905

(905/5860) = 15%

Staffed ICU Beds Occupied by COVID-19 Patients:

527

(527/1363) = 39%

Change from day before:

-2 patients

Change from day before:

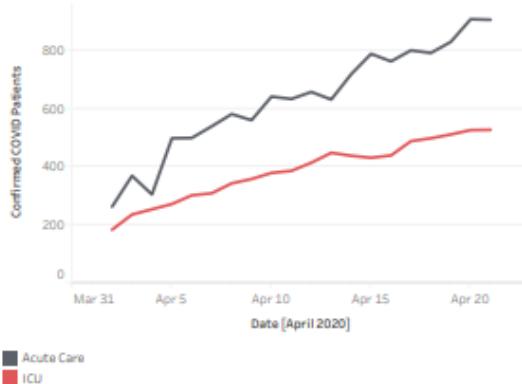
+1 patients

Bed Summary

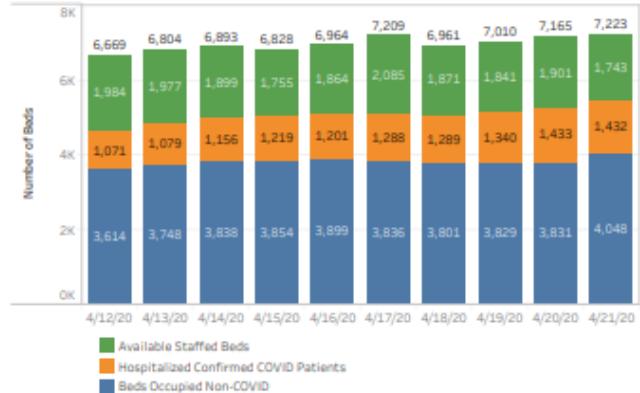
	Physical Beds	Staffed Beds	Occupied Beds	% Occupied Physical Bed	% Occupied Staffed Bed
Adult Acute Care	7,507	5,860	4,343	58%	74%
Adult ICU	1,666	1,363	1,137	68%	83%
Pediatric Acute Care	310	253	112	36%	44%
Pediatric ICU	106	106	76	72%	72%

Hospitalized COVID-19 Patients

Number of COVID-19 Positive Patients in Acute Care and ICU



Statewide Occupied Staffed - Adult Acute Care and ICU - Lasts 10 Days



Source: CRISP, 2020. CRISP MIEMSS FRED SmartSheet Download.



MISCELLANEOUS

Nothing new to report

Respectfully submitted by Charles County PHEP



HOSPITAL BRIEF 4-22-2020

- The trigger point for starting up the tent operations outside of the hospital has not yet been activated. Activation will be determined by both staffing levels and patient census presenting to the ED.
- Hospital Bed Capacity = 166. Census = 79
- Hospital ICU Census = 18
- Hospital ICU is now a dedicated COVID-19 Unit, and 3 East is for ICU overflow.
- Isolation Room Capacity = 12
- Isolation Rooms Occupied = 6
- Confirmed positive cases of COVID-19 patient admissions = 24
 - Of the total 26 COVID-19 positive patients. Nine (9) of the patients are located in the ICU. Fifteen (15) are located in the 3 South dedicated COVID-19 unit
- PUI admissions = 6
- Ventilated COVID-19 positive patients = 8
- Ventilators not in use = 12
- COVID-19 related deaths = 29
- CRMC has implemented a policy that requires ALL staff, visitors (which would be very limited), and contractors of any kind to wear a mask while in the hospital at all times.
- The 3 South patient unit at CRMC is dedicated to COVID-19 positive patients only.
- On Monday, 4/21/2020, patients transported by EMS that were PUI and tested as COVID-19 positive = 1.

First Responder Hours at Local Stores as of 4-21-2020

- Costco- first responder and health care workers can move the front of the line with ID
- Sam's Club- Hero Hours, Sunday morning 0800-1000 with ID- no membership required
- BJ's- Appreciation Hour, Sunday morning 0800-0900 with ID- no membership required
- Walgreens- April 25th, "Frontline Heroes Discount Day," and will give first responders, police and medical personnel 30% off regularly-priced Walgreens brands and 20% off regularly priced national brand products.
- Verizon - announced that starting April 23 it is expanding its unlimited pricing plan to include nurses and teachers. New and existing Verizon customers are eligible for the plans along with active-duty military, veterans and first responders.
- Walmart: The retail giant is reserving an hour each day for pickup orders for first responders as well as shoppers most at risk for the coronavirus. The "pickup hour" is from 7 to 8 a.m. daily.
- Big Lots: Through at least April 30, the retailer is giving all first responders, medical professionals, active military, veterans and commercial truck drivers 15% off everything in stores and online. In stores show your work ID, military ID, commercial driver's license or badge. Online use code BIGHEROES at checkout.
- Bojangles': Through June 10, the chain is giving away free cups of its Legendary Iced Tea to healthcare workers, first responders and law enforcement. No purchase is necessary.
- BP: First responders and health care workers get 50 cents off per gallon on their next fill up at BP and Amoco stations. To get the discount, you'll have to verify your employment status. Learn more at www.bp.com/localheroes.
- Checkers and Rally's: For a limited time at more than 250 of the fast-food chain's company-owned locations, uniformed medical workers and first responders get a free combo.
- Crocs: The company is giving away free footwear to health care workers including doctors and nurses and others in the industry who are on the frontlines of the pandemic. Choose between Crocs Classic Clogs and Crocs At Work styles. The free Crocs are available while supplies last at www.crocs.com/freeforhealthcare.
- Dollar General: Through April 30, all medical personnel, first responders and activated National Guardsmen get a 10% discount on qualifying purchases when they show their employment badge or ID at more than 16,300 stores. The discount store said in a news release that the program could be extended.

- Krispy Kreme: Every Monday through National Nurses Week (May 6-12), Krispy Kreme is giving all health care workers with a badge free dozens of its Original Glazed Doughnuts. This drive-thru offer is for anyone who works at a hospital, as well as physicians, nurses, surgeons, psychologists, dentists, optometrists, pharmacists and their staff. While supplies last.
- McDonald's: Starting Wednesday and through May 5, health care workers, police officers, firefighters and paramedics can get free "Thank You" meals at participating restaurants nationwide available at the drive thru or for carry out.
- Starbucks: The coffee giant is serving up free coffee for first responders and health care workers through May 3. The offer is for police officers, firefighters, paramedics, doctors, nurses, hospital and medical staff and medical researchers, Starbucks said.
- Wawa: For a limited time, the convenience store chain is giving free coffee to health care workers and first responders
- Chipotle to give free burritos to health care, medical professionals

Chipotle Mexican Grill announced Monday that it launching a new buy-one-get-one program to "support healthcare heroes across the U.S.," the fast-casual chain said in a news release.

Starting Tuesday through April 26, Chipotle says it will donate a burrito to medical professionals every time a Chipotle digital customer names their burrito order "4HEROES" on the Chipotle app or Chipotle.com.

Health care workers will be able to sign up to request free burritos for their medical facility starting at noon ET May 6, which is Nurses Day.

According to the fine print, the maximum number of burritos to be donated is 100,000 but the "actual number of donated burritos will depend on redemption rate by qualifying health care providers during the promotional period."

Respectfully submitted by Jason Stoddard, Intel Section Chief

Recovery Articles and Notes:

- <https://www.aei.org/research-products/report/national-coronavirus-response-a-road-map-to-reopening/>
- <https://cadmusgroup.com/articles/the-covid-19-recovery-conversation-must-start-today/>
- <https://www.aei.org/wp-content/uploads/2020/03/National-Coronavirus-Response-a-Road-Map-to-Recovering.pdf>

CCPS Draft Consideration List

(this is not all inclusive nor is it complete. It is a living document. We are keeping notes of questions that need to be asked and things to be considered)

Denmark Case Study on re-opening schools:

<https://www.cnn.com/2020/04/17/europe/denmark-coronavirus-first-school-intl/index.html>

- Do we stagger opening.
 - A-B schedule
 - Staggered arrival times
 - 1 day of school, 4 days virtual
- What do we need to add to grade level curriculum about hygiene and mental health in wake of this
- Section off playground
- Spacing of desks
- Required hand sanitizing hourly,
 - Require hand sanitizer in classroom. Class begins pass the bottle, everyone gets a handful on the way out?
 - Add time to lunch and breakfast for hygiene
- Teleworking for back office staff?
 - Staggered?
- Professional Development for staff? Travel, recruitment?
- Hiring process for new employees over the summer with the “new normal”
- Do we allow students and staff to wear masks and gloves?
 - How do we say no?
 - Do we supply?
 - How do you deal with parents to demand it
 - Food service required?
- How do we deal with parents who refuse to send kids to school due to health concerns or family situation, but want CCPS to supply work and accommodation
- How do you determine the amount of PPE and cleaning needed in the warehouse
- How do we include these types of crisis in labor contracts
- Additional EAP, counseling support for staff
- Additional mental health support for students
- Who’s responsible for monitoring the daily threat

- What percentage of 55+ aged subs and staff are we going to loose. What is workforce reduction plan?
- School cleaning and tracking mandates
 - How often do high traffic and touch point areas get cleaned
 - Cleaning of desks between classes
- Fall sports requirements
 - Masks
 - Limiting spectator numbers
- If we are closed how to we return property to students and staffs.
 - Lockers
 - Staff workspace and offices

Respectful submitted by Jason Stoddard, Intel Section Chief

Mass Fatality Management Plan (MFMP) - Covid 19 Update 4/17/20

Dr. Howard Haft, Incident Commander MFMP

Background: The Maryland Department of Health (MDH) Mass Fatality Management Plan (MFMP), adopted in 2012, establishes a single, comprehensive framework for the management of fatalities in a mass fatality incident. The MFMP is implemented when the normal Maryland death management process capacity is exceeded or likely to be exceeded.

COVID-19 Challenge: The Covid-19 pandemic is a public health threat which may result in large numbers of fatalities acutely or over an extended time period. If not managed in a systematic manner at each level in the process, this may exceed the capabilities of the extant system of managing fatalities and become a public health crisis.

MFMP Programmatic Response: Increase Capacity in Existing Institutions: The first response is to maximize the normal process and existing holding capacity within the various agencies and organizations involved in death management.

- For *Funeral Homes and Crematoriums* this means, to the extent possible on a voluntary basis, expediting timelines, working within family budgets on funeral services, maximizing the capacity to store remains pending funeral and burial and enhancing the ability to meet demand for cremation through extension of hours and days of operation.
- For *hospitals* this means expanding, as best possible within their organization, the holding of decedents pending transfer to funeral homes or mortuaries and assisting families with making those arrangements promptly.
- For the *Maryland State Anatomy Board* this means shortening the time post-death (to 4 days) that remains are held before being transferred for State cremation in order to maximize the agency holding capacity.

Role of Hospital Administrations: Normal decedent process should be followed as best possible, in a respectful and compassionate manner by hospital grief counseling teams telephonically with the family as soon as feasible after death to ensure funeral homes can take custody promptly. Having a list of local funeral establishments may assist in the timeliness of this facilitation contact and coordination process. Cause of death should be attested as COVID or other cause as determined by the attending physicians as soon as possible (see recent guidance from the MDH Vital Records Administration), no special notification to local health/MES services are needed as Vital Records collates all death statistics. Hospitals should manage their mortuary resources as appropriate for the size of their facility and nature of patient care occurring. This includes the ordering of appropriate body bag numbers through normal vendors (FEMA contact number XYX can supplement if a facility is at imminent risk of insufficient supply). The use of refrigeration trailers is a decision for each hospital administration to make factoring in their mortuary resources, facility size, and patient mix.

COVID19 Decedent Handling: Staff should wear appropriate PPE for any decedent with an infectious disease. Decedents should be placed into a mortuary body bag, with clear and accurate external labeling of the decedent's identity. Identity should be triple verified for accuracy of the external labeling, as the external labeling will subsequently become a primary identification of these decedents. The bag should be closed, and the decedent held in the facility mortuary services at refrigeration until claimed by funeral establishments or transferred to other State agencies articulated below.

Role of the Office of the Chief Medical Examiner (OCME - phone 410 333 3271) - Deaths in a medical facility under the supervision of an attending are deemed 'attended deaths' and certified by physicians on duty. The OCME would not be involved in those cases or receive decedents when they are determined by medical personnel to be natural causes.

Role of the State Anatomy Board (SAB - phone 410 547-1222 or 800 879-2728): Normal process is followed that if a decedent is a donor of the body donor program the SAB should be contacted promptly to make removal. If the decedent has no next of kin, or next-of-kin do not make claim, the SAB is contacted to take custody. Under Maryland statute if the facility where the patient died has refrigeration capability, then the facility is to contact the SAB at 72 hours post death to report an unclaimed decedent, if the facility lacks refrigeration the SAB should be contacted promptly to make removal.

Overflow Situation: In the event that a hospital is in an emergency overflow situation, with no ability to store decedents properly, the State Anatomy Board (SAB) should be contacted to provide overflow assistance. After 4/25/20 the Temporary Mortuary Affairs Center (TMAC - phone 240 636-9804) would be contacted to assist with overflow situations. Hospitals should make every effort to ensure adequate capability for their facility size, as well as smooth and efficient operation of their mortuary affairs division so the normal processes above can occur for families. The TMAC will require the standard details of the decedent to be received (name, date of death, etc.) and cause of death (death certificate completed by the hospital facility promptly into EDRS), location of the decedent, next of kin details. The same information that is passed to funeral homes under normal process is required by the TMAC for proper processing of the decedent.



MARYLAND

Maryland Department of Health and Mental Hygiene Mass Fatality Management Plan

March 2012



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Maryland Department of Health and Mental Hygiene
Mass Fatality Management Plan
Emergency Support Function #8

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Foreword

Maryland Governor Martin O’Malley established Twelve Core Goals for a Prepared Maryland in order to ensure that the state is adequately prepared for any emergency or disaster. As the lead state agency for Emergency Support Function #8: Public Health & Medical Services, the Maryland Department of Health and Mental Hygiene (DHMH) was tasked with developing a state Mass Fatality Management Plan as part of Core Goal 9 – Mass Casualty/Hospital Surge.

This document is a result of the collaborative efforts among the DHMH administrations, ESF #8 partners and the local health departments. The final plan incorporates comments and suggestions received from a variety of stakeholders including organizations that will provide critical support to DHMH during a mass fatality incident.

This plan establishes the overall roles and responsibilities as well as the concept of operations for the management of a mass fatality incident. It assumes, as with most emergency operations, that the management of the overall incident is the responsibility of the local jurisdiction. However, it recognizes that, unless the fatalities are the result of a naturally occurring disease, a response from the Office of the Chief Medical Examiner will be required to manage the fatalities. Additionally, in a mass fatality incident regardless of the cause, resources from the state and perhaps the federal government may be necessary. Because legal authorities have been assigned to both the state and the local jurisdiction to manage different aspects of fatalities, this plan attempts to clarify the expectations and the roles of both the local and state government. This plan is intended to be used in conjunction with established policies, operational procedures, and protocols.

Users of this document are encouraged to recommend changes that will improve the clarity and use of this plan.

Questions or comments concerning this document should be directed to:

Maryland Department of Health and Mental Hygiene
Office of Preparedness and Response
300 W. Preston Street, Suite 202
Baltimore, MD 21201
410-767-0823

Letter of Promulgation

In accordance with the powers vested in me, I hereby approve and promulgate the Department of Health and Mental Hygiene Mass Fatality Management Plan. The Plan denotes the concept of operations and roles and responsibilities of state agencies with regard to a response to a mass fatality incident. It describes the process for coordination of resources to manage the incident effectively.

This plan is effective as of December 2011.

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health and Mental Hygiene

Frances B. Phillips, R.N., MHA
Deputy Secretary for Public Health Services
Maryland Department of Health and Mental Hygiene

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Director, Office of Preparedness and Response
Maryland Department of Health and Mental Hygiene

Executive Summary

The Department of Health and Mental Hygiene (DHMH) Mass Fatality Management Plan (MFMP) is a functional specific plan that establishes a single, comprehensive framework for the management of fatalities in a mass fatality incident. The plan is implemented when the normal death management process capacity is exceeded. The Plan incorporates National Incident Management System (NIMS) concepts and is consistent with and complementary to the Maryland Emergency Operations Core Plan and the DHMH Emergency Support Function #8: Public Health and Medical Services Operations Plan.

The plan assigns roles and responsibilities to Maryland state government agencies and administrations within DHMH and identifies the legal authorities and roles and responsibilities for both state agencies and local governments in fatality management. This plan is not intended as a standalone document but rather establishes the basis for more detailed planning by the individual agencies and organizations with assigned responsibilities. The plan is intended to be used in conjunction with more detailed department and agency plans and operating procedures.

Because of the unique characteristics of mass fatality incidents to which local and state agencies will be required to respond, this plan does not detail the specifics of how to respond to every aspect of an incident; rather, it provides the framework in which the response is organized and decisions are made. The successful implementation of the plan is contingent upon a collaborative approach with a wide range of organizations providing crucial support during emergency operations. The plan recognizes the significant role of the local health departments in coordination with local emergency management, law enforcement, fire and emergency medical services (EMS) departments, and hospitals in response to a mass fatality incident while maintaining priority for the provision of services to the surviving victims. The roles and responsibilities of these entities are also included in the plan.

The MFMP is organized into two sections: Section One is the Base Plan and includes the federal, state, and local authorities and other references that provide the basis for this plan. This section establishes the planning background (situation) and assumptions for the plan and defines the roles and responsibilities for state agencies, local government agencies, and supporting non-governmental (partner) agencies. The core of Section One is the concept of operations section that describes how a mass fatality incident will be managed.

Section Two includes the appendices that support the base plan. It includes supporting information such as data on Maryland funeral homes, cultural and religious considerations, and sample forms.

Plan Development, Maintenance, and Distribution

1. The DHMH Office of Preparedness and Response (OP&R) is responsible for developing, maintaining, and distributing the DHMH MFMP.
2. The plan will be reviewed periodically to incorporate changes in government structure, technological changes, changes to or new state and federal legislation, directives, or guidelines and/or to address operational issues identified through actual emergency response operations or exercises.
3. Copies of the plan, either hard copy or electronic, will be distributed to all state agencies and DHMH administrations with assigned roles and responsibilities, local health departments, and other state and federal partner agencies and organizations as appropriate. Additional copies will be available from DHMH if requested.
4. After-action reviews are essential for identifying issues that impeded operations and/or innovative approaches that were introduced during the response and recovery that may be applicable to future incidents. In order for issues to be addressed, they need to be identified and documented. During any major public health, medical, or other major disaster incident, including mass fatality incidents, as well as related exercises, information regarding the outcomes, effects, and impact of the incident should be recorded.
5. DHMH will facilitate an after-action review after a mass fatality related state of emergency has ended or as operations begin to return to normal. All agencies and stakeholders that provided support to DHMH during the operation will be invited to participate. The after-action review will be used to identify issues, concerns, and successes that need to be addressed or incorporated into existing plans and procedures. An after-action report that includes a corrective action (improvement) plan will be produced after the after-action review.
 - DHMH OP&R will manage the corrective action program by documenting issues and tracking the status of resolutions.

Record of Changes

1. Changes will include additions of new or supplementary material or deletions of outdated information. All requests for changes will be submitted to DHMH OP&R for coordination, approval, and distribution.
2. Notices of Change will be prepared and distributed by DHMH. The Notice of Change will include the change number, effective date, description of change, and action required by the departments and agencies. The Notice of Change will include instructions for updating the plan.
3. Upon publication, the change will be considered as part of the Mass Fatality Management Plan. All entities with roles and responsibilities identified in this plan will be responsible for maintaining current editions of the plan.

Plan Version	Effective Date	Description of Change	Name and Agency
1.0	March 2012	Initial Plan	Mass Fatality Management Working Group

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Section I Base Plan

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I. Introduction

A. Purpose

The purpose of this plan is to outline the response by the Department of Health and Mental Hygiene (DHMH), supporting state agencies, and local jurisdictions to a mass fatality incident that overwhelms the normal fatality management operations. This plan assigns roles and responsibilities to various state agencies and provides a concept of operations for managing the response.

B. Scope and Applicability

1. This Mass Fatality Management Plan (MFMP):
 - Applies to any incident within the state which results in a number of (human) deaths that significantly impacts or exceeds the capabilities of the local jurisdiction, the death care industry, and/or the Office of Chief Medical Examiner (OCME) to respond to or manage the incident. It does not automatically apply to incidents in which the OCME has jurisdiction; rather, the plan applies to incidents that overwhelm the normal day-to-day fatality management capabilities.
 - Applies to the DHMH and all state agencies designated as support to Emergency Support Function (ESF) #8 by the State of Maryland Core Plan for Emergency Operations as well as additional agencies listed under the roles and responsibilities section of this plan.
 - Will be used in conjunction with existing emergency operations plans and response policies, protocols, and procedures.
 - Is intended to be used as a guide and does not replace sound judgment or anticipate all situations and contingencies.
 - Defines the roles and responsibilities for mass fatality management from the local government to state government to address the entire spectrum of operations that provides for the care of the decedent. This includes (as applicable to an incident):

- Recovery and examination of the decedents
- Determination of the nature and extent of injuries
- Recovery of forensic, medical, and physical evidence
- Identification of the fatalities
- Certification of the cause and manner of death
- Decontamination of remains and personal effects
- Temporary storage of human remains
- Notification of the next of kin
- Processing of personal effects
- Release of remains to next of kin/families
- Temporary interment
- Behavioral health support

2. This plan acknowledges that some mass fatality incidents will fall under the jurisdiction of the OCME and some will not. Therefore, the determination and establishment of jurisdictional authority is a critical decision that should be addressed early in the incident to allow for notification of all pertinent agencies and to reduce response time and delays in set up.
3. The OCME will respond to mass fatality incidents within their jurisdiction as outlined in the OCME MFMP. DHMH and other state agencies will provide assistance when OCME capabilities are overwhelmed or as requested.
4. Regardless of the scenario and jurisdiction, the response to a mass fatality incident will require coordination among numerous government agencies and private sector partners.

C. Training and Exercises

1. The DHMH Office of Preparedness and Response (OP&R) is responsible for identifying recommended mass fatality management training and providing education and training on the state MFMP to DHMH employees, the Maryland Professional Volunteer Corps (MPVC), other state agencies, local health departments, hospitals, and partner organizations.
2. Just-in-Time Training (JITT) is specific, concise training provided just prior to performance of the duties assigned during the operations (implementation) phase of the plan. While this is not ideal, the incident circumstances may

result in staffing shortages, procedural changes or new staff and JITT will be necessary. The training should be conducted as an orientation for staff members and may include the following topics:

- Incident command structure
- Situation overview
- Description of mass fatality management operations
- Review of responsibilities
- Reporting requirements
- Safety

3. Exercises validate plans and training; determine strengths and areas for improvement; and identify lessons learned and corrective actions to drive subsequent planning, training, and exercise activities. The state MFMP should be exercised regularly. Exercises will be evaluated so that shortcomings in the plan, training, coordination, and operational procedures can be identified and corrected.
4. DHMH exercises will be planned and conducted in accordance with the guidelines of the Homeland Security Exercise and Evaluation Program (HSEEP).
5. Each agency assigned roles and responsibilities in this plan will ensure that staff members are trained for their emergency roles and responsibilities and provided the opportunity to participate in exercises as appropriate.

II. Planning Background

A. Mass Fatality Incident Management Objectives

The following objectives generally guide the overall response to a mass fatality incident.

- Investigate, recover, and process decedents in a dignified and respectful manner.
- Determine cause and manner of death.
- Perform accurate and efficient identification of victims.
- Provide families with factual and timely information in a compassionate manner.
- Conduct rapid return of decedents to their legal next of kin.

B. Characteristics of Mass Fatality Incidents

1. The characteristics of a mass fatality incident will dictate the type of response and resources necessary to effectively manage the fatalities. For example, an incident with a fast rate of recovery and largely intact remains will quickly overwhelm the system, but the response will not necessarily be as long term as that following an incident that results in badly fragmented remains with a slow, difficult recovery rate.
2. The following factors are generally used to describe or characterize the magnitude of a mass fatality incident.
 - *Number of Fatalities.* The number of fatalities is key to identifying resource needs. The condition of remains and manifest issues are resource multipliers.
 - *Rate of Recovery.* A fast rate of remains recovery can overwhelm local resources and storage capacities. It can also raise the expectation of fast identifications. A slow rate of recovery allows time to build resources, but will increase the duration of the incident.
 - *Manifest.* In transportation incidents, the existence of a manifest (a detailed inventory/list of occupants/cargo), is a key identification factor. Knowing who is likely dead will expedite the identification and limit the need for more extensive identification processes.

- *Condition of Remains.* Fire-damaged, decomposed, fragmented, or contaminated remains will have a multiplying effect on the resource needs for identification. In non-manifest incidents, fragmented remains will require that each remain be treated as a potential individual.
- *Geography.* A local incident within a single geographic jurisdiction allows for a single, local identification center. An incident across jurisdictions requires a regional or national (if survivors are displaced) identification effort and coordination among jurisdictions.

3. Additional characteristics of the disaster itself such as the type of disaster (natural, accidental, or criminal/terrorist), scene location and terrain (e.g., land, water, mountains), type of location (e.g., field, collapsed building), environmental conditions, and other situations (e.g., fire, contamination, and debris) will further dictate the type of response necessary.

C. Situation

The DHMH is the lead agency for ESF #8, Health and Medical Services. Responsibility for mass fatality management at the state level has been tasked by the Governor to DHMH. However, no single agency in Maryland has complete authority for mass fatality management, nor can any single agency handle the full responsibility of the management, whether those fatalities are naturally occurring or are the result of human actions. In either situation, there will be multiple disciplines involved in the management of the mass fatality incident at both the state and local levels, and a coordinated response will be necessary.

General

1. Mass fatality management is the ability to coordinate with other organizations (e.g., law enforcement, fire and rescue, hospitals, and emergency management) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposition of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.
2. A large number of fatalities may result from a variety of causes including natural disasters, hazardous material incidents, terrorist attacks,

transportation accidents, or as the result of a naturally occurring disease outbreak.

3. For purposes of this plan, a mass fatality incident is defined as any situation that results in more fatalities than the local jurisdiction and/or death care industry can handle utilizing the usual standard of care and processes.
4. The authority for handling decedents is fully vested in the State of Maryland and not in the local jurisdictions. The State of Maryland has not given jurisdiction or authority to county or local governments to perform funeral or regulation functions. Under the Maryland Emergency Management Act, the Governor may delegate mass fatality authority to local and county jurisdictions.
5. Jurisdiction over the body is determined by the place of death and not the location of the incident. For example, a person injured at a federal installation who is transported to a civilian hospital in Maryland and subsequently dies would fall under the jurisdiction of OCME.
6. Each death requires an investigation by competent and trained law enforcement personnel to ensure the cause of death is a result of a natural disease such as influenza versus death by other mechanisms (e.g., fall, homicide, abuse, etc.). When a non-natural cause of death is suspected, law enforcement is required to notify the OCME.
7. The processing of individual human remains must be respectful and dignified and cannot be "rushed." Specific industry health and safety standards must also be maintained. Therefore, it can be expected this will be a "choke" point in the mass fatality operation.
8. Consideration for cultural and religious beliefs and the sensitivity in handling the decedents during a mass fatality is paramount regardless of the size of the incident. The appropriate and respectful treatment of decedents is a moral obligation and will be of significant psychological impact to the affected families and the community as a whole.
9. Additional obstacles that will challenge the response include the availability of supplies and equipment, personnel/staffing, transportation, funeral home processing, and time necessary to conduct funeral services. Sustained

operations will require a coordinated approach to resource management including coordination with the death care industry.

10. Funeral directors, in coordination with religious leaders, are the only service providers that offer final disposition and memorial services for the families by providing a burial or cremation with a ceremony. The State Board of Morticians and Funeral Directors licenses funeral directors and funeral homes (establishments).
11. Death pronouncement is performed by physicians and is NOT required in Maryland. Death determination is the time death is determined or the time the body is found. Any person may determine death. Death determination is assumed when first responders such as fire/EMS and law enforcement do not initiate resuscitation or obtain orders to stop resuscitation in accordance with protocols. During a mass fatality incident, persons who are clearly dead should not be transported to a hospital. Decedent remains are part of the official investigation, and doing so may overwhelm the system if it is already stressed.

OCME Jurisdiction Incidents

1. The Maryland OCME, in accordance with state code, has jurisdiction (custody) over any death that results, wholly or in part, from a casualty or accident, homicide, poisoning, suicide, rape, therapeutic misadventure, drowning, or a death of suspicious or unusual nature, or of an apparently healthy individual while not under the care of a physician. All other cases, including deaths resulting from natural diseases, are the responsibility of the local jurisdiction.
2. The OCME contracts with individuals to serve as deputy medical examiners and forensic investigators in each Maryland jurisdiction. Most investigators maintain other employment and thus are not always available. In a mass fatality incident, it may be necessary for emergency authorizations to be granted to establish surge capacity for this function.
3. The OCME has primary jurisdictional authority over deaths occurring on federal installations that have previously been declared "concurrent," "partial," or "proprietary" jurisdictions. In the event of conflicts over jurisdiction, the federal government prevails under the Supremacy Clause of the Constitution.

Local Jurisdiction Incidents

1. Under normal conditions, approximately 75 percent of the fatalities in the region are not OCME cases because these deaths are due to natural diseases occurring under natural circumstances. Non-OCME deaths are not reported to the OCME. They are managed by the local law enforcement agency, Emergency Medical Services (EMS), treating physicians, healthcare systems, funeral directors, cemetery or cremation owners, and individual families.
2. In naturally occurring deaths such as those resulting from a pandemic, the local law enforcement agency is responsible for confirming the death is not an OCME case. Deaths due to a pandemic infection are NOT under the jurisdiction of the OCME. In a pandemic situation, deaths will occur outside of hospitals and may place additional stress on local responders in the field (i.e., EMS and law enforcement). The number of deaths may also overwhelm hospitals and the death care industry resulting in a delay of transport, storage, and final disposition of the decedents. In this type of mass fatality incident, local jurisdictions may implement their emergency operations plan to manage the situation. It is the responsibility of the local jurisdiction to organize the response to a mass fatality incident in accordance with local operations plans.
3. Hospitals and healthcare facilities may experience a surge in fatalities that occur in their facilities and should plan for an increase in the number of bodies that could require storage due to likely delaying in transporting bodies to funeral homes or temporary storage sites. Local health departments and partner agencies should coordinate with hospitals, healthcare facilities, and the local death care industry to form public/private partnerships to address fatality management and surge capacity issues.

D. Planning Assumptions

1. Operations under this plan will be conducted in accordance with the National Incident Management System (NIMS).

2. All entities with roles and responsibilities in this plan are responsible for developing policies, plans, and procedures to fulfill their roles and for training and exercising the same.
3. All administrations and organizations will provide support as outlined in the "Roles and Responsibilities" section of this plan and as assigned by the State of Maryland Core Plan for Emergency Operations.
4. Deaths not related to the mass fatality incident will be ongoing and local emergency medical system, law enforcement, hospitals, and the death care industry will have to continue to respond to these needs as well.
5. Investigation into each death by local law enforcement will continue to be necessary to differentiate between naturally occurring deaths versus other activity (violence, other disease related, suicide, etc.). Local law enforcement personnel will make an initial determination as to whether or not the death is an OCME case (non-natural death) and will make the notifications as appropriate.
6. An incident that disrupts grave sites may also result in the need to identify and reinter fatalities that are not a direct result of the incident.
7. Fatality management resources may be adversely impacted by the emergency or quickly overwhelmed by the number of fatalities.
 - There may be shortages of resources such as caskets, litters and transportation vehicles, and/or storage facilities for human remains.
 - The availability of personnel to perform processing, funeral services, and transportation services will also impact mortuary services.
 - Large numbers of deaths may backlog the entire process in the state including law enforcement, OCME, hospital morgues, funeral homes, cemeteries, crematories, and the Vital Statistics Administration.
8. The entire process of managing the fatalities may take months to years to completely resolve. In some instances, it may not be possible to recover and identify all decedent remains.

9. As local resources become depleted, neighboring counties, the state, and/or federal authorities may be asked to provide additional resources. In a localized, acute incident, mutual aid may be available; however, for an incident with regional or national impacts and a high number of fatalities, the mutual aid available to both the local jurisdiction and the state may be extremely limited or not available.
10. The incident may have a significant impact on local and state government employees and resources rendering them unavailable and as such it may be necessary to depend heavily on mutual aid resources.
11. Maryland does not have its own Disaster Mortuary Operational Response Team (DMORT). However, the Maryland (MSFDA) has a Disaster Response Team that may be requested to support a mass fatality incident. Federal DMORT teams and the MSFDA team may not be available during an infectious outbreak because the members, who are all employees performing similar functions in their own communities, may be directly impacted by the incident.
12. Incidents that involve biological, chemical, or radiological agents or materials may require special handling of the remains. Guidance for the proper handling of the remains will be the responsibility of subject matter experts from local hazardous materials teams, the Maryland Department of the Environment, or specialty teams such as DMORT-Weapons of Mass Destruction (WMD) team. While these cases are under the jurisdiction of the medical examiner, the OCME does not maintain the subject matter expertise nor the capability to handle contaminated remains.
13. Terrorist incidents or other mass fatality incidents may occur with little or no warning. However, it may be a period of days or weeks before recognition or confirmation that, through established surveillance methodologies, a bioterrorism attack has occurred.
14. When a mass fatality incident overwhelms local and state resources and/or is of catastrophic proportions, customary funeral/memorial practices may need to be adapted. Religious and cultural leaders should work with death care industry personnel to create strategies to manage the surge of deaths such as abbreviated or group funerals, rapid burial/cremation with postponed memorial services, etc.

15. Management of the deceased will be conducted with reasonable care in a respectful, dignified manner. To the greatest extent possible, respect will be paid to faith based or cultural beliefs related to the disposition and handling of remains.
16. During a mass fatality incident, media representatives will quickly attempt to establish a strong on-scene presence. It will be important for local law enforcement to establish an effective security perimeter.
17. Family members and loved ones will report to the incident scene or local hospitals seeking information even if there are no known survivors. Local plans must include processes for scene- and specific-site security as well as a communication plan for information sharing with the families.
18. If the mass fatalities are the result of an infectious outbreak:
 - 911 call centers will be overwhelmed and it may be necessary to augment capacity or establish a call center to receive reports of death.
 - Usual funeral/memorial practices may need to be modified in order to reduce disease transmission.
 - Social distancing factors, isolation, and/or quarantine, limitations on public gatherings, and establishment of curfews should be considered (e.g., use of internet-based services, limiting number of attendees).
 - Family members living in the same household as the deceased may be in quarantine and unable to make final disposition arrangements.
 - Funeral homes with just-in-time inventory plus reduced industrial capacity due to illness and death (in a pandemic) will result in shortages of all products and capabilities.
 - The capacity of existing morgues and/or the autopsy facility in the state will be exceeded quickly during an infectious outbreak.

E. Relationship with Other Operational Plans

1. This plan is designed to be complementary to other state plans and focuses on the management of fatalities.
2. Depending upon the nature of the incident, this plan may be implemented on a “stand-alone basis” or in conjunction with other state plans including the State of Maryland Core Plan for Emergency Operations, the DHMH Public Health and Medical Services Operations Plan, the DHMH Pandemic Influenza Response Annex, the DHMH Public Health and Medical Surge Capacities and Capabilities Incident Response Annex, and/or the OCME MFMP.
3. For mass fatality incidents under the jurisdiction of the OCME, this plan will be implemented in conjunction with the OCME MFMP.
4. For mass fatality incidents not under OCME jurisdiction (e.g., naturally occurring disease outbreak), this plan may be implemented in conjunction with the DHMH Public Health and Medical Services Operations Plan.
5. Depending upon the scope and magnitude of the incident, the Maryland Emergency Management Agency (MEMA) may also activate the State of Maryland Core Plan for Emergency Operations.

III. Concept of Operations

A. General

1. All mass fatality incidents begin with a local response by law enforcement and/or EMS. The management of the overall incident will remain the responsibility of the local jurisdiction in accordance with their emergency operations plans. The fatalities will be managed primarily by the local jurisdiction(s) until:
 - A death is determined to satisfy criteria for an investigation or management by the OCME;

- The number of deaths significantly impacts or exceeds the capabilities of the local jurisdiction to manage the incident; or
- Otherwise instructed by the Maryland Secretary of Health.

2. If jurisdiction for the fatalities does not fall under the OCME, such as in the case of naturally occurring communicable diseases¹, the local jurisdiction will be responsible for them including but not limited to:

- Storage of fatalities exceeding the capacity of the death care industry
- Coordination of the public health and medical response
- Establishing appropriate incident or unified command.

3. The DHMH Operations Center will facilitate the provision of technical assistance and resources, including the technical expertise of the OCME if determined appropriate, to support the operations of the local health department(s). Other state organizations may be requested to provide support in accordance with their assigned functional roles and responsibilities in the State of Maryland Core Plan for Emergency Operations.

4. While the overall incident management is the responsibility of the local jurisdiction, there are state and federal legal authorities that assign responsibility for components of fatality management to a variety of entities including the OCME, Federal Bureau of Investigation (FBI), and the National Transportation Safety Board (NTSB). This will require the establishment of a Unified Command that will incorporate the local agencies, such as public health, emergency management, law enforcement, fire, rescue, and hazardous materials teams and representatives from the state, federal, and private organizations such as the NTSB, OCME, FBI, and airline/airport.

5. The following outlines the local, regional, state, and federal response to a mass fatality incident.

¹ The Maryland OCME may have some initial responsibility and jurisdiction in the identification and confirmation of the communicable disease and will continue to be responsible for certain categories of cases that fit criteria established by law (e.g., deaths for which there is no attending physician, unidentified decedents).

- **Tier 1: Single or Multiple Fatality Incident**

An incident that occurs during this tier involves one or multiple fatalities that can be handled through normal available resources and processes. This situation corresponds to routine, day-to-day fatality activities such as a naturally occurring death in a private home or a multi-fatality vehicle accident.

- **Tier 2: Jurisdiction Response**

In Tier 2, the situation warrants a response from additional local government agencies such as emergency management and the health department for the management of the incident. An example of this is a building collapse resulting in a prolonged incident.

- **Tier 3: Intrastate Regional Response**

In Tier 3, a mass fatality incident has become regional in nature and several counties are involved in the response. In terms of a mass fatality incident, an example may be a pandemic that has resulted in fatalities in multiple jurisdictions that exceed the capabilities of the local death-care industry.

- **Tier 4: State Response**

This tier represents a response to a mass fatality incident that affects multiple counties in the state in which local and regional mutual aid resource capabilities have been exceeded. Depending on the nature and severity of the incident, the state may declare a catastrophic health emergency in accordance with Maryland laws.

- **Tier 5: Interstate Response**

The key aspect of this response is coordination with neighboring states (Pennsylvania, West Virginia, Virginia, Delaware, New Jersey, and the District of Columbia) to coordinate mass fatality incident management during an incident that crosses state lines.

- **Tier 6: Federal Response**

A mass fatality incident that impacts multiple jurisdictions in the state or across state lines may require a federal response if the number of fatalities threatens to exceed the capabilities of the state. Additionally, some federal agencies have a legal obligation to respond to certain types of

incidents, such as suspected terrorist incidents (FBI) regardless of the magnitude.

Although Tier 1, 2, and 3 incidents speak to local and regional response, the OCME (an administration of the DHMH) may have legal authority for involvement in the response. This does not automatically escalate the type of incident to a Tier 4 State Response.

Generally, this plan will not be implemented during a Tier 1 situation. It may be implemented for a Tier 2 response for an incident that results in mass fatalities in one jurisdiction and requires a significant response by the OCME. For Tier 3, 4, 5, or 6 responses that involve mass fatalities, this plan will be implemented and the DHMH Operations Center activated.

B. Plan Activation

1. The Deputy Secretary for Public Health Services or designee will make the determination to implement the state MFMP based upon actual or anticipated requirements for state support for mass fatality assistance. The plan may be implemented in conjunction with other state emergency plans to specifically address mass fatalities. The determination to implement this plan may be based on one or more of the following criteria:
 - Recognition of a mass casualty incident with expected deaths that exceed current day-to-day capacity to manage the decedents.
 - Recognition that a naturally occurring disease is resulting in increasing numbers of deaths that may exceed local capabilities.
 - Recognition of a bioterrorism incident with a high homicide rate.
 - Notification from one or more local health officers that the local hospitals and funeral homes have exceeded their capacity to process and store bodies.
 - Recognition of any mass fatality incident as defined by the Maryland OCME: Any incident with fatalities that exceed or overwhelm usual local or OCME resources.

2. Upon determination to implement the plan, the Office of Preparedness and Response will activate the DHMH Operations Center to coordinate the DHMH response.

C. Notification Process

1. The DHMH may become aware of a mass fatality incident through any number of channels.
 - The OCME may be directly notified by local law enforcement or emergency medical services personnel.
 - Notification may come from the State Emergency Operations Center (SEOC).
 - In circumstances such as an influenza pandemic, DHMH may become aware of the incident through its on-going health surveillance activities.
 - In biological incidents, the state laboratory or the OCME may be the one who identifies the agent and notifies public health authorities of their findings.
 - If the death is on federal property within the state, notification may come directly from authorities associated with the facility or property or from other federal entities.
2. In the event that first responders or others suspect the incident or threatened incident is the result of a terrorist act or involves a WMD, the Maryland Joint Operations Center (MJOC), the Maryland Coordination and Analysis Center (MCAC), and DHMH will be notified. The FBI and any other necessary agencies will be notified through procedures established by the MJOC.
3. DHMH will notify the appropriate local and regional public health and healthcare partners through available and immediate communication technologies, such as the Maryland Health Alert Network, in accordance with appropriate plans, policies, and standard operating guidelines.

4. DHMH will notify the appropriate federal agencies when necessary, such as the U.S. Department of Health and Human Services, in accordance with appropriate plans, policies, and standard operating guidelines.

D. State Emergency Operations Organization

1. During an emergency that requires public health and medical surge, DHMH, as the lead agency for ESF #8, is responsible for coordination of all aspects of public health and medical response in the state, which includes providing for mass fatality management.
2. One of the key roles of DHMH during an emergency is to maintain statewide situational awareness regarding the public health and medical response. DHMH accomplishes this through communication and coordination with local health departments, hospitals and other healthcare facilities, state agencies including MEMA and the Maryland Institute for Emergency Medical Services Systems (MIEMSS), as well as other organizations and private sector partners.
 - If the Governor has not declared a State of Emergency, the SEOC may or may not be activated depending on the type and extent of incident.
 - If the SEOC is not activated, the DHMH Operations Center will be operational to coordinate response operations.
 - If/when the SEOC is activated, DHMH will provide a representative to staff ESF #8 to serve as the liaison from the SEOC to DHMH and other ESF #8 partners providing situational awareness and processing resource requests from local jurisdictions.

E. Emergency Declarations

A number of declarations that provide emergency authorities to various officials and/or access to state or federal resources may be issued as a result of an incident resulting in mass fatalities.

1. State Emergency Declaration

- The Maryland Emergency Management Act, found in the Annotated Code of Maryland, Public Safety Article, § 14-101, et. seq., prescribes the authority and implications of a declaration of a state of emergency by the Governor.
- The Governor may declare a state of emergency to exist whenever the Governor finds an emergency has developed or is impending due to any cause. The state of emergency is declared by executive order or proclamation.
- The Governor's declaration of a state of emergency provides for the expeditious provision of assistance to local jurisdictions included in the declaration, including use of the Maryland National Guard.

2. State Catastrophic Health Emergency

- Annotated Code of Maryland, Public Safety ("Public Safety"), Title 14, Subtitle 3A, Governor's Health Emergency Powers provides the Governor of Maryland with the legal authority to declare a catastrophic health emergency. Under Public Safety § 14-3A-01(b), a catastrophic health emergency is defined as "a situation in which extensive loss of life or serious disability is threatened imminently because of exposure to a deadly agent." A deadly agent is defined in Public Safety § 14-3A-01(c) as one of a wide range of biological, chemical, or radiological items that could potentially cause extensive loss of life or serious disability.
- If the Governor determines that a catastrophic health emergency exists, the Governor will issue such proclamation. The proclamation will include: the nature of the catastrophic health emergency, the areas threatened, and the conditions that led to the catastrophic health emergency. The proclamation will last for 30 days after the issuance and is renewable by the Governor for successive 30-day periods during the catastrophic health emergency.
- After the Governor issues a proclamation, the Governor may also issue specific orders to the Secretary or other designated officials under Public Safety §14-3A-03 (b)-(d) to facilitate the response.

3. Federal Declaration

- Under the provisions of the Robert T. Stafford Act, the Governor may request the President declare a major disaster or emergency declaration for incidents that are (or threaten to be) beyond the scope of the local jurisdictions and the state to effectively respond.
- A federal declaration provides access to federal assistance and resources to augment the local and state capabilities.

F. Direction and Control

1. National Incident Management System (NIMS)

- By Executive Order on March 4, 2005, the State of Maryland adopted the federally mandated NIMS as the state standard for incident management. The Executive Order directs all state governmental agencies to adopt this system as a basis for command and control of emergency incidents in cooperation with the local jurisdiction response partners. NIMS incorporates the Incident Command System (ICS) as the national standard for incident management. This plan has incorporated these concepts as appropriate.

2. Incident Command System (ICS)

- ICS is an emergency management system designed to enable effective and efficient management of incidents by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. The ICS is widely applicable to organize both short-term and long-term field operations for the full spectrum of emergencies.
- The responsibility for implementing ICS initially rests with the local emergency services agencies (e.g., fire, EMS, and police). The organizational structure will be established to address the full range of response operations at all involved incident locations.
- The Incident Commander (IC) is the individual responsible for all incident activities including the development of incident objectives, approving on-scene strategies and tactics, and the ordering and release of on-scene

resources. The IC is delegated overall authority and responsibility for conducting incident operations.

- Unified Command (UC) will be used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC to establish common objectives and strategies under a single Incident Action Plan (IAP).
- At the local jurisdiction, the health department is integrated into the local command system as appropriate at the Incident Command Post (ICP) and/or the local Emergency Operations Center (EOC). For incidents resulting from an outbreak of a naturally occurring communicable disease, the local health department may assume the IC role.

3. Upon activation of this plan, the DHMH Operations Center will provide command, control, and management for planning and executing the DHMH response. The primary functions of the DHMH Operations Center are:

- Coordinating support from within the department for operations in the local jurisdiction(s).
- Coordinating logistical and other support to the OCME for incidents under the OCME's jurisdiction.
- Facilitating the process of identifying resources among the local health departments.
- Collecting, analyzing, and summarizing information on the incident and ensuring that current information is provided to appropriate government officials.
- Providing assistance and coordination for public information activities.
- Coordinating with MEMA/SEOC to obtain resources from other state departments and agencies as needed.

- Coordinating with MEMA/SEOC to request assistance from other states as needed through the Emergency Management Assistance Compact (EMAC).
- Coordinating with MEMA/SEOC on emergency declarations and authorities.
- Coordinating with MEMA/SEOC as needed to request federal assistance such as DMORTs.
- Coordinating with subject matter experts, (i.e., those with expertise in epidemiology, surveillance, community cultural/religious beliefs, mortuary science, and chemical, biological, radiological contamination, etc.) to ensure an appropriate and effective response to the incident.

4. State resources deploying to the incident will integrate into the on-scene IC/UC.

- For incidents under OCME jurisdiction, OCME staff will integrate within the established incident or unified command structure.
- For incidents under OCME jurisdiction, as staff resources allow, a liaison will be assigned to the IC/UC and staff will integrate under the Operations Section in order to oversee the recovery, processing, and disposition of remains.
- A mass fatality management branch or group, headed by the OCME, may be established under the Operations Section to manage the handling and processing of fatalities.

G. Jurisdiction/Authority

OCME Jurisdiction

1. The OCME has jurisdiction over any death that results, wholly or in part, from a casualty or accident, homicide, poisoning, suicide, rape, therapeutic misadventure, or drowning, or a death of suspicious or unusual nature, or a death of an apparently healthy individual while not under the care of a

physician. The DDHM OCME has statewide jurisdiction; there are no local medical examiners. As a result, almost all mass fatality incidents will fall under the jurisdiction of the OCME.

2. Except in rare circumstances involving military or certain federal employees, the OCME will retain control of, and responsibility for, handling the decedents under their jurisdiction.
3. The OCME maintains a supporting MFMP that addresses the specific operations for the OCME in responding to mass fatality incidents.
4. In OCME cases, the OCME is responsible for the following:
 - Investigating and determining the cause of sudden, unexpected, violent, and non-natural deaths.
 - Providing emergency information on body identification and morgue operations for coordinated dissemination of incident information.
 - Covering, tagging, and protecting bodies.
 - Establishing a temporary autopsy facility if determined necessary.
 - Coordinating the removal of remains to storage areas.
 - Maintaining security of bodies and personal effects/evidence.
 - Assisting with body identification through forensics, if requested.
 - Establishing a data collection system for recording information on all deaths resulting from the disaster.
 - Coordinating morgue services and disposition of bodies.
 - Performing tasks to ensure accurate certification of death.

Local Jurisdiction

1. If a mass fatality incident does not fall under the jurisdiction of the OCME, such as in the case of naturally occurring communicable disease outbreak, the local jurisdiction will be responsible for coordinating the management of the fatalities exceeding the capacity of the local death care industry.
2. The following are the general actions that will be taken or considered by the local jurisdictions in accordance with local emergency operations plans and local mass fatality management plans.
 - Establish operations utilizing the ICS.
 - Activate local EOCs and/or departmental operations centers as appropriate.
 - Notify local, state, and federal partners in accordance with established standard operating procedures, including hospitals, local funeral homes, DHMH (OP&R, OCME, Vital Statistics), and MEMA.
 - Coordinate with primary partners on the operational and logistical needs required to manage decedents.
 - Coordinate with primary partners to determine the need to establish mortuary affairs collection points (MACPs) or other storage options and identify resources for such.
 - When funeral home capacity becomes overwhelmed, collect, store, and/or preserve decedents until they can be transported or released to the funeral home chosen by the family.
 - Identify transportation assets that may be used for the collection of decedents.
 - In coordination with DHMH, develop and distribute safety criteria for managing the decedents.
 - As applicable, provide prophylactic medication or vaccine to those responders who have not yet received it.

- Determine the need for a Family Assistance Center (FAC). Generally this is the responsibility of local ESF #6 partners in coordination with the Maryland Department of Human Resources.
- Coordinate public information activities with local and state public information officers.
- Request additional resources.

H. Operations

The overall mass fatality management operation is described according to functional areas of response. Where the operational considerations are different, depending on whether the fatalities are the responsibility of the OCME or local jurisdiction, they are separated by authority for clarity.

General

1. The DHMH Operations Center will support the OCME and local health department response as needed.
2. If the disposition of remains poses a public health threat, DHMH will determine the actions to be taken in the prevention, detection, management, and containment of the disease/agent.
3. If prophylactic medications are recommended for those handling the living, they may also be recommended for those handling the remains. If this is the case, DHMH shall ensure all persons responding to the mass fatality incident, including the death care industry, are classified as responders to the incident and receive appropriate treatment.

OCME Jurisdiction

1. Upon receiving notification of a mass fatality incident, the OCME will deploy a representative to the scene, (typically to the Incident Command Post if established). This representative will work with the local jurisdiction and serve as a liaison to the OCME Baltimore office, relaying information on the initial scene assessment including:

- Type of incident (e.g., plane crash, train wreck, flood, bombing, etc.)
- Whether this is an open or closed population, i.e., whether a manifest exists
- Number of confirmed fatalities. Number of injured.
- Type of trauma suffered by victims (burns, significant fragmentation, etc.)
- Compounding circumstances at the scene (e.g., fire, flooding, terrain, etc.)
- Whether a disaster has been declared by the jurisdiction involved
- Whether MEMA has been notified
- What agencies are involved
- Whether a command post has been set up. Who the incident commander is and contact information
- Whether criminal activity is suspected in the incident
- What scene hazards exist (topography, structural collapse, hazardous materials)
- Whether an estimated time for the recovery of bodies has been determined
- What are the current weather conditions

2. The OCME representatives will work concurrently with law enforcement and other responders to begin developing a fatality management plan that will be incorporated into the IAP.
3. All assets requested and activated to assist with fatality management operate under the direction of the OCME within the ICS.
4. The OCME may establish a mortuary affairs collection point (MACP) near the incident scene or in areas designated by the local jurisdiction to store

recovered remains until transportation to a central incident facility can be coordinated. At the MACP, all remains will be inventoried and placed in a secure facility (a building or refrigerated trucks).

5. Additional secure facilities may be required to store refrigerated trucks with remains to accommodate large numbers of fatalities. The local jurisdiction will be asked to assist in identifying possible locations.
6. Depending upon the nature and number of fatalities involved, a decision may be made by the OCME to establish a temporary autopsy facility.
 - This facility may be used to store bodies prior to transport, serve as a facility for visual identification, or serve as a substitute location for the routine processing (such as autopsy if necessary) and related activities that normally would occur at the OCME's Baltimore facility. A temporary autopsy facility may serve all or a combination of these functions. Establishing a temporary autopsy facility and determining what functions it will serve is a decision of the Chief Medical Examiner. Location of this facility will be incident dependent, with priority given to existing OCME structures. The OCME will request assistance as needed from the local jurisdiction through the ICS chain of command.
7. In the event a temporary autopsy facility is established, the OCME will provide management and staff and may request that local law enforcement provide security.
8. Expenses incurred by the OCME in response to a disaster may be reimbursable depending on the nature of the disaster and whether a disaster declaration was issued at the state or federal level.

Local Jurisdiction

1. The local health department (LHD) is the lead agency for coordinating the public health and medical response to epidemic diseases. An incident involving a contagious communicable disease will not normally have an "incident scene" at which on-scene command would be established. For these incidents, the local jurisdiction may establish command at the local health department or at the local EOC.

2. The DHMH Public Health and Medical Services Operations Plan provides the operations structure for coordinated state assistance to supplement local resources in response to public health and medical emergencies, and it provides the overall framework for DHMH support for mass fatality incidents.
3. The 24 LHDs in the state provide active disease surveillance in coordination with the DHMH, neighboring state health departments, and the healthcare community. Upon recognition of an emerging incident caused by a naturally occurring contagious disease, an initial and ongoing assessment of the case fatality rate will be done by the LHDs to determine the need for temporary storage sites to store decedent bodies.

Body Recovery and Collection

1. Recovery (extrication) and collection are two distinct processes generally supported by separate agencies.
 - *Recovery* generally involves the search for and the extraction or extrication of a decedent from the disaster debris and is generally associated with fire and rescue operations.
 - *Collection* generally refers to the movement of a body from the location of death to a temporary storage site or funeral home. This is generally conducted by a funeral home or contracted livery service.
2. Body recovery is the first step in managing dead bodies. The process of body recovery is a critical step in the investigatory phase and the identification process and, therefore, must be coordinated effectively.
3. Rapid recovery is a priority because it aids identification and reduces the psychological burden on survivors. However, body recovery may last a few hours, a few days, a few weeks, or may be prolonged depending on the circumstances of the incident.
4. Operations for the recovery and collection of bodies will be managed by either the lead local law enforcement agency or the OCME depending on case jurisdiction and will be coordinated through the incident command

structure so as not to interrupt other interventions aimed at helping survivors.

5. The actual extrication process is the responsibility of the fire department and/or other technical search and rescue experts that have the expertise and capacity to conduct such operations.
6. Remains shall not be moved or touched by emergency workers until approval and direction has been given by the responsible authority as determined by "jurisdiction," i.e., either the local law enforcement agency or the OCME, unless the remains impede access to survivors or compromise the safety of first responders.
 - The collection of body parts and personal belongings is the responsibility of the OCME or the investigating police authority.
 - All information required for the investigation must be collected prior to the movement and collection of the body.
 - Body parts should be treated as individual bodies. Recovery teams should not attempt to match the body parts at the scene.
 - Personal belongings, jewelry, and documents should not be separated from the corresponding decedent bodies during recovery.
7. Conditions and circumstances sometimes preclude the recovery of remains in spite of exhaustive efforts and resources expended by those involved.
8. Proper protective equipment should be worn during recovery and retrieval. Medical treatment should be available in case of injury to recovery workers.

Local Jurisdiction

1. During an infectious disease outbreak, law enforcement will determine the need for OCME.
2. If it is determined the death is not an OCME case, the family is responsible for making proper transportation arrangements for the decedent's body with

the funeral homes. Law enforcement representatives may assist with this process.

3. When transportation services become overwhelmed or funeral home capacities are exceeded, it will be necessary for the local jurisdiction to assist with the fatality management. This may include, but is not limited to, the coordination of transportation services and the provision of temporary storage facilities or other resources.

Transportation

1. Transportation of the decedent from the scene to a funeral home, temporary storage, or the OCME facility is normally provided by a funeral home or livery service. However, during a mass fatality incident those transportation resources may be scarce or overwhelmed and additional resources may be required to support transportation of decedent bodies.
2. Additional transportation resource needs will be addressed through the local jurisdiction's incident command organization and the EOC. In the event that local resources are insufficient, the local EOC will request additional assistance through the SEOC, ESF #1, Transportation.
3. When deployed, the OCME will respond with its internal transportation assets. If additional transportation resources are needed, the OCME will request support through the command structure and the local EOC. In the event the local jurisdiction is unable to meet the request, it will be forwarded to the SEOC.
4. Decedents will not be transported from the incident scene by EMS or others to hospitals or other healthcare facilities. The priority for EMS services is provision of care to the living.
5. In general, the following guidelines are recommended when providing transportation services:
 - Transfer of remains to other locations should be handled discreetly, with respect and sensitive care of the remains.

- Transport vehicles should be “closed” (i.e., no pick-up trucks) when possible, and all names or identifying information on transport vehicles should be covered or removed when possible.
- Vehicles should travel the same route from the incident scene to the OCME facility, MACP, or funeral home. These routes should be established in coordination with law enforcement.
- Vehicles should travel at a moderate speed, in convoy style, maintaining order and dignity. At no time should a vehicle make unnecessary stops while transporting.
- When possible, stacking of remains should be avoided. Use of vehicles equipped with shelves is acceptable.
- Loading and unloading of the vehicle shall be accomplished discreetly. Tarps or other ways of blocking the view may be used. The top should also be covered to prevent observance from the air.
- The interior area used to store bodies should have a plastic lining. After use, or if the plastic lining is grossly contaminated and must be changed out, disposal should be in accordance with the Occupational Safety and Health Administration’s Blood Borne Pathogens Standard (29 Code of Federal Regulations [CFR] 1910.1030).
- When possible, shelving should not be wood or materials that may absorb bodily fluids. Metal or plastic shelving that may be cleaned is acceptable. A method of securing the body on the shelf should be utilized when possible.

Storage

General

1. The Anatomy Board maintains storage facilities that may be available for surge storage capacity.
2. Additional storage resource options, such as warehouses or refrigerated trucks, may become necessary to enhance capacity.

3. Post-autopsy and/or post-identification storage may be necessary depending on the circumstances of the incident. If the remains will be returned to family members, storage may be necessary until arrangements for funeral directors to retrieve them can be made. Retrieval rates will depend on the capacities and capabilities of the funeral homes to receive decedents.
4. If law enforcement requires that the remains be retained for evidentiary or identification purposes, longer-term storage will be necessary.
5. Temporary burial will be used only when the numbers of bodies exceed the cold storage and embalming capacities or in cases where the bodies may pose a public health risk due to contamination by a chemical, biological, or radiological substance. Temporary burial sites should be constructed in such a manner to help ensure future locating and recovery of bodies.
6. Embalming may be considered as a means of preserving human remains in instances where extended storage time is deemed necessary.

OCME Jurisdiction

1. The OCME maintains one facility located in Baltimore. Depending on the circumstances of the incident and available resources, the OCME will determine if the remains will be transported to this facility or if a temporary autopsy facility will be established.
2. Springfield Hospital Center is the OCME's secondary site. This site may be utilized if the Baltimore office is evacuated, inoperable, or if the OCME determines the mass fatality incident should be separated from the daily case load.
3. A temporary autopsy facility may be used for the temporary housing of the bodies, identification, sanitation, preservation (as authorized), and autopsy, as well as the distribution point for release of the decedent body to the next of kin or their agent.

Local Jurisdiction

1. In Non-OCME cases, the local jurisdiction may establish MACPs.

2. Where the numbers of decedent remains are in excess of the capacity to maintain bodies under refrigeration, alternate means of cold storage such as refrigerated trucks or other cooled facilities may be necessary. Without cold storage, decomposition advances rapidly. Cold storage slows the rate of decomposition and preserves the body for identification.

Morgue Operations

OCME Jurisdiction

1. The OCME will determine if fatalities will be transported to the OCME facility for processing or if a temporary autopsy site will be utilized.
2. All fatalities resulting from a terrorist attack are homicides. The Chief Medical Examiner will evaluate the situation and decide which cases require an autopsy.
3. The OCME will coordinate and staff all morgue and autopsy operations in accordance with established standard operating procedures.
4. DMORT resources may be available (in a non pandemic incident) to augment OCME operations. Requests for DMORT assets must be made by the governor through MEMA.

Tracking and Identification

Tracking of Fatalities

1. When managing remains, each body or body part must be tracked from the site of recovery, retrieval, transportation, storage, autopsy, identification processes, and transfer to the funeral homes for final disposition.
2. Tracking of remains is a shared responsibility among all agencies that will handle the fatalities such as law enforcement agencies, hospitals, the OCME, the State Anatomy Board, and funeral homes.
3. Currently, Maryland does not have a standardized process or technology based system, for tracking mass fatalities from the scene of death to final

disposition. Specific procedures for the identification and tracking of fatalities will be established at the scene through a coordinated effort with local law enforcement and the OCME (when applicable). In many jurisdictions, use of the MIEMSS triage tags may be implemented, as well as the Electronic Patient Tracking System.

4. Regardless of the methodology implemented:
 - It will be important that all entities involved are familiar with the chosen tracking system and implement it consistently. This may require just in time training on the agreed-upon system.
 - Decedent tracking must be verified, validated, and maintained throughout the entire process.
 - Fatalities as a result of the disaster should be easily distinguishable from the normal daily caseload.
 - Antemortem data and tracking information should be cross referenced.

Identification of Fatalities

1. Identification, regardless of case jurisdiction, is the responsibility of law enforcement.
2. The World Health Organization advocates for the identification of all disaster victims before final disposition, regardless of the number of victims. Additionally, identification is an accepted and expected practice of American culture. Deviations from this practice will have a profound impact on the affected families and the community.
3. In order for a death certificate to be completed and remains returned to the appropriate next of kin, proper identification of the decedent must be made.
4. During naturally occurring disease outbreaks when a death occurs in a residence or public place, it will be investigated by a law enforcement officer. The investigating officer will follow established investigatory operating procedures for the definitive identification of the decedent.

5. In traumatic mass fatality incidents, the identification of decedents may be complex and methodologies implemented by law enforcement will depend on the condition of the remains and the availability of antemortem records.
 - Identification may be done by matching the deceased (physical features, clothes, etc.) with similar information about individuals who are missing or presumed dead.
 - In some cases, it will be impossible to utilize the conventional means to identify the dead because of the lack of identification on the body or reliable witnesses, decomposition, or mitigating purposes.
 - If identification is unsuccessful, forensic identification support from the OCME may be requested by law enforcement.
6. Identification of foreign, undocumented nationals and homeless individuals may require much greater effort.
 - Coordination with the State Department or other government entities may be required.
 - It may be necessary for those not easily identified to be placed in temporary storage or temporarily interred while waiting for identification at a later date.

Antemortem/Postmortem Data Collection

1. Antemortem data collection for identification purposes is a coordinated effort between law enforcement, the OCME, and supporting organizations such as the Maryland State Funeral Directors Association and DMORT.
2. The collection of antemortem and post mortem data is a complex process and one that will be dependent on many factors including the ability to identify and communicate with the next of kin and the ability to recover decedents from an incident scene.
3. Personnel skilled in interviewing family members such as law enforcement, OCME representatives, funeral directors, hospice staff, and DMORT

personnel should be utilized when possible. Just in time training may be necessary for antemortem data collection surge capacity.

4. To facilitate communication with the next of kin, translation services and/or liaison with consulate/embassy representatives may be necessary.
5. Procedures for collecting antemortem data will be established based on the type and scope of the incident. Data collection and dissemination may be conducted through a family assistance center, a virtual family assistance center (web-based), a reception center, or a call center.
6. To ensure effective communication and data management, it will be necessary to implement a consistent records management system to track fatality management information including but not limited to: fatality statistics, case information (identification, status, etc.), and antemortem data. Currently, Maryland does not utilize an electronic death reporting system; therefore, the establishment of a data collection method, such as the DMORT Victim Identification Profile forms and the National Association of Medical Examiners Initial Incident Assessment and Scene Recovery Checklist (see Appendix F Sample Forms), may be considered.
7. To maintain an accurate records management system, it will be necessary to identify staff resources for interviews, data entry, and administrative activities.
8. All fatality data, including tracking information and antemortem data, should be accessible by all appropriate functional areas such as the storage site, Family Assistance Center location, autopsy facility, and the incident scene.

Notification of Next of Kin

1. After a positive identification is made, it is the responsibility of local law enforcement to notify the next of kin. A process for ensuring release of "official" information only and consistency in notifications should be established and should consider:
 - Where, when, and how a notification occurs

- Who should be notified and how they are contacted
- Specific information that will be released (i.e., identification methodology)
- Procedures for receiving the decedent's remains and/or personal effects for final disposition

2. Notification teams consisting of law enforcement representatives, mental health professionals, medical staff, and clergy may be formed to conduct the notifications.
3. Clergy from a variety of religions as well as behavioral health specialists should be available to families (through the Family Assistance Center) if they require or choose to seek their aid.
4. Notifications of next of kin outside of the region should be conducted in person through coordination with local law enforcement officials.
5. Once the determination has been made that one or more remains are unrecoverable and/or unidentifiable, all families should be notified.
6. Contingency plans should be established by local law enforcement.

Release of Remains

1. In incidents where the OCME has custody, the remains will be released to funeral homes of the family's choice.
2. Remains of out-of-area residents will be released to funeral homes of the family's choice or in accordance with mutual aid agreements or as the Medical Examiner determines to be appropriate.
3. The release of remains requiring transfer out of the United States will be coordinated with the appropriate federal and foreign agencies, such as the Department of State, and the local health department to ensure the international shipping regulations requirements are met.
4. The Anatomy Board is responsible for decedents that remain unclaimed after a reasonable search has been performed to locate the next of kin.

- 72 hours after the Anatomy Board is notified, the Anatomy Board has exclusive control over the body and may order that the body be embalmed.
- Any relative or friend of the deceased may claim the body upon payment of the cost of moving and embalming the body.
- In a mass fatality incident, it may be necessary to request the governor order a suspension of this process to allow for a longer reunification period.

Disposition

General

1. The ultimate goal of fatality management is to identify decedents and reunify them with family for final disposition in accordance with the wishes of the family.
2. Disposition services (funeral, cremation, burial) for deaths are handled by the death care industry in coordination with some faith based organizations.
3. Normal disposition practices will continue for as long as they can be supported by the death care industry. When these resources have reached their capacity, it may be necessary to consider alternate methodologies and/or temporary interment.
4. Each funeral home has different processing capabilities, and the number of decedents each can handle will vary at the time of the mass fatality incident.
5. In general, funeral homes do not “stockpile” supplies; rather, they practice just in time ordering of supplies and equipment necessary to maintain their services.
6. During a mass fatality incident, additional supplies and equipment will be obtained through existing business ordering processes as well as through

“mutual aid/shared resources” with other less impacted funeral homes in the region.

7. However, if the incident is widespread (i.e., pandemic), the demand for such resources will be significant and the supply chain limited. These shortages may delay final disposition, and, therefore, increase the need for storage of decedents.
8. Local jurisdictions should engage the local death care industry in preparedness/planning efforts to increase understanding of capacities and capabilities. Local jurisdictions should also partner with the local death care industry when a mass fatality incident occurs to establish communication and coordination regarding capacities and resource needs.
9. Not all funeral homes maintain on site crematory services and as such contract these services to private crematoriums.
 - There are a limited number of crematoriums within the state and surrounding region.
 - Additionally, cremation services are constrained by standard practices that limit the number of cremations allowed during a specific time frame as the equipment requires a cool down period as well as a standard daily shut down process.
 - During a mass fatality incident, cremation services may be a choke point in the disposition process depending on the demand for these services.
10. Cemeteries are privately owned businesses. The Office of Cemetery Oversight regulates public and some private cemeteries; however, not all cemeteries are regulated, particularly those operated by religious institutions.
 - Every cemetery has different processing capabilities and the number of decedents that can be buried will vary at the time of the mass fatality incident.

- The ability of a cemetery to accept a decedent from a funeral home will impact the storage capacity of the funeral home. If there is a delay in the burial process, the post-processing storage capacity will be impacted.

11. The Code of Maryland (MD § 62A) states, “The authority and directions of any next of kin shall govern the disposal of the body.”

- However, the State Secretary of Health, in consultation with the Governor, shall have the authority to determine if human remains are hazardous to the public health.
- “Hazardous human remains” refers to remains that are contaminated to a degree that renders them unsafe to handle without specialized personal protective equipment or decontamination.
- If the officials determine that such remains are hazardous, the jurisdiction, with direction from the local health department and the OCME shall be charged with the safe handling, identification, and disposition of the remains, and shall erect a memorial, as appropriate, at any disposition site.
- It is not anticipated that a natural disease outbreak such as influenza will meet the criteria of “hazardous” because there has never been an influenza virus strain that has been demonstrated to be hazardous. However, since the etiology of the natural disease outbreak may not be known, universal standard precautions should always be followed.

12. Generally, funeral and interment or cremation expenses of a decedent are obligations of the decedent’s estate or next of kin (MD § 8-108); however, there are certain circumstances in which the state may pay limited benefits.

13. Regulations adopted for the transportation of decedents state that decedents may not be transported within or out of Maryland without a valid burial-transit permit, and the permit must remain with the decedent until it reaches its final destination.

- Code of Maryland Regulations (COMAR) 10.03.01.05(A)-When a decedent is to be shipped via common carrier, the remains must be transported in a casket that is designed to “prevent seepage or escape of odors.”

- In order to proceed with burial, the mortician must obtain a burial-transit permit within 72 hours of taking possession of the decedent and prior to final burial or removal from the state (MD. CODE ANN., HEALTH-GEN. § 4-215[b]). Without this authorization, the manager of a cemetery “may not permit final disposition” (§ 4-215[c][1]). When the manager of the cemetery is presented with the burial-transit permit, the manager must write upon it the date of final disposition, sign the permit, and return it to the Secretary of Health and Mental Hygiene within 10 days (§ 4-215[c][2]).
- Title 5, Business Regulation Article, Annotated Code of Maryland, contains the Maryland Cemeteries Act, which establishes the Office of Cemetery Oversight. The regulations adopted by the Office of Cemetery Oversight may be found in COMAR, Title 09, Section 34.

Unidentified Remains

1. In some instances, it may not be possible to recover and identify all decedent remains. The decision on how to best handle this situation must be a coordinated one as it will have a profound psychological impact on the families and the community.
2. Disposition of unidentified remains and/or tissue is the responsibility of the authority having jurisdiction of the decedent. Planning for the disposition of unidentified remains should be a coordinated effort among local and state agencies and victim’s families. The following should be considered:
 - Under no circumstances should unidentified or unassociated remains or tissue be commingled with identified remains.
 - Remains should be prepared by applicable standard preparation procedures.
 - Interment in a local cemetery should be the preferred choice. Cremation should be avoided for religious reasons and availability for identification at a later date.
 - Religious considerations should be observed. Non-denominational rites should be held at the site of interment.

- Records and procedures for interment should follow standard procedures.
- Arrangements for memorial services should be coordinated by local and state officials and include the families in the planning process. All efforts should be made to notify and include the surviving family members in this service. Assistance in post-death activities should be extended to the surviving family members. The family should be given the opportunity to select the location of the non-denominational service if so desired.

Temporary Interment

1. Temporary interment is the process of burying remains in order to preserve them, with the intention of disinterring them for examination or for final disposition at a later time.
2. Temporary interment may be utilized as a method of temporary storage but should only be used when the numbers of decedent bodies exceed cold storage and embalming capacities or when the bodies may pose a public health risk due to contamination by a chemical, biological, or radiological substance.
3. When temporary interment is implemented, processes must be utilized to ensure the ability to locate and disinter the remains for identification and reunification in the future. Plans for disinterment must be considered at the time of temporary interment. Processes should include:
 - Positive identification and/or labeling with a consistent numbering system,
 - Proper tagging procedures,
 - Remains should be placed in a protective container, and placed into the ground,
 - Remains should be marked at the ground level, and
 - Coordinates for the remains should be documented by GPS readings.

4. Consideration should be given to memorializing the incident scene even if all remains have been disinterred. Reutilization of this land for other purposes is generally not likely to be accepted.
5. Preference for sites is given to existing regulated cemeteries. Additionally, local jurisdictions may identify government-owned land and parks that can be used for temporary interment.
6. The Department of Natural Resources has identified state-owned land that may be suitable for temporary interment if local jurisdictions are not able to identify appropriate sites. State parks suitable for temporary interment are listed in Appendix I (redacted).
7. Temporary interment may have significant psychological and legal impacts on the survivors.
 - Cultural and religious beliefs may be challenged by this situation and the grieving process may prove difficult for many.
 - Additionally, there may be difficulties in settling legal affairs when identification and final disposition is not possible.

Vital Records

1. The efficient and proper completion of the required documentation for death certification is an essential step in the processing of fatalities.
2. It is important that those authorized to complete death certificates (OCME, Anatomy Board, physicians, and nurse practitioners) are educated on this process and available to complete them in a timely manner.
3. During a mass fatality incident, it may be necessary or more practical to provide an alternative death certificate that can be pre-populated with known information to minimize processing time. Additionally, it may be necessary to provide just in time training to and authorize other personnel to complete the death certificate.
4. The Maryland Code (MD § 4-212.) (1) states that a certificate of death regardless of age of decedent shall be filled out and signed by:

- The medical examiner, if the medical examiner takes charge of the body; or
- If the medical examiner does not take charge of the body, the physician who last attended the deceased.

5. In an emergency, waivers may be instituted to authorize additional license professionals to sign death certificates. This may include physician assistants and licensed emergency medical personnel.
6. The medical certification shall be completed within 24 hours after receipt of the death certificate by the physician in charge of the patient's care for the illness or condition that resulted in death, except when inquiry is required by the medical examiner.
7. In a mass fatality incident, decedents may not be recovered and/or identified; in such instances, a death certification may have to be completed through alternate means such as judicial decree.
8. The DHMH Vital Statistics Administration is responsible for processing and registering the death certificates when they are received from funeral homes, the Anatomy Board, or the OCME.
9. Death certificates may be required for transportation across state lines and approval of receiving state(s) may be needed. Transportation across international lines may require State Department approval and the receiving nation's approval.
10. Death certificates are necessary for decedent family members to access important resources, including insurance. Timely receipt of death certification may facilitate the final disposition process, i.e. burial or cremation, and aid the family in their recovery.

Disinterment

1. It may be necessary to disinter decedents that were buried following a mass fatality incident because temporary interment processes were utilized and/or because further examination is necessary.

2. Regulations for the disinterment and re-interment of decedent remains are set forth in COMAR 10.03.01.06.
3. 10-402 Criminal Law Article, Annotated Code of Maryland, allows that the State's Attorney for a county may authorize in writing the removal of decedent remains from a burial site in the State's Attorney's jurisdiction:
 - To ascertain the cause of death of the person whose remains are to be removed;
 - To determine whether the human remains were interred erroneously;
 - For the purpose of reburial; or
 - For medical or scientific examination or study allowed by law.
4. When decedent remains are to be removed from a cemetery or other final resting place and transferred to another cemetery or location, a disinterment and re-interment permit shall be obtained from the health department in the jurisdiction in which the decedent remains are located or the DHMH.
 - The DHMH or local health department may issue a permit only on written authorization from the State's Attorney of the jurisdiction in which the decedent remains are located or in compliance with a court order.
 - If the decedent remains are moved to a grave or tomb within the same cemetery for relocation purposes only, a permit is not required.
5. When it is required to disinter decedent remains for an autopsy purpose, even though the decedent remains are to be reinterred in the same cemetery, an application for a disinterment and re-interment permit shall be made to the local health department or DHMH by the Medical Examiner, or by the State's Attorney of Baltimore City or any county of Maryland when acting in the State's Attorney's official capacity in investigating the death.
6. When it is proposed to disinter and relocate a number of decedents remains, only one application shall be made by the mortician.

- The mortician shall submit with the application an original and copy of a list of the decedent remains to be disinterred. One disinterment and re-interment permit will be issued.
- The original of the list shall be attached to the permit and made a part of it, and a copy or electronic file of the list shall be retained by the local health department or DHMH.
- If the names of the decedents are not known, this fact shall be indicated on the application. The mortician shall include in the application an identification number, grave space grid number, or other means to identify every one of the decedent remains to be disinterred and reinterred.

7. The application for a disinterment and re-interment permit shall be made on a form prescribed by the Secretary. Upon approval of the completed application, the Secretary, Commissioner of Health of Baltimore City, or the county health officer or their designees, depending on where the decedent is located, shall sign and issue a disinterment and re-interment permit to:

- An individual qualified in the interment of decedent remains, such as a mortician or cemetery custodian;
- An individual qualified in the funerary rites appropriate to the cultural affiliation of the decedent, such as a minister, priest, or other religious leader; or
- An anthropologist or archaeologist.

8. The disinterment and re-interment permit shall be endorsed by the cemetery authority from which the decedent is disinterred, and also by the cemetery authority in which the decedent is reinterred.

- The authority of the latter cemetery shall return the permit to the appropriate authority as per normal operating procedures. This may be DHMH or a local health department. This should occur within 10 days after re-interment if re-interment took place in a Maryland county.

- If there is no cemetery authority, the mortician shall endorse the permit and return it to the appropriate health department within the time limit specified in this section.

I. Death Care Industry Operations

1. Local death care industry resources may be overwhelmed and it may become necessary to adjust normal operating processes.
2. Funeral homes may be inundated and have difficulty keeping up with the demand in a timely fashion. This will impact the families' ability to choose the funeral home that handles the final disposition of their loved one or have an impact on pre-arrangement agreements.
3. Incident/Unified Command should establish and maintain communication with local death care industry representatives to monitor the situation status and provide alternative operation recommendations, such as alternate storage and disposition methods, if necessary. A funeral home liaison position within the incident command structure may be considered.
4. Coordination with death care industry representatives on public information messages to the community on behalf of the death care industry may be necessary to ease concerns.

J. Specialized Resources

1. The U.S. Department of Health and Human Services (DHHS), as the lead agency for ESF #8 under the National Response Framework, may be able to provide resources from the National Disaster Medical System (NDMS) to assist with mass fatality incidents.
 - DMORT, as part of the NDMS, can provide assistance with victim identification and mortuary services.
 - DMORTs are composed of private citizens with expertise in victim identification and mortuary response, such as funeral directors, medical examiners, coroners, pathologists, forensic anthropologists, medical

records technicians and transcribers, fingerprint specialists, forensic odontologists, dental assistants, x-ray technicians, mental health specialists, computer professionals, administrative support staff, and security and investigative personnel.

- There are 10 teams, one for each of the 10 Federal Emergency Management Agency (FEMA) regions including Maryland in Region III. Team members are activated and federalized when requested to assist with a disaster.
- Capabilities of the DMORTs include:
 - Temporary morgue facilities; the team maintains two disaster portable morgue units (DPMU)
 - The DPMU is a depository of equipment and supplies for deployment to an incident scene.
 - It contains a complete morgue with designated workstations for each processing element and prepackaged equipment and supplies.
 - Victim identification
 - Forensic dental pathology
 - Forensic anthropology methods
 - Processing
 - Preparation
 - Disposition of remains
- DMORT *does not* assist with the recovery or collection of decedents from the incident scene.
- During an emergency response, DMORTs work under the guidance of state/local authorities, which are typically the OCME but occasionally the state/federal law enforcement agency or the state emergency management

agency.

2. Maryland State Funeral Directors Association (MSFDA)

- The MSFDA has a Disaster Response Team comprised of trained death care industry professionals that are capable of performing necessary functions required to resolve a mass fatality incident.
- The team can be mobilized at the request of the OCME, the Governor, and/or FEMA.
- The capabilities of the team include:
 - Assisting with body recovery and collection
 - Coordination with DMORT
 - Family Assistance Center services such as antemortem data collection
 - Transportation services
 - Investigation on behalf of the OCME
 - Resource coordination with death care industry partners
 - Facilitating release of identified remains to the next of kin
 - Embalming and funeral services in conjunction with local funeral homes.

K. Public Information and Media Relations

General

1. Effective communication with the public and the families of the victims will be critical during mass fatality incidents.
 - Good public communication contributes to a successful victim recovery, identification, and reunification process.

- Accurate, clear, timely, and updated information can reduce the stress experienced by those affected, defuse rumors, and clarify incorrect information.

2. The information sharing process for providing current information to families of the missing and the dead should be established as soon as possible.
 - The information provided will include the process of the recovery, identification, storage, death certification, and other incident specific information.
 - When possible, families should be provided access to this information prior to its release to the public.
3. Fatality information is very sensitive and requires knowledgeable and well-versed communications. Public information officers will provide the necessary information to the media in a manner that respects the privacy of the families involved and does not compromise the investigation of the incident.
4. Demands from a variety of sources for estimates of the number of victims, the number of missing, the number identified, and the names will be almost immediate. Officials must be prepared to direct responses to these questions appropriately.
5. Social media will have a significant role in public information sharing. Social media can be leveraged to release official information; however, it will also pose a challenge to ensure accurate and consistent information is being shared.

OCME Jurisdiction

1. In cases where the OCME has jurisdiction, DHMH will be the lead agency for disseminating public information. DHMH will conduct public information activities as outlined in the DHMH Public Health and Medical Services Operations Plan and will coordinate with the local Joint Information Center (JIC) if established. DHMH will provide Public Information Officers

(PIOs) to the OCME. PIOs will ensure the OCME approves all information releases pertaining to the dead or OCME operations prior to any press releases. If a FAC is established for the incident, the PIO will also ensure the families are briefed on all OCME activities before the press.

Local Jurisdiction

1. In non-OCME jurisdiction incidents, the local jurisdiction may establish a JIC to coordinate the development and release of public information. DHMH will provide technical assistance and support to the local JIC as appropriate. The DHMH will coordinate state-wide public information activities as outlined in the DHMH Public Health and Medical Services Operations Plan.

L. Family Assistance Center (FAC)

1. Depending upon the scope and magnitude of the incident, the local jurisdiction may establish a FAC to provide assistance to the families of disaster victims. In some instances, multiple FACs may be necessary and/or virtual FACs may be established.
2. Generally, FAC operations are established and conducted by local ESF #6 partners and supported by the Maryland Department of Human Resources as the State lead for ESF #6. Significant coordination and cooperation with law enforcement and the OCME (in OCME cases) will be necessary for the success of a FAC.
3. The primary purpose of a FAC is victim identification and family reunification. It is intended to serve as a private and dignified avenue for information exchange including victim antemortem data collection and response operations briefings for families. It may also include services such as information and referral to local, state, and federal resources for additional assistance.
4. In aviation incidents, the airline carrier is responsible for the establishment of a Joint Family Support Operations Center (JFSOC) – a Family Assistance Center - which also incorporates federal, state, and local resources. The NTSB coordinates the local, state, federal, and volunteer resources providing assistance to disaster victims and their families.

5. A Family Victim Identification Center may be established within the FAC where pertinent antemortem information and items will be collected to assist in the identification of the dead and to aid in the identification of unidentified survivors in medical treatment facilities. Local law enforcement, responsible for victim identification, will coordinate with the OCME to establish this process. In OCME jurisdiction cases, the OCME will provide a representative to the FAC to coordinate the collection of victim information necessary for the identification process. The Maryland State Funeral Directors Association, under the direction of the OCME, DMORT, hospice staff, and funeral directors are resources for staffing the antemortem data collection efforts.
6. A mass fatality incident is likely to result in long-term effects. Consideration must be given to establishing a long-term family management response, to include the coordination of services from local government, businesses, and non-profit organizations, regardless of whether or not a FAC is initially established.

M.Logistics

Staffing

1. The DHMH OP&R will provide the core staff for the DHMH Operations Center. Other DHMH administrations will provide representatives as requested.
2. In the event the state EOC is activated, DHMH Emergency Management Team will provide staff to serve as the ESF#8 representative.
3. Additional staffing support is available through the Maryland Professional Volunteer Corps (MPVC).
 - The MPVC is composed of licensed health care practitioners ready to assist communities to recover from declared emergencies or disasters.
 - Requests for volunteer support will be coordinated by the DHMH Operations Center as outlined in the Public Health and Medical Surge Capacity and Capability Incident Response Annex.

4. The OCME will provide staff for field operations for incidents under OCME jurisdiction.
 - The OCME may also request additional assistance through the DHMH Operations Center.
 - The OCME may request that the governor, under emergency management powers, authorize the release of forensic investigators from their employment obligations with other entities in order to augment staff capacity.
5. Personnel resources from DHMH and other state agencies may be requested and utilized to perform various roles to support the response. Just-in-time training may be provided to meet the needs of the incident response.

Resource Requests

1. As the lead agency for ESF #8, DHMH will coordinate with its public health and medical partners in order to address resource requests. DHMH will coordinate with MEMA, through the SEOC, to obtain support from other state agencies.
2. The OCME will determine the need for specialized federal assistance, such as DMORT, to assist with mass fatality operations and will submit the request through the local incident command system and/or make the request through DHMH ESF#8 procedures, depending on the nature of the incident and the response organization.

Local Resource Requests

1. Most resource requests are generated at the scene and submitted to the local EOC. In the event the local EOC cannot acquire or does not have access to the resources needed, the request is forwarded to the state EOC.
2. In the event that additional assistance is needed from DHMH or other state agencies, the requests for support will be forwarded from the SEOC to the appropriate state agency. The DHMH representative at the SEOC will

coordinate with the DHMH Operations Center and/or ESF #8 partners to address the request.

3. As necessary, the DHMH Operations Center will work with the local health officers throughout the state to determine what resources may be available for deployment to another jurisdiction in order to meet their needs.

State Resource Requests

1. In a mass fatality incident that exceeds state capacities, assistance may be sought from other states, through standing mutual aid agreements or through the Emergency Management Assistance Compact.

Federal Resource Requests

1. Federal assistance may be available through the processes established in the National Response Framework.
2. Requests for federal resources will be coordinated through the SEOC.
3. A federal declaration of emergency or major disaster must be in place in order for federal assistance to be authorized.

Communications

1. When the OCME deploys to the incident scene, internal communication assets will also be deployed.
2. In the event that additional communications resources or capabilities (e.g., radios) are needed, the request will be made through the incident command structure and the local EOC.
3. In the event that the local jurisdiction is unable to meet the requests, assistance will be requested from the SEOC. The Department of Information Technology, as the lead agency for ESF #2, Communications, will coordinate providing communications resources and technical assistance to meet the communications requirements.

Supply Management

General

1. Resource requests for resources or support that is not readily available will be made following existing standard operating procedures.
2. Death care industry resources may be depleted, and local or state resources may be requested.
3. Families experiencing multiple deaths are unlikely to be able to afford multiple higher-end products or arrangements. Funeral homes could quickly exhaust lower-cost items (e.g., inexpensive caskets) and should be prepared to provide alternatives.

OCME Jurisdiction

1. The OCME will deploy with its internal supplies and equipment as outlined in the OCME MFMP. The OCME maintains stocks of disposable protective equipment at several locations.
2. The OCME will request additional resources through the on-scene command structure and the local EOC. If local resources are not sufficient, the local EOC will forward the request to the SEOC.

Local Jurisdiction

1. The LHDs generally keep an inventory of healthcare resources maintained within their department and may be aware of resources maintained by healthcare partners. The DHMH Operations Center will coordinate with the LHDs to identify available resources as required.
2. In a pandemic situation, it is recommended that funeral directors not order excessive amounts of supplies such as embalming fluids, human remains pouches, etc., but have enough on hand in a rotating inventory to handle the first wave of the pandemic (i.e., enough for six months of normal operation). Fluids can be stored for years, but human remains pouches and other supplies may have a limited shelf life. Cremations generally require fewer supplies since embalming is not required.

Law Enforcement/Security

1. Law enforcement resources may be requested through established mutual aid agreements or requests may be made through the SEOC for state and federal law enforcement resources to support the following local law enforcement responsibilities:
 - Security of the incident scene
 - Security and traffic control at any operating facilities (such as incident command posts, MACPs, temporary autopsy facilities or FACs)
 - Traffic control
 - Investigation of the incident
 - Collection, preservation, and storage of evidence
 - Identification of the fatalities
 - Notification of next of kin

Health, Safety, and Behavioral Health

1. Standard universal precautions will be recommended for all personnel responsible for the management of decedents unless more advanced personal protective equipment is otherwise recommended or required. Personal protective equipment that may be necessary includes but is not limited to:
 - Protective clothing (e.g., suit, coveralls, hoods, gloves, boots, cooling systems, and/or inner garments)
 - Respiratory equipment
 - Air purifying respirators

- Head, ear, and eye protection

2. Health and safety of the on scene resources will be the responsibility of the Safety Officer as part of the Incident/Unified Command. This should be coordinated with the appropriate subject matter expertise, such as the local Hazardous Materials Team or the LHD. A formal health and safety plan for all operational sites should be developed.
3. DHMH will provide public health related information and guidance to the LHDs as appropriate or if requested.
4. The OCME will request information relative to safety and security issues as part of the initial meeting with the Incident or Unified Command.
 - Based upon this initial briefing, the OCME will assess the need for additional support to assist with potential environmental hazards and request such support through the on-scene command.
 - The Maryland Department of the Environment Hazmat team will advise as to equipment and staff safety depending on the nature of the incident
5. A mass fatality incident will expose responders, the death care industry, and family members to unfamiliar and difficult situations. Behavioral health services will need to be established to assist responders, family members of the decedents, and incident survivors.
 - The provision of behavioral health services should be a coordinated effort among mental health/behavioral health professionals, spiritual care providers, and other related organizations (i.e., hospices or non-profit disaster mental health organizations).
 - Plans for the provision of behavioral health services will be necessary during the immediate response and as part of the long-term recovery.

N. Demobilization

General

1. The DHMH Operations Center will develop the statewide demobilization plan in coordination with the local jurisdiction(s).
2. Local demobilization plans will be prepared by the Planning Section of the IC/UC and the EOC as applicable.
3. The need for continued storage and processing of the deceased may extend beyond the life of the initial incident. This may be a result of difficulty in body identification, locating the next of kin, and the backlog in achieving a final disposition for each decedent.
4. The following are actions to be considered in the aftermath of a mass fatality incident:
 - If a final resting place has been established, move remains from the temporary interment location to that final resting place.
 - Closing, cleanup, and restoration of temporary morgue and/or MACP sites.
 - Plan for a return to normal operating procedures.
 - Provide ongoing stress management/behavioral health support for the staff who worked mass fatality functions.
 - Complete and process all records kept during the course of the incident.
 - Establish the plan to coordinate memorial services, often conducted annually on the anniversary of the incident.
 - Restore depleted supplies.
 - Conduct an after-action review.

OCME Jurisdiction

1. The OCME will support the development of the local jurisdiction's demobilization plan through the on-scene command structure and the local EOC.

2. In the event that a temporary morgue was established, the OCME will develop and implement the demobilization plan for that facility.

IV. Special Considerations

A. Terrorist/Criminal Incidents

1. The incident scene and/or remains resulting from a chemical, biological, radiological, nuclear, or explosive (CBRNE) incident is a crime scene making all remains and personal effects associated with the incident forensic evidence.
2. All fatalities resulting from a terrorist attack are homicides. The Chief Medical Examiner will evaluate the situation and decide which cases require an autopsy.
3. The FBI is the lead agency for the criminal investigation of acts of terrorism or suspected terrorism. However, local and state law enforcement will be expected to provide law enforcement support and coordination in this effort.
4. The Maryland OCME will maintain jurisdiction for managing the fatalities except in very rare circumstances when jurisdictional authority lies with U.S. Code Title 10 Sec. 1471 (e.g., involves the President of the United States, etc.).
5. The FBI has a Victim Assistance Team they may deploy to a terrorist incident that can assist in establishing a FAC.

B. Chemical, Biological, Radiological, Nuclear, Explosive Incidents

1. If a mass fatality incident is the result of a CBRNE incident, fatalities may be contaminated with hazardous materials.
2. Subject matter expertise will be required for guidance on the proper handling of the contaminated remains.
3. Decontamination of remains must be conducted by trained personnel prior to the removal from the scene and transfer to processing facilities.

4. The FBI is the lead investigative agency for CBRNE incidents and the OCME will work concurrently with the FBI to ensure proper fatality management operations take place.

C. Transportation Incidents

1. A mass fatality incident that results from a transportation accident or involves the transportation system will be managed by the local jurisdiction in cooperation with the NTSB.
2. The NTSB is an independent federal agency charged by Congress to investigate all civil aviation accidents in the United States and significant accidents in other modes of transportation – railroad, highway, marine, and pipeline.
 - As such, it is the lead investigative agency in determining the cause of an accident involving an aircraft, rail, or pipeline that results in loss of life, serious injury, or major damage.
 - The Aviation Disaster Family Assistance Act of 1996 and the Rail Passenger Disaster Family Assistance Act of 2008 require the NTSB to coordinate disaster assistance to victims and their families on scene of aviation and select rail incidents. The NTSB Transportation Disaster Assistance team will work closely with federal, state, local, and volunteer agencies to meet the needs of aviation and Amtrak rail disaster victims and their families on scene.
 - The NTSB partners with the FBI and has developed a mutual aid agreement that brings in the FBI early in an NTSB investigation.
3. In the event the incident is determined to be a terrorist act, the FBI assumes investigative jurisdiction.
4. The OCME will remain the lead agency for managing the collection, processing, and disposition of the fatalities and will work in close coordination with both the NTSB and the FBI.

5. In aviation incidents, airlines are responsible for the establishment of a JFSOC, which also incorporates federal, state, and local resources. Local and state resources may be required to support the JFSOC operations.

V. Legal Authority Considerations

The normal fatality management process is based on state laws and regulations that assign specific roles and responsibilities to state and local government agencies and the private death care industry. The mass fatality management planning process has highlighted potential challenges to the effective management of a mass fatality incident based on these legal authorities. The following describes the areas that may need modification to the scope of practice and/or legal authority that will need further assessment and planning prior to a mass fatality incident as well as specific action to alter, suspend, or revise the legal authorities at the time of a mass fatality incident.

1. The State of Maryland has not given jurisdiction or authority to county or local governments to perform funerary or regulation functions. In a pandemic, or in a mass fatality incident of such catastrophic magnitude that it overwhelms state and federal resources, it will be incumbent upon the local jurisdictions to manage the surge of fatalities. It may be necessary for the local jurisdictions to work directly with the death care industry to identify alternate methods of fatality management.
 - Authority may need to be granted to the local jurisdictions under the emergency powers of the Governor to directly manage this process.
2. The death certification process may be a chokepoint in large scale mass fatality incidents, specifically in pandemic incidents.
 - Alternate death certificates, such as abbreviated forms modified to require only core information, may need to be authorized.
 - Temporary authority, along with appropriate just in time training and indemnification, may need to be granted to alternate personnel, to complete/sign the death certificate. Authority may be granted to additional licensed professionals, such as physician assistants and licensed emergency medical personnel, to sign certificates with written authorization.

3. Authorities regulating the death care industry may impact the processing time and capabilities in a mass fatality incident.
 - Alternate standards or procedures may need to be identified for funeral homes, crematories, and cemeteries including the requirement for a minimum of 12 hours between death and cremation.
 - Authorities for temporary interment may be necessary if alternate storage options have been exhausted.
4. Final disposition of remains may be significantly delayed depending on the capacity and capabilities of the death care industry.
 - Regulations regarding transportation and burial (burial-transit permits) may need to be altered for more flexibility.
5. The resources of the OCME may be overwhelmed in a mass fatality incident. There is a finite number of staff authorized to conduct OCME fatality operations, including forensic investigators and medical staff.
 - Emergency authorizations releasing forensic investigators from other employment in order to perform OCME duties may be necessary, and/or authorizing alternate personnel to perform certain OCME responsibilities may be necessary to establish surge capacity for the response.
 - The conventional methods for managing fatalities and the deceased will continue for as long as possible until circumstances dictate a change in operational policy and procedures. The DHMH will coordinate with state government officials through established processes and protocols to effect necessary state level policy and procedure changes. DHMH will provide guidance and communication to local jurisdictions when changes are implemented.
 - It will be necessary to request the Governor, under the emergency management powers, to suspend or dictate a change in legal authorities, routine regulations, and/or policies regarding the death management process. This may include directions for disposition of both identified and/or unidentified remains, and the need for actions such as temporary

interment, disinterment, and alternate death certificate processes for which authority is not clearly defined in state or local law.

6. The augmentation of staffing for mass fatality management functions, e.g., law enforcement, medical examiner, family assistance, may be necessary. Licensing and liability issues may need to be evaluated and addressed to allow for non-conventional uses of personnel including, volunteer, retired, and out-of-state, resources.

VI. Roles and Responsibilities

A. Local

Local jurisdictions will be responsible for:

1. Forming and activating local emergency operations plans that assign specific roles and responsibilities to government agencies and partner organizations.
2. Mobilizing necessary resources to conduct response operations.
3. Coordinating with state agencies (MEMA, DHMH, etc.)
4. Coordinating with hospitals and death care industry representatives to identify resource needs and alternate methods for processing fatalities when necessary.
5. Establishing processes for managing fatalities in non-OCME jurisdiction incidents including:
 - Body Recovery and Collection
 - Transportation
 - Storage
 - Tracking and Identification
 - Notification of Next of Kin
 - Release of Remains
 - Disposition
 - Vital records (death registration)
 - Disinterment

Emergency Management

1. Activate and manage the local EOC.
2. Coordinate the overall response to the mass fatality incident.
3. Determine the need for a local emergency declaration.

4. In consultation with the IC/UC, determine the need to activate a JIC and/or FAC.
5. Coordinate with MEMA/SEOC to request state and federal assistance as applicable.

Fire and EMS

1. Provide mass casualty, mass fatality, and hazardous materials emergency response.
2. Coordinate and execute extrication and recovery operations.
3. As expertise allows, recommend protective measures for responders, including the OCME, to protect against exposure to hazardous materials and blood-borne pathogens.

Health Department

General

1. Develop and maintain a local MFMP.
2. Collect and coordinate information on critical resources necessary in a mass fatality incident with the jurisdiction Emergency Operations Center.
3. Coordinate and disseminate personal protective equipment protocols under guidance from the CDC, DHMH, and other appropriate state agencies.
4. When necessary, ensure that appropriate vaccines and/or medication are provided to responding agency personnel and the death care industry.
5. Maintain communication with local hospitals and other healthcare facilities, local emergency management agency, local EMS, and other local partners during an emergency to ensure an effective response at the local level.

Local Jurisdiction Incidents

1. During mass fatality incidents caused by natural disease, provide public information about disease prevention and control strategies.
2. During mass fatality incidents caused by natural disease, provide daily reports to DHMH.
3. During mass fatality incidents caused by natural disease, advise skilled nursing facilities and other healthcare partners regarding management of increased deaths among residents (e.g., access to supplies, expediting the issuance and filing of death certificates).
4. In conjunction with other local organizations, coordinate resources for the storage, disposition, identification, and handling of human fatalities.

Hospitals

1. Establish working relationships with the local health department, the state, and other partners on mass fatality issues.
2. Maintain priority of providing medical care to the living.
3. Develop plans for prolonged storage of fatalities that occur within the facility until they can be received by the funeral home, medical examiner, anatomy board, or transferred to a MACP.
4. Share resource information with local and state health department.
5. Request additional resources through the local jurisdiction emergency operations center.

Law Enforcement

1. Provide site access control and protection.
2. Provide initial notification to OCME as appropriate.
3. Provide traffic management and control.
4. Provide security as requested for temporary facilities such as incident morgues, collection points, or FACs.
5. Locate, collect, protect, and document non-human evidence.
6. Provide support in processing of bodies (fingerprinting, collecting personal effects, and documentation of injuries).
7. Conduct victim identification.
8. Conduct investigations.
9. Conduct next of kin notifications.
10. As appropriate, conduct accident reconstruction.
11. Coordinate and authorize the removal of human remains to temporary storage or funeral homes in local jurisdiction cases.

Social Services

1. In accordance with local plans, establish and conduct family assistance center (FAC) operations with support from the Maryland Department of Human Resources as the State lead for ESF #6.

B. State**Maryland Department of Budgeting and Management**

1. Assist state agencies in identifying potential additional costs associated with supporting local agencies during mass fatality incidents and accompanying strategies to request appropriation authority for such additional costs.

Maryland Department of the Environment

1. In coordination with DHMH and MIEMSS, develop procedures for evaluating and decontaminating fatalities exposed to radiation, chemical agents, or hazardous materials and assist with decontamination operations. This guidance should be communicated to healthcare systems.
2. Provide personal protective equipment (PPE) as necessary and provide consultation on chemical agents and incident morgue set-up and management.
3. Develop criteria for location and construction specifications for the establishment of temporary burial sites outside of existing permitted cemeteries.
4. Establish contracts for environmental remediation services if necessary.

Maryland Department of General Services

1. Procure resources and services as necessary in support of mass fatality operations.
2. Provide coordination and documentation of personnel, equipment, supplies, facilities, and services.

Maryland Department of Human Resources

1. Establish, staff, and maintain a FAC if requested by the local jurisdiction.
2. Coordinate with local social service agencies to meet the childcare and other dependent care needs of disaster victims unable to care for their children or elderly relatives.
3. Assist in procurement of temporary staff to assist in implementation of the MFMP.

Maryland Department of Information Technology

1. Provide information technology and telecommunications resources and services as needed to support field operations (e.g., temporary autopsy facility).

Maryland Department of Labor, Licensing, and Regulation Office of Cemetery Oversight

1. Provide guidance on acceptable alternate standards for the operation of cemetery, crematory, or the provision of burial goods.
2. Evaluate the need for and provide guidance on utilizing alternate locations (non-licensed cemeteries) for temporary interment.

Department of Health and Mental Hygiene

DHMH Office of the Secretary

1. Ensure that the Governor and other officials are kept informed of the status of operations.
2. Monitor the DHMH response and provide direction where appropriate.
3. Provide recommendations to the Governor when provisions of the state law may need to be altered.
4. Declare a public health state of emergency and enact all associated provisions, if applicable to the incident.
5. Authorize the assignment of DHMH personnel when additional staffing is necessary to support the incident response.

DHMH Deputy Secretary Behavioral Health and Disabilities

1. Provide representation to DHMH Operations Center as needed.
2. Provide behavioral health specialists for grief and stress management to the FAC and in support of responders as needed.
3. Assist Public Information Officers in outreach regarding deaths at home and messages to address stress management to the community.
4. Liaison with the Office of Preparedness and Response to ensure that information is provided to the DHMH facilities.

DHMH Deputy Secretary Health Care Financing

1. Provide representation to DHMH Operations Center.

DHMH Deputy Secretary for Public Health Services

1. Review and approve the state MFMP.
2. Determine the need to implement the Plan and coordinate the state's mass fatality response operations.
3. Maintain statewide situational awareness regarding the public health and medical response in coordination with local health departments, hospitals, other healthcare facilities, state agencies, as well as other organizations and private partners

DHMH Deputy Secretary Operations

1. Provide representation to DHMH Operations Center as needed.
2. Provide technical assistance to the DHMH Operations Center to maintain communications and information systems capabilities to support emergency operations.

3. Advise DHMH officials on record keeping requirements and other documentation necessary for fiscal accountability.
4. Provide support to DHMH in procuring resources and contract services.

DHMH Board of Morticians and Funeral Directors

1. Provide guidance on acceptable alternate standards of mortuary science practice.
2. Provide guidance on recognizing out-of-state mortician and funeral directors' licenses for surge staffing capacity.
3. Provide information on funeral home establishments in Maryland.

DHMH Laboratories

1. Conduct specimen collection and processing when an incident is the result of an unknown agent to help prevent, diagnose, and control human diseases.

Maryland Institute for Emergency Medical Services Systems

1. Provide hospitals with information and guidance related to the incident and a hospital's expected level of involvement in response and recovery activities.
2. Provide local EMS providers and local emergency managers with information and guidance related to the incident.
3. Collaborate with DHMH and Maryland Department of the Environment to develop procedures for evaluating and decontaminating individuals exposed to radiation, chemical agents, or hazardous materials, and assist with decontamination operations.
4. Coordinate with DHMH to develop a reporting system for fatality/injury/treatment data and information.
5. Through established reporting protocols provide incident-specific data including numbers of fatalities.

DHMH Mental Health Administration

1. Notify OP&R if DHMH facilities are impacted by a mass fatality incident.
2. Coordinate with OP&R and the OCME on the availability of DHMH facilities for resources to support a mass fatality incident to include space, transportation, and food.
3. Provide behavioral health specialists for grief and stress management to the FAC and in support of responders as needed.

DHMH Office of the Attorney General

1. Review or assist with development of executive orders, emergency proclamations, memoranda of understanding, or special legislation, as necessary.
2. Provide legal advice and counsel regarding emergency operations or activities to state government officials, agencies, and local health departments (where authorized) on incident-specific issues.

DHMH Office of Capital Planning, Budgeting, and Engineering Services (Facilities)

1. Notify OP&R if DHMH facilities are impacted by a mass fatality incident.
2. Coordinate with OP&R and the OCME on the availability of DHMH facilities for resources to support a mass fatality incident to include space, transportation, and food.

DHMH Office of the Chief Medical Examiner (OCME)**In OCME Jurisdiction Cases:**

1. Act as the primary authority for the recovery, identification, and management of human remains, and operate a temporary autopsy facility if necessary.
2. Provide a representative to join the Incident/Unified Command as staff resources allow.
3. Ensure an accurate system is developed to track and report deaths that occur as a result of the incident.
4. Obtain supplies and coordinate assistance from the Maryland State Funeral Directors Association, Disaster Mortuary Teams, the Armed Forces Institute of Pathology, the Maryland State Dental Association, Maryland State Police Crime Scene Search Teams, and other support organizations as necessary.
5. Develop and maintain the OCME plan for surging and responding to mass fatality incidents.
6. Coordinate with the lead investigating authority to document, collect, and recover decedents.
7. Prepare death certificates for OCME jurisdiction cases.
8. Order or conduct autopsies if necessary to determine cause of death.
9. Order or conduct forensic investigations to identify unidentified bodies.
10. Authorize removal of bodies from the incident scene to temporary storage or autopsy facilities.
11. Determine the need for and establish a temporary autopsy facility for incidents where OCME has jurisdiction.

12. Coordinate requests for federal resources as necessary through the local EOC and/or the DHMH Operations Center.
13. Investigate and determine the cause of sudden, unexpected, violent, and non-natural deaths.
14. Provide emergency information to news media or DHMH public relations on fatality operations.
15. Maintain security of bodies and personal effects when in OCME custody.
16. Provide technical assistance to the local jurisdiction as needed.
17. Identify alternate methodologies for processing and storing fatalities when resources are overwhelmed.

DHMH Office of Preparedness and Response

1. Develop and maintain the state MFMP.
2. Conduct training and exercises on mass fatality management including training for Maryland Professional Volunteer Corps.
3. Manage the corrective action process for resolving issues related to mass fatality management.
4. Operate the DHMH Operations Center to coordinate the DHMH response to a mass fatality incident to include the availability and utilization of DHMH resources.
5. Develop, document, and maintain mutual support relationships with other governmental entities, professional associations, volunteer organizations, and other private services that may assist during a mass fatality incident.
6. Provide situational awareness to appropriate DHMH, local health department, hospital, and other local and state public health partners, including DHMH facilities.

State Anatomy Board

1. Provide a representative to the DHMH Operations Center.
2. Develop, maintain, and implement when necessary the Board's MFMP to provide for proper identification, forensic procedures, preparation of bodies for burial or cremation, storage of bodies, and interstate transport according to protocols.
3. Provide surge support to the OCME as requested.
4. Provide surge support for local jurisdiction storage augmentation.
5. Receive, store, and provide for the disposition of unidentified decedent bodies.
6. Provide for final disposition of decedents whose families are unable to afford it.

7. Provide recommendations on alternate methodologies when the system may be overwhelmed.
8. The State Anatomy Board may be able to provide the following services and support resources after a mass fatality event: administrative and technical mortuary staff, embalming facilities, refrigerated body storage, chemicals and embalming supplies, and disaster body pouches.

DHMH Vital Statistics Administration

1. Provide a representative to the DHMH Operations Center.
2. Issue and file death certificates for the deceased.
3. Register all deaths occurring in the State of Maryland.
4. Issue copies of death certificates.
5. Compile and analyze vital statistics data.
6. Provide recommendations on alternate methodologies for processing death certificates when the system may be overwhelmed.
7. Issue guidance to physicians (through Board of Physicians) and any other persons given the authority to sign death certificates on what information should be confirmed prior to signing and what documentation will need to be maintained after signing for medico-legal and health record purposes.
8. Provide specific reference material on Vital Statistics Administration and Board of Physicians websites
9. Provide recommendations to the Governor's Office/Attorney General on additions to the authorized list of persons permitted to sign death certificates.

Maryland Department of Transportation

1. Provide for coordination, control, and allocation of transportation assets in support of the movement of emergency personnel, fatalities, and resources.
2. Provide assistance in storage and transportation of remains.

Maryland Emergency Management Agency

1. Act as the primary state agency for coordinating the activities of all organizations for emergency management operations within the state.
2. Activate the Emergency Alert System and disseminate warnings or emergency information to the public.
3. Activate the state's Emergency Operations Center (SEOC) and implement emergency response and recovery activities.
4. Coordinate emergency activities and resources at the operational level.

5. Notify local jurisdictions, other state agencies, appropriate private organizations, and neighboring states of any relevant incident or impending threat.
6. Maintain unimpeded communication capabilities with state agencies and local jurisdictions, and continually monitor alert and warning systems.
7. Maintain knowledge of and assess the need for additional resources from outside the state and request those resources as needed.
8. Cooperate with state agencies and local jurisdictions to maintain the JIC and a statewide emergency public information system, and implement procedures for responding to requests from the media for information and access to the incident scene.
9. Coordinate federal, state, and private assistance programs.
10. Prepare proclamations, executive orders, and requests for a declaration of emergency or major disaster, as necessary.
11. Manage long term recovery as needed.

Maryland State Police

1. Assist the local law enforcement agency in identifying remains and making next of kin notifications.
2. Provide the crime lab facility and investigation teams to assist the OCME as outlined in an existing Memorandum of Understanding.
3. Assist in management of evidence collection and storage.
4. Maintain on-call list for and dispatch Forensic Investigators when requested.
5. Coordinate with local law enforcement and National Guard forces to provide security at response-related facilities such as temporary morgues and FACs.
6. Support efforts by local law enforcement agencies to provide traffic control and perimeter security as necessary for an incident scene.
7. Coordinate with local law enforcement agencies to ensure that access to the incident scene is restricted and to implement access control.
8. Provide law enforcement services according to legal authorities and/or mutual aid agreements with local jurisdictions.
9. Act as the state's liaison to the FBI.
10. Maintain an accurate record of persons unaccounted for and presumed involved in an incident.

C. Federal**Department of Defense**

1. Provide military support to civilian authorities.

2. Provide specialized military resources such as CBRN teams or Office of the Armed Forces Medical Examiner and Armed Forces DNA Identification Laboratory (to assist with victim identification).

Department of Health and Human Services

1. Deploy DMORT(s) if available when requested
2. Deploy additional National Disaster Medical System resources when requested.
3. Through the Centers for Disease Control (CDC), provide public health related guidance and technical assistance on disease epidemiology, infection control, contaminated remains, and laboratory testing.

Department of Homeland Security - Federal Emergency Management Agency

1. Coordinate the provision of federal resources through the National Response Framework.

Department of Justice

1. Provide resources and services for survivors of fatalities resulting from a criminal incident.

Department of State

1. Provide guidance and assistance in the repatriation of foreign remains.
2. Act as a liaison with foreign governments when incidents have international dimensions.

Federal Bureau of Investigation

1. Conduct criminal investigations in suspected terrorist related incidents.
2. Provide Victim Assistance Teams as appropriate to support FAC operations.
3. Provide specialized resources for assistance with forensic identification.

D. Others**American Red Cross**

1. Support family assistance center operations
2. Assist with the mass care feeding services for emergency workers
3. Provide support to the NTSB in transportation incidents in accordance with the established Statement of Understanding. This may include support services such as mass care feeding and crisis and grief counseling.

Funeral Homes

1. Establish working relationships with the local health department, the state, and other partners on mass fatality issues.
2. Develop internal mass fatality plans.
3. Assist with managing fatalities by augmenting storage capacity and operating capabilities, if feasible.
4. Share resource and operating capacity information with local and state health department.
5. Coordinate resource needs and operating status with the local jurisdiction during a mass fatality incident.

Hospice Associations

1. Establish working relationships with the local health department, the state, and other partners.
2. Coordinate hospice professionals to serve in a Family Assistance Center and/or provide surge capacity in appropriate functions such as antemortem data collection (family interviews), next of kin notification, and grief counseling.

Maryland State Funeral Directors Association and Funeral Directors and Morticians Association of Maryland

1. Respond as requested by the OCME, Maryland Emergency Management Agency, Department of Health and Mental Hygiene, the Governor's Office of Homeland Security, U.S. Department of Homeland Security, and/or FEMA.
2. Coordinate with the OCME and local jurisdiction authorities to establish processes for fatality management.
3. Coordinate requests for death care industry related resources.
4. Provide direct support to the OCME for autopsy and investigation services.
5. At the request of the OCME, establish initial FAC operations for the collection of victim antemortem data and provision of information to clients as requested.
6. Provide liaison support to DMORT operations for family reunification and victim identification.

National Transportation Safety Board

1. Investigate aviation and significant accidents in other modes of transportation – railroad, highway, marine, and pipeline.
2. Coordinate services for the families of victims with the transportation carriers.

Next of Kin/Families

1. Next of Kin are responsible for making the final disposition arrangements for the decedent. In a naturally occurring death, local law enforcement may assist the family with identifying funeral home resources to transport the decedent. In an OCME case, the next of kin/family is responsible for coordinating with the funeral home and OCME for the release and transport of the decedent.

Transportation Carrier

1. Provide reunification services, as required, to families of decedents.
2. Coordinate with law enforcement agencies and the OCME for the identification of all fatalities.

VII. Legal Authorities and Statutory Citations

1. State of Maryland Executive Order 01.01.2005.09 State of Maryland Adoption of the National Incident Management System (NIMS).
2. State of Maryland Core Plan for Emergency Operations, Volume I, August 26, 2009.
3. Annotated Code of Maryland
 - Health General Article
 - Title 4 Statistics and Records
 - Title 5 Death
 - Title 10 Mental Hygiene Law
 - Health Occupations, Title 7 Morticians and Funeral Directors
 - Public Safety Article
 - Title 14, Emergency Management Act of the Annotated Code of Maryland.
 - Executive Order 1991.
 - Criminal Law Article

- Title 10, Crimes Against Public Health, Conduct, and Sensibilities
- Business Regulation, Title 5 Cemeteries

4. Code of Maryland Regulations

- Title 10 Subtitle 3 Health Statistics
- Title 10 Subtitle 35 Postmortem Examiners Commission
- Title 9 Subtitle 34 – Office of Cemetery Oversight

5. Public Law 93-28, Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended.

6. Title 44 (Emergency Management and Assistance), Code of Federal Regulations.

7. Occupational Safety and Health Administration's Blood Borne Pathogens Standard (29 CFR 1910.1030).

VIII. References

1. National Response Framework (2008).
2. State of Maryland Core Plan for Emergency Operations (2009).
3. Office of the Chief Medical Examiner (OCME) MFMP.
4. DHMH Emergency Support Function 8: Public Health and Medical Services Operations Plan (Version 2.2 July 2009).
5. DHMH Emergency Support Function 8: Pandemic Influenza Response Annex (August 2009).
6. DHMH Emergency Support Function 8: Public Health and Medical Surge Capacity and Capability Incident Response Annex (July 2009).
7. National Transportation Safety Board Federal Family Assistance Plan for Aviation Disasters (August 1, 2000).

8. Maryland State Funeral Directors Association Mass Fatality Response Plan.
9. National Association of Medical Examiners Standard Operating Procedures for Mass Fatality Management (2010).
10. Various local and state mass fatality management plans to include:
 - Frederick County, Maryland, Mass Fatality Plan
 - Montgomery County, Maryland, Department of Health and Human Services Public Health Services All Hazards Emergency Response Plan Mass Fatality Incident Plan
 - Maryland Mass Fatality Framework
 - Ohio Emergency Operations Plan Tab D to Emergency Support Function #8, Public Health and Medical Services Acute Mass Fatalities Incident Response Plan
 - State of Delaware Department of Health and Social Services Division of Public Health MFMP
 - Commonwealth of Massachusetts MFMP
 - Supplement to the Massachusetts Comprehensive Emergency Management Plan
 - The South Carolina MFMP Annex 4 to the South Carolina Mass Casualty Plan
 - The State of Florida Fatality Management Response Plan of the Florida Medical Examiners Commission
 - State of Oregon EOP Support Annex H Mass Fatality
 - The California Mass Fatality Management Guide: A Supplement to the State of California Coroners' Mutual Aid Plan
 - Texas Annex H Health and Medical Services Appendix 4 Mass Fatality Management

IX. Definitions

Anatomy Board

The State Anatomy Board is responsible for regulating the use of bodies for medical study in the state and is responsible for the disposition and storage of unclaimed bodies.

Antemortem Data

Personal descriptive data such as name, physical description, medical history, and biological relatives.

Assistant Medical Examiner

A forensic pathologist appointed by the Office of the Chief Medical Examiner to conduct forensic autopsies.

Burial Permit

Form, prescribed by the DHMH Secretary, that is required for the transportation of human remains and identifies the final disposition details of the decedent.

Cemetery

Land used or to be used for interment and includes structures used or to be used for interment.

Certificate of Death (Death Certificate)

A document containing pertinent identifying information, such as age and sex, about a deceased person and certifying the time, place, and cause of death.

Certificate of Death DHMH Form 17, is the official record of death maintained by the Vital Statistics Administration. The term certificate of death and death certificate are used interchangeably.

Chief Medical Examiner

The governing forensic pathologist for the Maryland Office of the Chief Medical Examiner authorized to carry out the provisions of the Health-General Article, 5-301, Annotated Code of Maryland.

Cremation

The process of reducing human remains to bone fragments through intense heat and evaporation, including any mechanical or thermal process.

Crematory

A building, portion of a building, or structure that houses the necessary appliances and facilities for cremation.

Death Care Industry

The entities, such as funeral homes, crematories, and cemeteries, that provide the products, services, and arrangements having to do with funerals and burials including care of the dead and services offered to surviving family members.

Decedent

A dead human being.

Deputy Chief Medical Examiner

A forensic pathologist assigned to the Office of the Chief Medical Examiner responsible for statewide services and autopsy services.

Deputy Medical Examiner

A physician who is appointed to a county to sign death certificates on behalf of the Office of the Chief Medical Examiner. A DME is not a pathologist, does not conduct autopsies, and is not trained in forensics. Many DMEs do not do scene investigations and not all counties have DMEs.

Disaster Mortuary Operations Response Team (DMORT)

A federal team of experts in the fields of victim identification and mortuary services.

Disinterment

The removal of human remains from a cemetery or other final resting place.

Family Assistance Center (FAC)

A location for exchange of information between families of victims and appropriate governmental agencies for the purposes of identifying victims and reunifying families. It is a physical facility, staffed by trained professionals who have the expertise to gather identifying, antemortem information that will assist in the identification of deceased victims and the reunification of missing victims with their families. Examples of actual locations might include community centers, office buildings, hotels, or unused military facilities.

Fatality Management

The ability to coordinate with other organizations (e.g., law enforcement, healthcare, and emergency management) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposition of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.

Final Disposition

The burial, interment, cremation, or other authorized disposition, such as donation to medical science of human remains.

Forensic Investigators

A person appointed by the Office of the Chief Medical Examiner who has privileges to enter a crime scene and investigate the circumstances surrounding deaths meeting Office of the Chief Medical Examiner reporting criteria. Forensic investigators act on behalf of the medical examiner.

Funeral Director

A person who is licensed by the Board of Morticians and Funeral Directors to practice funeral direction, which means: to operate a funeral establishment, prepare a dead human body for disposition, and/or arrange for or make final disposition of a dead human body for compensation.

Funeral Home

Also known as a funeral "establishment"; any building, structure, or premises from which the business of practicing mortuary science is conducted.

Hazardous Human Remains

Remains that have been contaminated with hazardous materials.

Health Officer

Each county in Maryland has a health officer who is the executive officer and secretary of the county health board. The health officer is responsible for enforcing the State health laws and the policies, rules, and regulation that the Secretary adopts and the rules and regulations that the county board of health adopts.

Human Remains

The body of a deceased person, or a part of a body or limb that has been removed from a living person. Human remains include the body or part of a body or limb in any state of decomposition.

Incident Command System (ICS)

A model for disaster response that uses common terminology, modular organization, integrated communications, unified command structure, action planning, manageable span-of-control, pre-designated facilities, and

comprehensive resource management. In ICS, there are five functional elements: Command, Operations, Logistics, Planning, and Finance/Administration.

Interment

Final disposition of human remains, including: earth burial, mausoleum entombment, and niche or columbarium interment.

Joint Family Support Operations Center (JFSOC)

The JFSOC is a central location where participating organizations are brought together by the responsible airline to monitor, plan, coordinate, and execute a response operation maximizing the utilization of all available resources following an aviation accident or incident.

Joint Information Center (JIC)

The JIC is a facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating agencies should co-locate at the JIC.

Just-in-Time Training (JITT)

Specific, concise training provided just prior to the performance of the duties assigned during the operations (implementation) phase of the plan.

Mass Fatality Incident (MFI)

An incident that results in more fatalities than the local jurisdiction and/or the local death care industry can handle utilizing the usual standard of care and processes.

Medical Examiner (ME)

A Chief Medical Examiner, Deputy Chief Medical Examiner, or Assistant Medical Examiner who is a forensic pathologist authorized to carry out the provisions of Health-General Article, 5-301, Annotated Code of Maryland. A medical examiner also means a Deputy Medical Examiner or Forensic Investigator who is appointed by the Postmortem Examiners Commission in accordance with Health-General Article, 5-306, Annotated Code of Maryland and COMAR 10-35.

Mortician

An individual who practices mortuary science.

Mortuary Affairs Collection Point (MACP)

MACPs are locations throughout the community where non-contaminated remains are collected, stored, and preserved before being transported to the incident morgue or released to the funeral home chosen by the next of kin.

Mortuary Science

The practice of operating a funeral establishment; preparing a dead human body for disposition, arranging for or making final disposition of a dead human body.

National Disaster Medical System (NDMS)

A nation-wide mutual aid network consisting of federal agencies, businesses, and other organizations that coordinates disaster medical response, patient evacuation, and definitive medical care. At the federal level, it is a partnership among the DHHS, the Department of Defense (DoD), the Department of Veterans Affairs (DVA), and the Federal Emergency Management Agency (FEMA). Non-federal participants include major pharmaceutical companies and hospital suppliers, the National Foundation for Mortuary Care, and certain international disaster response and health organizations.

National Incident Management System (NIMS)

A system mandated by Homeland Security Presidential Directive (HSPD) 5 that provides a consistent nationwide approach for federal, state, local, and tribal governments; the private-sector and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity.

National Transportation Safety Board (NTSB)

An independent federal agency charged by congress to investigate all civil aviation accidents in the United States and significant accidents in other modes of transportation – railroad, highway, marine, and pipeline.

Office of the Chief Medical Examiner (OCME)

An administration within the Maryland Department of Health and Mental Hygiene that is charged with determining the cause of death in non-natural fatalities.

Re-interment

Returning human remains to a cemetery or final resting place.

Repatriation

Returning human remains to the country of origin.

Temporary Autopsy Facility

A facility established to store bodies prior to transport, serve as a facility for visual identification, or serve as a substitute location for the routine processing and related activities, such as autopsies, which normally would occur at the Office of the Chief Medical Examiner's facility.

Temporary Interment

The process of burying remains temporarily to preserve the remains.

Unified Command (UC)

An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the Unified Command to establish their designated Incident Commanders at a single Incident Command Post and to establish a common set of objectives and strategies and a single Incident Action Plan (IAP).

Vital Records

Vital records refer to records of birth, death, fetal death, marriage, divorce, adoption, and adjudication of paternity that are required by law to be registered with the Secretary of DHMH.

Section II Appendices

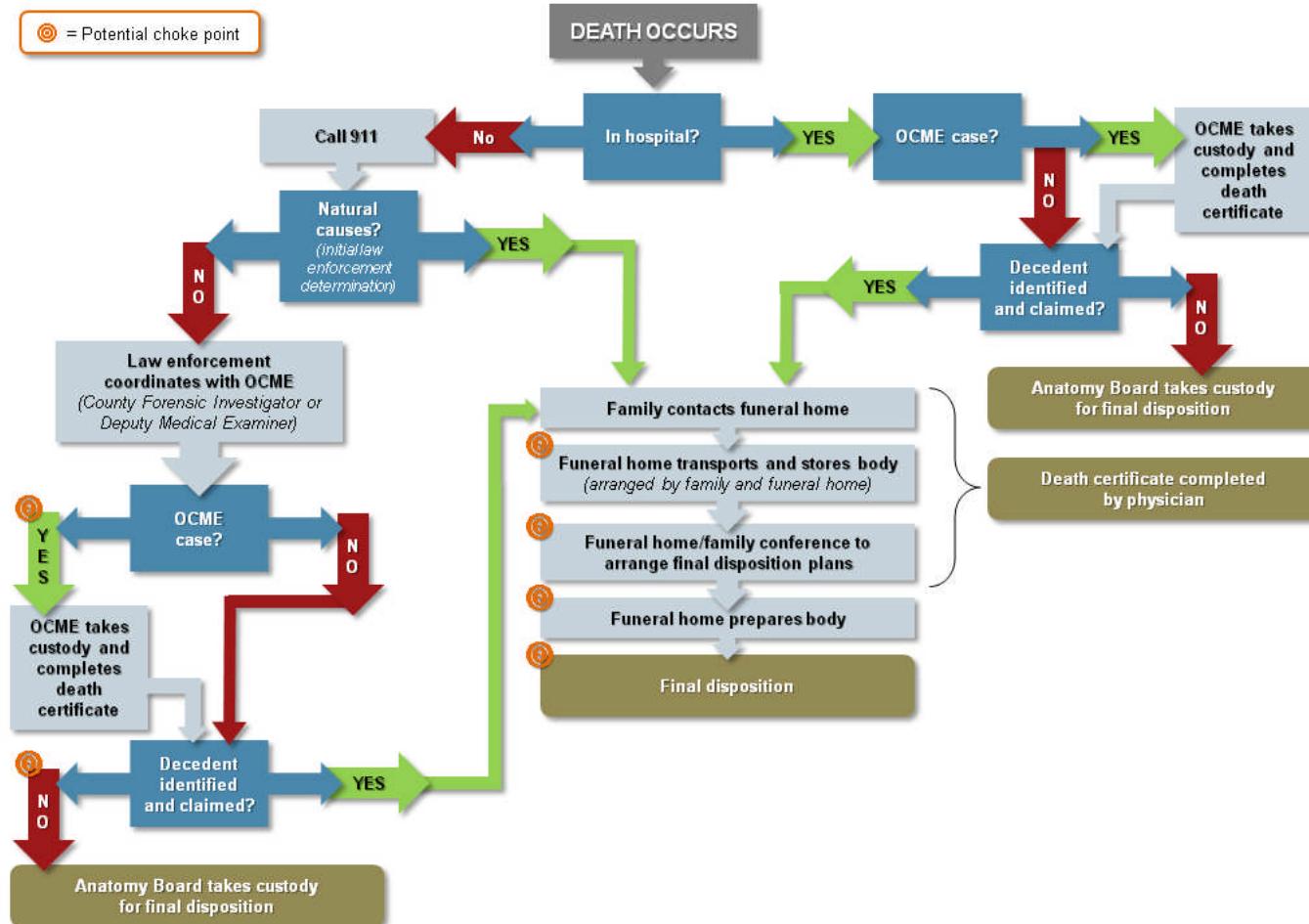
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Appendix A Acronyms

CBRNE	Chemical, biological, radiological, nuclear or explosive
CDC	Centers for Disease Control
CFR	Code of Federal Regulations
COMAR	Code of Maryland Regulations
DHHS	U.S. Department of health and Human Services
DHMH	Department of Health and Mental Hygiene
DMORT	Disaster Mortuary Operations Response Team
DPMU	Disaster Portable Morgue Unit
EAS	Emergency Alert System
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EOC	Emergency Operations Center
ESF	Emergency Support Function
FAC	Family Assistance Center
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
HSEEP	Homeland Security Exercise and Evaluation Program
IAP	Incident Action Plan
IC	Incident Command(er)
ICS	Incident Command System
JFSOC	Joint Family Support Operations Center
JIC	Joint Information Center
JITT	Just In Time Training
LHDs	Local Health Departments
MACP	Mortuary Affairs Collection Point
MEMA	Maryland Emergency Management Agency
MFMP	Mass Fatality Management Plan
MIEMSS	Maryland Institute of Emergency Medical Services System
MJOC	Maryland Joint Operations Center

MPVC	Maryland Professional Volunteer Corps
MSFDA	Maryland State Funeral Directors Association
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NRF	National Response Framework
NTSB	National Transportation Safety Board
OCME	Office of Chief Medical Examiner
OP&R	Office of Preparedness and Response
PIO	Public Information Officer
PPE	Personal Protective Equipment
SEOC	State Emergency Operations Center
UC	Unified Command
WMD	Weapons of Mass Destruction

Appendix B Death Management Process



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Appendix C Cultural and Religious Considerations

During a disaster, the expectation of respect for personal cultural and religious practices remains. However, in a mass fatality situation, the extent to which this can be accommodated may need to be addressed. While every effort will be made to honor the beliefs of the deceased and wishes of the living, extraordinary circumstances will challenge the extent to which accommodations can be made.

To help ensure that the greatest good can come from response and recovery efforts, relationships with community cultural and religious leaders should be established in advance. Local jurisdiction leaders should establish these relationships. Discussions regarding the incorporation of religious considerations into the mass fatality management process should take place and a method for informing the public of these efforts during a response should be identified.

The religious and cultural makeup of communities will vary across the state. Knowing that disasters are indiscriminate in terms of where and who they strike, it is important for local jurisdictions to be familiar with unique communities represented within their boundaries so they can coordinate with responding medical examiners.

Approaches to Being Aware of Survivors' Religious and Cultural Attitudes Surrounding Death¹

All societies have funeral rituals that have developed over many generations to help people cope with death and loss. Family members and loved ones will have a strong psychological need to identify lost loved ones and to grieve for them in customary ways. 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
- Religious ceremonies and/or items to be left with the dead

A mass fatality's victims may be local residents, a combination of local residents and residents of other communities and/or countries, or predominantly residents of other

¹ Adapted from the Santa Clara County Public Health Department Advanced Practice Center, *Managing Mass Fatalities: A Toolkit for Planning*.

communities and/or countries. There is no way to predict this beforehand. Strategies for getting information on religious and cultural beliefs and death practices of victims' families will be important to demonstrating cultural competence and sensitivity in a mass fatality incident—even when it is impossible to meet family requests. The population of Maryland and the surrounding jurisdictions is very diverse. Example strategies for ensuring cultural sensitivity during a mass fatality incident include:

- When families are interviewed to collect antemortem data at the family assistance center (FAC), also collect information about the family's religious or cultural beliefs, including practices and rituals, daily prayer times, important dates, beliefs about autopsy, and other information that may be relevant to the rescue, recovery, and disposition of their loved ones.
- As mass fatality victims are identified and cultural/religious backgrounds become known, consult with leaders of the appropriate religious or ethnic communities for guidance on practices and beliefs concerning death. Connect with religious leaders during the planning stages so that as many of these considerations as possible can be worked out in advance.

Communication with Families When Requests Cannot Be Met

A mass fatality is, by nature, a traumatic large-scale incident that will place extraordinary demands on all resources. If the mass fatality is the result of a crime or terrorism, this will further complicate the situation. As a result, religious and cultural beliefs and practices will most likely lead to requests irreconcilable with the demands on the OCME and the death care industry. Whether they are unable to meet family requests at all or can only meet some requests partially, it is critical to convey this information to families with compassion and sensitivity.

- Communicate with families. Explain why requests cannot be met and assure them of the commitment to treating their loved ones with dignity and respect.
- Consider having representatives of impacted faith communities bless the incident scene and morgue daily.
- Inform appropriate faith and ethnic community leaders about the role of the death care industry and OCME in a mass fatality:
 - Commitment to treating the dead with dignity and respect
 - Determination of the decedent's identification
 - Determination of the cause of death
 - Death notification

- With compassion and sensitivity, explain the reasons that family requests cannot be met or can be only partially met. Affirm professionalism and commitment to treating the dead with dignity and respect.
- Seek the support and leadership of appropriate faith/cultural/ethnic communities during this difficult time in providing information to families/communities that are impacted.
- Keep the Joint Information Center (JIC) and Family Assistance Center (FAC) informed of these concerns so that public communications are culturally competent and respectful.

Specific Religious Directives¹

Most religious and ethnic groups have very specific directives about how bodies are managed after death, and such needs must be considered as a part of mass fatality planning. Christian sects, Indian Nations, Jews, Hindus, and Muslims all have specific directives for the treatment of bodies and for funerals. The wishes of the family will provide guidance; however, if no family is available, local religious or ethnic communities can be contacted for information.

As a result of these special requirements, some religious groups maintain facilities such as small morgues, crematoria, and other facilities, which are generally operated by volunteers. Religious groups should be contacted to ensure that these facilities and volunteers are prepared to deal with mass fatality issues. Religious leaders should also be involved in planning for funeral management, bereavement counseling, and communications, particularly in ethnic communities with large numbers of people who do not speak English.

Buddhist

- Many Buddhists wish to maintain a clear mind when dying, and a quiet space for silent reflection is appreciated.
- There is respect for the doctors' views on medical treatment, but there may sometimes be a refusal of pain-relieving drugs if these impair mental alertness. This is a matter of individual choice.
- It is acceptable for medical examination and treatment to be performed by members of the opposite sex.
- There are no religious objections to blood transfusions or transplants.

¹ Source: Arlington County, Virginia, *Mass Fatality Management Plan, Annex IX to the Public Health Emergency Response Plan*, July 2009.

- It is helpful for someone who is dying to have some quiet, and it is customary to summon a monk to perform some chanting of sacred texts in order to engender wholesome thoughts in the mind of the dying person.
- After death, the body of the deceased may be handled by non-Buddhists. In some cases a monk may perform some additional chanting, but this is not a universal practice. There are no objections to postmortems.
- Preparation of the body for the funeral is generally left to the undertaker, but in some instances relatives may also wish to be involved. The body may be put in a coffin, or wrapped in cloth (sometimes white), or dressed in the deceased's own clothes. It may be surrounded by candles, flowers, incense, photographs, and colored lights, but this is a matter of individual choice and there are no hard-and-fast rules.
- The body is usually cremated, at a time dependent upon the undertaker and the availability of the crematorium's facilities.

Christian

- The terminally ill or dying may wish to keep a copy of the Bible close by.
- A quiet space for prayer and reflection, as well as access to a priest or minister, are appreciated.
- Christians involved in a disaster will value prayers being said for them, or with them, and short readings from scripture, such as the Lord's Prayer and the 23rd Psalm.
- Those who are injured or distressed may wish to receive Holy Communion and/or the Sacrament of Anointing of the Sick (which used to be called Extreme Unction). Other Christians may ask for prayer for healing with the laying on of hands.
- Catholics, the largest of the Christian denominations, are encouraged to make a final confession of sins and to receive forgiveness so they can enter death with a clear conscience.
- It is acceptable for medical examinations and treatment to be performed by members of the opposite sex.
- Treatments such as blood transfusions, surgery, organ transplants, or the administration of drugs is permissible.
- The choice between cremation and burial can either be a matter of personal choice or a denominational requirement. In all cases, the wishes of the deceased's family or friends should be sought if possible. If this cannot be done, then Christians should be buried.

Church of Jesus Christ of Latter-day Saints (Mormons)

- Members may request a priesthood blessing. A quiet private place is appropriate for the blessing.
- The Church takes no position on postmortem examinations.
- There are no religious objections to examination by members of the opposite sex or medical procedures such as transplants, transfusions, or organ donation.
- Church or family members will usually arrange for the body to be clothed for burial.
- Burial rather than cremation is recommended by the Church, but the final decision is left for the family of the deceased.

Hindu

- A Hindu would prefer to be comforted by a person of the same sex, but medical examinations and treatments by members of the opposite sex are permitted.
- There are no religious objections to medical procedures such as transplants or transfusions.
- Requests for organ donation should be made to the head of the family.
- Most fatally ill Hindus would prefer to pray with a *mala* (rosary). A Hindu will appreciate being with someone, preferably of the same sex.
- It is preferred that all Hindu bodies be kept together after death, if possible.
- A dead body should be placed with the head facing north and the feet south.
- Cleanliness is important and the body can be undressed and cleaned, but the family should be consulted when possible. The arms should be placed to the sides and the legs should be straightened. The face should be pointed upward with eyes closed and the whole body must be covered with white cloth. Any detached body parts must be treated with respect as if they were a complete body. Postmortems are permitted, usually with prior agreement of the immediate family. The bereavement in the family lasts a minimum of two weeks during which several rituals are followed. Hindus believe in cremating the body so that the soul is completely free of any attachment to the past physical matter.

Humanists (Atheist/Agnostic)

- Humanism is not a faith. It is a belief that people can live good lives without religious or superstitious beliefs.
- There are no specific restrictions for physical contact or medical treatments.
- Humanists may refuse treatment that they see simply as prolonging suffering.
- Some may strongly resent prayers being said for them or any reassurances based on a belief in god or an afterlife.
- Many humanists believe that when someone dies, the needs of the bereaved are more important than their own beliefs.

Jehovah's Witnesses

- The only two medical interventions that Jehovah's Witnesses object to are elective termination of pregnancy and allogeneic blood transfusion.
- There are no special rituals to perform for those who are dying, nor last rites to be administered to those *in extremis*. Pastoral visits from elders will be welcomed.
- An appropriate relative can decide if a limited postmortem is acceptable to determine cause of death.

Jewish

- The strictly Orthodox actively avoid physical contact with people of the opposite sex.
- All laws normally applying on the Sabbath or festival can be overruled for the purpose of saving life or safeguarding health.
- Medical treatments such as blood transfusion and transplants are permissible but may require advice from a Rabbi.
- A quiet area for prayer is appreciated.
- It is usual for a companion to remain with a dying Jewish person until death, reading or saying prayers. The dying person should not be touched or moved, since it is considered that such action will hasten death, which is not permitted in any circumstances. He or she may wish to recite the *Shema* prayer. The prompt and accurate identification of the dead is particularly important for the position of a widow in Jewish law. Postmortems are forbidden unless ordered by the civil authorities. Body parts must be treated with respect and remain with the corpse if possible.
- When a person dies, eyes should be closed and the jaws tied; fingers should be straight. The body is washed and wrapped in a plain white sheet, and placed with the feet towards the doorway. If possible it should not be left unattended. For men, a prayer shawl, *tallit*, is placed around the body and the fringes on the four corners cut off. The *Chevra Kadisha* (Holy Brotherhood) should be notified immediately after death. They will arrange the funeral, if possible before sunset on the day of death, but will not move the body on the Sabbath. Coffins are plain and wooden (without a Christian cross). Someone remains with the body constantly until the funeral. It is not usual to have floral tributes. Orthodox Jews require burial but Reform and Liberal Jews permit cremation.

Muslim

- Treatment by members of other religions is permissible, but treatment by staff of the same sex is preferred.
- Treatments such as transfusions and transplants are acceptable, but the family or Imam should be consulted about their particular views.
- A clean prayer room should be provided if possible, as well as amenities for ritual washing.
- If a Muslim is terminally ill or dying, the face should be turned towards Mecca. The patient's head should be above the rest of the body.
- The dying person will try and say the *Shahadah* prayer (the testimony of faith).
- Muslim dead should be placed in body-holding areas or temporary mortuaries, and ideally be kept together in a designated area (with male and female bodies separated).
- Postmortems are acceptable only when necessary for the issue of a death certificate or if required by the coroner.
- Ideally, only male Muslims should handle a male body and female Muslims a female body.
- The body should be laid on a clean surface and covered with plain cloth, three pieces for a man and five for a woman. The head should be turned on the right shoulder and the face positioned towards Mecca. Detached body parts must be treated with respect.
- Next of kin or the local Muslim community will make arrangements to prepare the body for burial. Muslims believe in burying their dead and would never cremate a body. Burial takes place quickly, preferably within 24 hours.

Rastafarians

- No particular rituals are observed. The dying person will wish to pray.
- Cutting of hair is prohibited in any circumstances. In a medical emergency, a patient should be consulted before taking action.
- When a Rastafarian person passes (dies), a gathering takes place where there is drumming, singing, scriptures read, and praises given. This usually occurs on the 9th and/or 40th night of the person's passing.

Seventh-day Adventists

- A quiet room for worship should be provided if possible, as well as access to a Bible.
- Adventists would prefer to have an Adventist clergyman or woman present when facing death. However, they would appreciate general prayers and other

spiritual care from clergy of other Christian denominations if Adventist clergy are not available.

- Adventists do not hold the sacraments as required rituals; hence, Sacrament of the Sick would not be necessary.
- Cremation or burial is a matter of personal or family preference.

Sikh

- Treatment by medical staff of any religion is permissible, but patients prefer to be treated by staff of the same sex.
- A clean, quiet prayer room should be provided if possible, as well as amenities for ritual washing.
- The dying person will want to have access to the Sikh scriptures where possible. The five Ks should be left on the dead body, which should, if possible, be cleaned and clothed, in clean garments before being placed in a coffin or on a bier.
- According to Sikh etiquette, comforting a member of the opposite sex by physical contact should be avoided, unless those involved are closely related.
- Deliberate expressions of grief or mourning by bereaved relatives are discouraged, though the bereaved will want to seek comfort from the Sikh scriptures.
- The dead person should always be cremated, with a close relative lighting the funeral pyre or activating the machinery. This may be carried out at any convenient time. The ashes of the deceased may be disposed of through immersion in flowing water or dispersal.

Appendix D Maryland Funeral Establishments

The Maryland State Board of Morticians and Funeral Directors, whose purpose is to protect the public's health and welfare through proper credentialing, examination, licensure, and discipline of morticians, funeral directors, surviving spouses, apprentices and funeral establishments in Maryland, maintains a list of licensed funeral establishments. The list provided below may not be all inclusive and may provide out of date information as the information may have changed. A current list of licensed funeral establishments is attached to the MFMP and can be requested from the Maryland State Board of Morticians and Funeral Directors. This list may be utilized to identify funeral homes within a jurisdiction for planning and response coordination.

Funeral Home	Address	Jurisdiction	County	Phone Number
Adams Family Funeral Home	404 Decatur Street Cumberland, MD 21502-1726	Cumberland	Allegany	(301) 722-5700
Scarpelli Funeral Home	108 Virginia Avenue Cumberland, MD 21502-3997	Cumberland	Allegany	(301) 724-4600
Upchurch Funeral Home	202 Greene Street Cumberland, MD 21502-2889	Cumberland	Allegany	(301) 724-2250
Kight Funeral Home	309 Decatur Street Cumberland, MD 21502-2416	Cumberland	Allegany	(301) 777-7100
Cumberland Crematory	404 Decatur Street Cumberland, MD 21502-1726	Cumberland	Allegany	(301) 722-5700
Kinsey Mary Ann	15205 McMullen Hwy Cumberland, MD 21502	Cumberland	Allegany	(301) 729-2139
Durst Funeral Home	57 Frost Avenue Frostburg, MD 21532-1636	Frostburg	Allegany	(301) 689-8833
Sowers Funeral Home	60 West Main Street Frostburg, MD 21532-1699	Frostburg	Allegany	(301) 689-8866
Frostburg Memorials	19406 National Highway Northwest, Frostburg, MD 21532	Frostburg	Allegany	(301) 689-1661
Hafer Funeral Services	1302 National Highway LaVale, MD 21502-7685	LaVale	Allegany	(301) 729-5000
Eichhorn-Mckenzie Funeral Home	19814 Big Lane Midland, MD 21542	Midland	Allegany	(301) 463-5535
Boal Funeral Services	111 Church Street Westernport, MD 21562-1402	Westernport	Allegany	(301) 359-3031
Eichhorn-Mckenzie Funeral Home	8 East Main Street Lonaconing, MD	Lonaconing	Allegany	(301) 463-5535

Funeral Home	Address	Jurisdiction	County	Phone Number
Lasting Tributes Cremation and Funeral Care, PA	814 Bestgate Road, Annapolis, MD 21401-3033	Annapolis	Anne Arundel	(410) 897-4852
John M Taylor Funeral Home	147 Duke of Gloucester St. Annapolis, MD 21401-2504	Annapolis	Anne Arundel	(410) 263-4422
Hardesty Funeral Homes	12 Ridgely Avenue, Annapolis, MD 21401-1499	Annapolis	Anne Arundel	(410) 263-2222
Advent Funeral and Cremation Services	42 Hudson St., # A210, Annapolis, MD 21401	Annapolis	Anne Arundel	(410) 573-1486
Kenneth Walley Funeral Services	821 West Street, Annapolis, MD 21401-3601	Annapolis	Anne Arundel	(410) 778-2773
William Reese & Sons Mortuary	1922 Forest Drive Annapolis, MD 21401-4319	Annapolis	Anne Arundel	(410) 268-6015
Eco Safe Funerals	P.O. Box 2996 Annapolis, MD 21404-2996	Annapolis	Anne Arundel	(410) 849-2093
Hardesty Funeral Homes	851 Annapolis Road, Gambrills, MD 21054-1112	Gambrills	Anne Arundel	(410) 923-2601
Singleton Funeral Home	1 2nd Avenue Southwest, Glen Burnie, MD 21061-3496	Glen Burnie	Anne Arundel	(410) 766-7070
Kirkley-Ruddick Funeral Home	421 Crain Highway South, Glen Burnie, MD 21061-3681	Glen Burnie	Anne Arundel	(410) 766-2200
Fink Funeral Home	426 Crain Highway South, Glen Burnie, MD 21061-3682	Glen Burnie	Anne Arundel	(410) 766-5690
Harman Funeral Services	7221 Grayburn Drive, Suite G, Glen Burnie, MD 21061	Glen Burnie	Anne Arundel	(410) 863-1115
Donaldson Funeral Home PA	1411 Annapolis Road, Odenton, MD 21113-1216	Odenton	Anne Arundel	(410) 672-2200
West Arundel Crematory	1411 Annapolis Road, Odenton, MD 21113-1216	Odenton	Anne Arundel	(410) 674-2600
McCully-Polyniak Funeral Home	3204 Mountain Road, Pasadena, MD 21122	Pasadena	Anne Arundel	(410) 255-2381
Stallings Funeral Home	3111 Mountain Road, Pasadena, MD 21122-2017	Pasadena	Anne Arundel	(410) 360-1770
Daugherty Family Funeral Home	2603 Mountain Road, Pasadena, MD 21122-1215	Pasadena	Anne Arundel	(410) 439-4510
Gregory J Gonce Funeral Home	169 Riviera Drive Pasadena, MD 21122-2870	Pasadena	Anne Arundel	(410) 255-2650
Barranco & Sons Funeral Home	495 Ritchie Highway, Severna Park, MD 21146-2910	Severna Park	Anne Arundel	(410) 647-2400
Chambers Funeral Services	621 Tewkesbury Lane Severna Park, MD 21146-3506	Severna Park	Anne Arundel	(410) 647-3831

Funeral Home	Address	Jurisdiction	County	Phone Number
Cvach-Rosedale Funeral Home	1211 Chesaco Avenue Rosedale, MD 21237	Rosedale	Baltimore County	(410) 682-2467
Sterling-Ashton-Schwab-Witzke	1630 Edmondson Avenue Catonsville, MD 21228	Catonsville	Baltimore County	(410) 744-8600
MacNabb Funeral Home	301 Frederick Road Catonsville, MD 21228	Catonsville	Baltimore County	(410) 747-4770
Kaczorowski Funeral Home, P.A.	1201 Dundalk Avenue Dundalk, MD 21222	Dundalk	Baltimore County	(410) 633-0000
Connelly Funeral Home of Essex	300 Mace Avenue Essex, MD 21221	Essex	Baltimore County	(410) 687-7100
Ambrose Funeral Home	1328 Sulphur Spring Road Halethorpe, MD 21227	Halethorpe	Baltimore County	(410) 242-2211
Ambrose Funeral Home	2719 Hammonds Ferry Road Halethorpe, MD 21227	Halethorpe	Baltimore County	(410) 242-2211
Bailey Funeral Home and Cremation Service, PA	4023 Annapolis Road Halethorpe, MD 21227	Halethorpe	Baltimore County	(410) 609-0009
Ardent Cremation Services	1900 Lansdowne Road Halethorpe, MD 21227-1747	Halethorpe	Baltimore County	(410) 536-0125
Rendon Funeral Home PA	4023 Annapolis Road Halethorpe, MD 21227	Halethorpe	Baltimore County	(410) 558-2435
EF Lassahn Funeral Home	11750 Belair Road Kingsville, MD 21087	Kingsville	Baltimore County	(410) 592-6100
Eckhardt Funeral Chapel	11605 Reisterstown Road Owings Mills, MD 21117	Owings Mills	Baltimore County	(410) 356-7676
Evans Funeral Chapel	8800 Harford Road Parkville, MD 21234	Parkville	Baltimore County	(410) 665-9444
State Wide Removal Services	8621 Lawrence Hill Road Perry Hall, MD 21128	Perry Hall	Baltimore County	(410) 931-2866
Sol Levinson & Bros., Inc. Funeral Home	8900 Reisterstown Road Pikesville, MD 21208	Pikesville	Baltimore County	(410) 653-8900
Wylie Funeral Home	9200 Liberty Road Randallstown, MD 21133	Randallstown	Baltimore County	(410) 655-9200
Vaughn C. Greene Funeral Services	8728 Liberty Road Randallstown, MD 21133	Randallstown	Baltimore County	(410) 655-0155
Loring Byers Funeral Directors, Inc.	8728 Liberty Road Randallstown, MD 21133	Randallstown	Baltimore County	(410) 922-6400
Eline Funeral Homes	11824 Reisterstown Road Reisterstown, MD 21136	Reisterstown	Baltimore County	(410) 833-1414

Funeral Home	Address	Jurisdiction	County	Phone Number
Lemmon Funeral Home of Dulaney Valley	10 West Padonia Road Timonium, MD 21093	Timonium	Baltimore County	(410) 252-6000
Peaceful Alternatives Funeral	2325 York Road Timonium, MD 21093	Timonium	Baltimore County	(410) 252-8720
Dulaney Valley Funeral Services	200 East Padonia Road Timonium, MD 21093	Timonium	Baltimore County	(410) 628-1930
Ruck Towson Funeral Home Inc.	1050 York Road Towson, Maryland 21204	Towson	Baltimore County	(410) 823-1700
Johnson Funeral Home PA	8521 Loch Raven Boulevard Towson, MD 21286	Towson	Baltimore County	(410) 668-2300
Cremation & Funeral	8717 Green Pastures Drive, Towson, MD	Towson	Baltimore County	(410) 321-1005
PJ's International Funeral Planners	P.O. Box 241	Reisterstown	Baltimore County	(443) 379-0405
Moore Funeral Home	12 South 2nd Street Denton, MD 21629	Denton	Caroline	(410) 479-2611
Williamson Funeral Home	311 South Main Street Federalsburg, MD 21632	Federalsburg	Caroline	(410) 754-5400
Fleegle and Helfenbein Funeral Home PA	106 West Sunset Avenue Greensboro, MD 21639	Greensboro	Caroline	(410) 482-8914
Framptom Funeral Home PA	216 North Main Street Federalsburg, MD 21632	Federalsburg	Caroline	(410) 754-8888
Eline Funeral Homes	934 South Main Street Hampstead, MD 21074	Hampstead	Carroll	(410) 239-8163
Eckhardt Funeral Chapel	3296 Charmil Drive Manchester, MD 21102	Manchester	Carroll	(410) 374-2626
Haight Funeral Home & Chapel	6416 Sykesville Road Sykesville, MD 21784	Sykesville	Carroll	(410) 781-4700
Burrier-Queen Funeral Home	1212 West Old Liberty Road Sykesville, MD 21784	Sykesville	Carroll	(410) 795-0300
Zumbrun Funeral Home	6028 Sykesville Road Sykesville, MD 21784	Sykesville	Carroll	(410) 795-2299
Myers-Durboraw Funeral Home PA	136 East Baltimore Street Taneytown, MD 21787	Taneytown	Carroll	(410) 756-6688
Pritts Funeral Home and Chapel, P.A.	412 Washington Road Westminster, MD 21157	Westminster	Carroll	(410) 848-7533
Myers-Durboraw Funeral Home PA	91 Willis Street Westminster, MD 21157	Westminster	Carroll	(410) 848-3933

Funeral Home	Address	Jurisdiction	County	Phone Number
Fletcher Funeral Home PA	254 East Main Street Westminster, MD 21157	Westminster	Carroll	(410) 848-7575
Hartzler Funeral Home PA	310 Church Street New Windsor, MD 21776	Windsor	Carroll	(410) 635-2000
Stauffer Funeral Homes PA	8 East Ridgeville Boulevard Mount Airy, MD 21771	Mount Airy	Carroll	(301) 829-9410
R.T. Foard Funeral Home, P.A.	318 George Street Chesapeake City, MD 21915	Chesapeake City	Cecil	(410) 885-5916
Hicks Home for Funerals, PA	103 W. Stockton Street Elkton, MD 21921	Elkton	Cecil	(410) 398-3122
R.T. Foard Funeral Home, P.A.	259 East Main Street Elkton, MD 21921	Elkton	Cecil	(410) 398-3388
Crouch Funeral Home	127 South Main Street North East, MD 21901	North East	Cecil	(410) 287-6166
Patterson Lee A & Son Funeral Home	1493 Clayton Street Perryville, MD 21903	Perryville	Cecil	(410) 642-2555
R.T. Foard Funeral Home, P.A.	111 South Queen Street Rising Sun, MD 21911	Rising Sun	Cecil	(410) 658-6030
Williams Funeral Home Inc.	4275 Hawthorne Road Indian Head, MD 20640	Indian Head	Charles	(301) 743-5478
Thornton's Funeral Home	3439 Livingston Road Indian Head, MD 20640	Indian Head	Charles	(301) 375-7855
Arehart Echols Funeral Home PA	211 Saint Marys Avenue La Plata, MD 20646	La Plata	Charles	(301) 934-8342
Raymond Funeral Services PA	5635 Washington Avenue La Plata, MD 20646	La Plata	Charles	(301) 934-2920
Huntt Funeral Home	3035 Old Washington Road Waldorf, MD 20601	Waldorf	Charles	(301) 645-7021
Briscoe-Tonic Funeral Home PA	2294 Old Washington Road Waldorf, MD 20601	Waldorf	Charles	(301) 632-6624
March Funeral Homes	1101 East North Avenue Baltimore, MD 21202-5899	Baltimore	City of Baltimore	(410) 727-3300
Wylie Funeral Home	638 North Gilmor Street Baltimore, MD 21217	Baltimore	City of Baltimore	(410) 383-2700
Joseph H. Brown, Jr. Funeral Home	2140 North Fulton Avenue Baltimore, MD 21217	Baltimore	City of Baltimore	(410) 383-2700
Calvin B Scruggs Funeral Home	1412 East Preston Street Baltimore, MD 21213-2826	Baltimore	City of Baltimore	(410) 837-4926
Lilly & Zeiler Inc.	1901 Eastern Avenue Baltimore, MD 21231	Baltimore	City of Baltimore	(410) 327-1442

Funeral Home	Address	Jurisdiction	County	Phone Number
Mitchell-Wiedefeld Funeral Home, Inc.	6500 York Road Baltimore, MD 21212-2114	Baltimore	City of Baltimore	(410) 377-8300
William C. Brown Community Funeral Homes P.A.	1206 W. North Avenue Baltimore, MD 21217	Baltimore	City of Baltimore	(410) 728-8422
Chatman-Harris Funeral Home West	5240-44 Reisterstown Road Baltimore, MD 21215	Baltimore	City of Baltimore	(410) 578-3822
Chatman-Harris Funeral Home East	4210 Belair Road Baltimore, MD 21206	Baltimore	City of Baltimore	(410) 488-5947
Charles S. Zeiler and Sons Inc.	6224 Eastern Avenue Baltimore, MD 21224	Baltimore	City of Baltimore	(410) 633-8390
REDD Funeral Home	1721 North Monroe Street Baltimore, MD 21217	Baltimore	City of Baltimore	(410) 523-1600
David J. Weber Funeral Home	401 S. Chester Street Baltimore, MD 21231	Baltimore	City of Baltimore	(410) 276-6600
Smith-Williams Funeral Home	2818 E. Baltimore Street Baltimore, MD 21224	Baltimore	City of Baltimore	(410) 534-2400
Estep Brothers Funeral SVC	1300 Eutaw Place Baltimore, MD 21217	Baltimore	City of Baltimore	(410) 728-2800
Betts Funeral Home	1129 N. Caroline Street Baltimore, MD 21213	Baltimore	City of Baltimore	(410) 522-0552
Beverly D. Cromartie Funeral Services	2700 Edmondson Avenue Baltimore, MD 21223	Baltimore	City of Baltimore	(410) 400-3440
Carlton C Douglass Funeral SVC	1701 McCulloh Street Baltimore, MD 21217	Baltimore	City of Baltimore	(410) 669-1738
Charles L. Stevens Funeral Home	1501 E. Fort Avenue Baltimore, MD 21230	Baltimore	City of Baltimore	(410) 752-7739
Charles S. Zeiler and Sons Inc.	901 S. Conkling Street Baltimore, MD 21224	Baltimore	City of Baltimore	(410) 276-3588
Chavis Funeral Home	1818 Eastern Avenue Baltimore, MD 21231	Baltimore	City of Baltimore	(410) 342-7400
Dabrowski-Chojnacki Funeral	1005 Dundalk Avenue Baltimore, MD, 21224	Baltimore	City of Baltimore	(410) 633-6630
Derrick C. Jones Funeral Home	4611 Park Heights Avenue Baltimore, MD 21215	Baltimore	City of Baltimore	(410) 542-1900
Dippel Funeral Homes Inc.	6415 Belair Road Baltimore, MD 21206	Baltimore	City of Baltimore	(410) 665-8400
Elizabeth L. Phillips Funeral Home	1727 N. Monroe Street Baltimore, MD 21217	Baltimore	City of Baltimore	(410) 523-4918
Gardens of Faith Memorial	5598 Trumps Mill Road, Baltimore, MD 21206	Baltimore	City of Baltimore	(410) 668-1086

Funeral Home	Address	Jurisdiction	County	Phone Number
Hari P Close Funeral Service	5126 Belair Road Baltimore, MD 21206	Baltimore	City of Baltimore	(410) 327-3100
Hubbard Funeral Home, Inc.	4107 Wilkens Avenue Baltimore, MD 21229	Baltimore	City of Baltimore	(410) 242-3300
James A Morton & Sons Funeral	1701 Laurens Street Baltimore, MD 21217	Baltimore	City of Baltimore	(410) 728-1100
Jeff Miller Funeral Home SVC	1639 N. Broadway Baltimore, MD 21213	Baltimore	City of Baltimore	(410) 327-2777
Joseph L Russ Funeral Home	2222 W. North Avenue Baltimore, MD 21216	Baltimore	City of Baltimore	(410) 523-3361
Joseph L Russ Funeral Home	2334 Jefferson Street Baltimore, MD 21205	Baltimore	City of Baltimore	(410) 675-1112
Kevin A. Parker Funeral Home	3512 Frederick Avenue Baltimore, MD 21229	Baltimore	City of Baltimore	(410) 945-4665
Locks Funeral Home	1304 N. Central Avenue Baltimore, MD 21202	Baltimore	City of Baltimore	(410) 685-7555
Loudon Park Funeral Home	3620 Wilkens Avenue Baltimore, MD 21217	Baltimore	City of Baltimore	(401) 644-1900
March Funeral Homes	4300 Wabash Avenue Baltimore, MD 21215	Baltimore	City of Baltimore	(410) 542-2400
March Gary P Funeral Home	270 Fredhilton Pass Baltimore, MD 21229	Baltimore	City of Baltimore	(410) 945-1100
Marzullo Funeral Chapel	6009 Hartford Road Baltimore, MD 21214	Baltimore	City of Baltimore	(888) 284-9426, (410) 254-5201
McCully-Polyniak Funeral Home	130 E. Fort Avenue Baltimore, MD 21230	Baltimore	City of Baltimore	(410) 752-6456
Miller-Dippel Funeral Home, Inc.	6415 Belair Road Baltimore, MD 21206	Baltimore	City of Baltimore	(410) 426-7171
Rendon Funeral Home	2818 E. Baltimore Street Baltimore, MD 21224	Baltimore	City of Baltimore	(410) 558-2435
Ruck Funeral Home Inc.	5305 Harford Road Baltimore, MD 21214	Baltimore	City of Baltimore	(410) 426-1517
Schimunek Funeral Home, Inc.	3331 Brehms Lane Baltimore, MD 21213	Baltimore	City of Baltimore	(410) 485-3500
Skarda Funeral Home	2829 Hudson Street Baltimore, MD 21224	Baltimore	City of Baltimore	(410) 342-7733
Taylor Ronald Funeral Home	108 W. North Avenue Baltimore, MD 21201	Baltimore	City of Baltimore	(410) 962-8290
Unity Funeral Home	108 W. North Avenue Baltimore, MD 21201	Baltimore	City of Baltimore	(410) 752-4941

Funeral Home	Address	Jurisdiction	County	Phone Number
Vaughn C. Greene Funeral SVC	4905 York Road Baltimore, MD 21212	Baltimore	City of Baltimore	(410) 433-7500
Vaughn C. Greene Funeral Home	4101 Edmondson Avenue Baltimore, MD 21229	Baltimore	City of Baltimore	(410) 945-2700
Vaughn C. Greene Funeral SVC	5151 Baltimore National Pike Baltimore, MD 21229	Baltimore	City of Baltimore	(410) 233-2400
Wallace Funeral SVC	3405 W. Franklin Street Baltimore, MD 21229	Baltimore	City of Baltimore	(410) 566-8315
Weatherford Phillip A Funeral Service PA	2431 E. Oliver Street Baltimore, MD 21213	Baltimore	City of Baltimore	(410) 327-7700
David J. Weber Funeral Home	5311 Edmondson Avenue Baltimore, MD 21229	Baltimore	City of Baltimore	(410) 624-7432
Zannino Funeral Home	263 S. Conkling Street Baltimore, MD 21224	Baltimore	City of Baltimore	(410) 327-4220
Zeiler & Lilly Inc Funeral Home	300 W. Pratt Street Baltimore, MD 21201	Baltimore	City of Baltimore	(410) 342-1222
Thomas Funeral Home PA	700 Locust Street Cambridge, MD 21613	Cambridge	Dorchester	(410) 228-4727
Bennie Smiths Funeral Home	524 Race Street Cambridge, MD 21613	Cambridge	Dorchester	(410) 228-7453
Boardley Funeral Home	812 Hubbard Street Cambridge, MD 21613	Cambridge	Dorchester	(410) 228-7317
Henry Funeral Home	510 Washington Street Cambridge, MD 21613	Cambridge	Dorchester	(410) 228-8220
Curran-Bromwell Funeral Home	2272 Hudson Road Cambridge, MD 21613	Cambridge	Dorchester	(410) 228-2645
Bennie Smith Funeral Home	516 North Main Street Hurlock, MD 21643	Hurlock	Dorchester	(410) 943-4488
Curran-Bromwell Funeral Home	308 High Street Cambridge, MD 21613	Cambridge	Dorchester	(410) 228-2616
Myers-Durboraw Funeral Home PA	210 West Main Street Emmitsburg, MD 21727	Emmitsburg	Frederick	(301) 447-6244
Stauffer Funeral Home PA	1621 Opossumtown Pike Frederick, MD 21702	Frederick	Frederick	(301) 663-1690
Keeney & Basford Funeral Home	106 East Church Street Frederick, MD 21701	Frederick	Frederick	(301) 662-2175
Robert E Dailey & Son Funeral Home	1201 North Market Street Frederick, MD 21701	Frederick	Frederick	(301) 662-5966
Gary Rollins Funeral Home	110 West South Street Frederick, MD 21701	Frederick	Frederick	(301) 662-5520

Funeral Home	Address	Jurisdiction	County	Phone Number
Lough Memorials	500 South Market Street Frederick, MD 21701	Frederick	Frederick	(301) 663-3441
Resthaven Funeral Services, Skkot Cody P.A.	9501 Catoctin Mountain Highway Frederick, MD 21701	Frederick	Frederick	(301) 898-1577
Hartzler Funeral Home PA	11802 Liberty Road Frederick, MD 21701	Frederick	Frederick	(410) 635-2000
Donald B Thompson Funeral Home	31 East Main Street Middletown, MD 21769	Middletown	Frederick	(301) 371-6070
Ricketts Funeral Home	504 Main Street Myersville, MD 21773	Myersville	Frederick	(301) 293-2331
Stauffer Funeral Homes PA	104 East Main Street Thurmont, MD 21788	Thurmont	Frederick	(301) 271-7777
Robert E Dailey & Son Funeral Home	615 East Main Street Thurmont, MD 21788	Thurmont	Frederick	(301) 271-2404
Hartzler Funeral Home PA	6 E Broadway Union Bridge, MD 21791	Union Bridge	Frederick	(410) 775-7200
Stauffer Funeral Homes PA	40 Fulton Street Walkersville, MD 21793	Walkersville	Frederick	(301) 845-8091
Hartzler Funeral Home PA	404 South Main Street Woodsboro, MD 21798	Woodsboro	Frederick	(301) 845-4300
Newman Funeral Home	26722 Garrett Highway Accident, MD 21520	Accident	Garrett	(301) 746-8222
Newman Funeral Home	943 2nd Avenue Friendsville, MD 21531	Friendsville	Garrett	(301) 746-5800
Newman Funeral Home	179 Miller Street Grantsville, MD 21536	Grantsville	Garrett	(301) 895-5188
David A Burdock Funeral Home	710 Church Street Kitzmiller, MD 21538	Kitzmiller	Garrett	(301) 453-3397
David A Burdock Funeral Home	21 North 2nd Street Oakland, MD 21550	Oakland	Garrett	(301) 334-3388
Newman Funeral Home	205 South 2nd Street Oakland, MD 21550	Oakland	Garrett	(301) 533-1960
Tarring-Cargo Funeral Home	333 South Parke Street, Aberdeen, MD 21001	Aberdeen	Harford	(410) 272-4500
William C. Brown Community Funeral Homes P.A.	321 South Philadelphia Boulevard Aberdeen, MD 21001	Aberdeen	Harford	(410) 272-5100
McComas Funeral Home	1317 Cokesbury Road Abingdon, MD 21009	Abingdon	Harford	(410) 676-4600
Schimunek Funeral Homes	610 West McPhail Road Bel Air, MD 21014	Bel Air	Harford	(410) 638-5360

Funeral Home	Address	Jurisdiction	County	Phone Number
Evans Funeral Chapel-Cremation	3 Newport Drive Forest Hill, MD 21050	Forest Hill	Harford	(410) 893-7575
McComas Funeral Home	50 West Broadway Bel Air, MD 21014	Bel Air	Harford	(410) 838-4040
Lisa Scott Funeral Home	552 Lewis Street Havre de Grace, MD 21078	Havre de Grace	Harford	(410) 939-4940
Zellman Funeral Home	123 South Washington Street Havre de Grace, MD 21078	Havre de Grace	Harford	(410) 939-2882
E G Kurtz & Son Funeral Home	1114 Baldwin Mill Road Jarrettsville, MD 21084	Jarrettsville	Harford	(410) 692-6000
Howell Funeral	10220 Guilford Road Jessup, MD 20794-9528	Jessup	Harford	(301) 604-0101
Going Home Cremation Services	P.O. Box 784 Clarksville, MD 21029	Clarksville	Howard	(301) 854-9038
Witzke Funeral Homes, Inc.	5555 Twin Knolls Road Columbia, MD 21045	Columbia	Howard	(410) 992-9090
Baltimore South Central Prep	5555 Twin Knolls Road Columbia, MD 21045	Columbia	Howard	(410) 992-3239
Gary L. Kaufman Funeral Home	7250 Washington Boulevard Elkridge, MD 21075	Elkridge	Howard	(410) 796-8024
Slack Funeral Home	3871 Old Columbia Pike Ellicott City, MD 21043	Ellicott City	Howard	(410) 465-4400
Fellows Helfenbein & Newman Funeral Home PA	130 Speer Road Chestertown, MD 21620	Chestertown	Kent	(410) 778-2772, (410) 778-0055
Bennie Smith Funeral Home	855 High Street, Suite 2 Chestertown, MD 21620	Chestertown	Kent	(410) 778-2161
Marvin V Williams Jr	Central Drive Chestertown, MD 21620	Chestertown	Kent	(410) 778-3582
Fellows Helfenbein & Newman Funeral Home PA	106 Shamrock Road Chester, MD 21619	Chestertown	Kent	(310) 643-2226
Galena Funeral Home	118 West Cross Street Galena, MD 21635	Galena	Kent	(410) 648-5338
Fellows Funeral Home PA	370 Cypress Street Millington, MD 21651	Millington	Kent	(410) 928-5311
Fellows Helfenbein & Newman Funeral Home PA	6179 Rock Hall Road Rock Hall, MD 21661	Rock Hall	Kent	(410) 639-2811
Hilton Funeral Home	22111 Beallsville Road Barnesville, MD 20838	Barnesville	Montgomery	(301) 349-2135

Funeral Home	Address	Jurisdiction	County	Phone Number
Robert A Pumphrey Funeral Homes	7557 Wisconsin Avenue Bethesda, MD 20814	Bethesda	Montgomery	(301) 652-2200
Funeral Consumers Alliance	9601 Cedar Lane Bethesda, MD 20814	Bethesda	Montgomery	(301) 564-0006
Garden of Remembrance Memorial Park	14321 Comus Road Clarksburg, MD 20871	Clarksburg	Montgomery	(301) 428-3000
Molesworth Funeral Home	26401 Ridge Road Damascus, MD 20872	Damascus	Montgomery	(301) 253-2138
Thibadeau Mortuary Service	7 Park Avenue Gaithersburg, MD 20877	Gaithersburg	Montgomery	(301) 495-4950
Devol Funeral Home	10 East Deer Park Drive Gaithersburg, MD 20877	Gaithersburg	Montgomery	(301) 948-6800
Barber Muriel H	21525 Etchison Laytonsville Road Gaithersburg, MD 20882	Gaithersburg	Montgomery	(301) 948-3500
Robert A Pumphrey Funeral Home	300 West Montgomery Avenue Rockville, MD 20850	Rockville	Montgomery	(301) 762-3939
Edward Sagel Funeral Direction, Inc.	1091 Rockville Pike Rockville, MD 20852	Rockville	Montgomery	(301) 217-9400
Danzansky-Goldberg Memorial Chapels, Inc.	1170 Rockville Pike Rockville, MD 20852	Rockville	Montgomery	(301) 340-1400
Simple Tribute Funeral & Cremation Center	1040 Rockville Pike Rockville, MD 20852	Rockville	Montgomery	(301) 545-0960
Snowden Funeral Home	246 North Washington Street Rockville, MD 20850	Rockville	Montgomery	(301) 762-2500
Parklawn Memorial Park	12800 Veirs Mill Road Rockville, MD 20852	Rockville	Montgomery	(301) 881-2151
Heavenly Days Animal Crematory	605 South Stonestreet Avenue Rockville, MD 20850	Rockville	Montgomery	(301) 340-9748
Pumphrey Robert A Funeral Homes Inc.	255 Rockville Pike Rockville, MD 20850	Rockville	Montgomery	(301) 762-3939
Charles Hinds Funeral Service	Rockville, MD 20850	Rockville	Montgomery	(240) 731-3634
Rapp Funeral & Cremation Services	933 Gist Avenue Silver Spring, MD 20910	Silver Spring	Montgomery	(301) 565-4100
Hines-Rinaldi Funeral Home Inc.	11800 New Hampshire Avenue Silver Spring, MD 20904	Silver Spring	Montgomery	(301) 622-2290

Funeral Home	Address	Jurisdiction	County	Phone Number
Philip D Rinaldi Funeral Services	9241 Columbia Boulevard Silver Spring, MD 20910	Silver Spring	Montgomery	(301) 585-4050
Francis J. Collins Funeral Home, Inc.	500 University Boulevard West Silver Spring, MD 20901	Silver Spring	Montgomery	(301) 593-9500
Pope Funeral Homes	8401 Colesville Road, Number 110 Silver Spring, MD 20910	Silver Spring	Montgomery	(301) 589-7590
Simplicity Plan of Maryland	11800 New Hampshire Avenue Silver Spring, MD 20904	Silver Spring	Montgomery	(301) 622-0540
Stewart Enterprises Inc.	11800 New Hampshire Avenue Silver Spring, MD 20904	Silver Spring	Montgomery	(301) 622-2290
Strano & Feeley Family Funeral	635 Churchmans Road Newark, DE	Newark, DE	New Castle	(410) 398-9552
MidAtlantic Cremation Society, LLC	7829 Belle Point Drive Suite B Greenbelt, MD 20770	Greenbelt	Prince George's	(301) 257-9904
Gaschs Funeral Home PA	4739 Baltimore Avenue Hyattsville, MD 20781	Hyattsville	Prince George's	(301) 927-6100
JB Jenkins Funeral Home	7474 Landover Road Hyattsville, MD 20785	Hyattsville	Prince George's	(301) 322-2300
Rendon-Hale Funeral Home	9013 Annapolis Road, Lanham MD 20706	Lanham	Prince George's	(301) 577-7787
Washington Wilbert Vault Works, Inc.	9939 Washington Boulevard Laurel, MD 20723	Laurel	Prince George's	(301) 776-7840
Donaldson Funeral Home PA	313 Talbott Avenue Laurel, MD 20707	Laurel	Prince George's	(301) 725-1690
Fleck Funeral Home, Inc.	7601 Sandy Spring Road Laurel, MD 20707	Laurel	Prince George's	(301) 490-0606
Cedar Hill Funeral Home	4111 Pennsylvania Avenue Suitland-Silver Hill, MD 20746	Suitland	Prince George's	(301) 817-0120
Hodges & Edwards Funeral Home	3910 Silver Hill Road Suitland, MD 20746	Suitland	Prince George's	(301) 899-0687
Freeman Funeral Services	P.O. Box 416 Suitland, MD 20752	Suitland	Prince George's	(301) 324-7144
JK Johnson Funeral Home	6503 Old Branch Avenue, Suite #1 Temple Hills, MD 20748	Temple Hills	Prince George's	(301) 449-9400
Strickland Funeral Services	6500 Allentown Road Temple Hills, MD 20748	Temple Hills	Prince George's	(301) 449-0400
Freeman Funeral Services	4594 Beech Road, Temple Hills MD 20748	Temple Hills	Prince George's	(301) 316-3733

Funeral Home	Address	Jurisdiction	County	Phone Number
Phillip Bell Sr and Winona Morrissette-Johnson, PA	4902 Stan Haven Road Temple Hills, MD 20748	Temple Hills	Prince George's	(301) 710-6272
Dieners Autopsy Services Inc.	1504 Robert Lewis Avenue Upper Marlboro, MD 20774	Upper Marlboro	Prince George's	(301) 430-0100
Donald V Borgwardt Funeral Home	4400 Powder Mill Road Beltsville, MD 20705	Beltsville	Prince George's	(301) 937-1707
Chesapeake Pet Crematory	107701 Tucker Street Beltsville, MD 20705	Beltsville	Prince George's	(301) 937-3187
Beall Funeral Home	6512 Crain Highway Bowie, MD 20715	Bowie	Prince George's	(301) 805-5544
Robert E. Evans Funeral Home	16000 Annapolis Road Bowie, MD 20715	Bowie	Prince George's	(301) 464-8836
Fort Lincoln Funeral Home	3401 Bladensburg Road Brentwood, MD 20722	Brentwood	Prince George's	(301) 864-5090
Wiseman Funeral Home	4710 Auth Place Camp Springs, MD 20746	Camp Springs	Prince George's	(301) 899-2005
Eternal Faith Funeral Services	5625 Allentown Road Camp Springs, MD 20746	Camp Springs	Prince George's	(240) 244-4099
Wiseman Funeral Home	7527 Old Alexandria Ferry Road Clinton, MD 20735	Clinton	Prince George's	(301) 877-2600
Pope Funeral Home	5538 Marlboro Pike District Heights, MD 20747	District Heights	Prince George's	(301) 754-6400
Fellows Helfenbein & Newman Funeral Home PA	408 South Liberty Street Centreville, MD 21617	Centreville	Queen Anne's	(410) 758-1151
Jolley Memorial Chapel	10080 Deal Island Road Deal Island, MD 21821	Deal Island	Somerset	(410) 784-2433
Brinsfield-Ecols Funeral Home	30195 Three Notch Road Charlotte Hall, MD 20622	Charlotte Hall	St. Mary's	(301) 472-4400
R Carroll Hurley Funeral Home	312 South Talbot Street St. Michaels, MD 21663	St. Michaels	Talbot	(410) 745-5021
Fellows Helfenbein & Newman Funeral	200 South Harrison Street Easton, MD 21601	Easton	Talbot County	(410) 822-3131
Bennie Smith Funeral Home	426 East Dover Street Easton, MD 21601	Easton	Talbot County	(410) 822-7228
Bast-Stauffer Funeral Home	7606 Old National Pike Boonsboro, MD 21713	Boonsboro	Washington	(301) 432-8388
Donald E Thompson Funeral Home	13607 National Pike Clear Spring, MD 21722	Clear Spring	Washington	(301) 842-2900
Minnich Funeral Home	415 East Wilson Boulevard Hagerstown, MD 21740	Hagerstown	Washington	(301) 739-6800

Funeral Home	Address	Jurisdiction	County	Phone Number
Gerald N Minnich Funeral Home	305 North Potomac Street Hagerstown, MD 21740	Hagerstown	Washington	(301) 739-1414
Douglas A. Fiery Funeral Home	1331 Eastern Boulevard North Hagerstown, MD 21742	Hagerstown	Washington	(301) 791-7759
Rest Haven Funeral Home	1601 Pennsylvania Avenue Hagerstown, MD 21742	Hagerstown	Washington	(301) 733-3575
Andrew K Coffman Funeral Home	40 East Antietam Street Hagerstown, MD 21740	Hagerstown	Washington	(301) 739-1444
Grover Funeral Home	141 West Main Street Hancock, MD 21750	Hancock	Washington	(301) 678-6178
Davis Funeral Homes Inc	12525 Bradbury Avenue Smithsburg, MD 21783	Smithsburg	Washington	(301) 791-1230
Osborne Funeral Home	425 South Conococheague Street Williamsport, MD 21795	Williamsport	Washington	(301) 582-3311
Messick Funeral Home	20941 Nanticoke Road Bivalve, MD 21814	Bivalve	Wicomico	(410) 546-0202
Holloway Funeral Home	501 Snow Hill Road Salisbury, MD 21804	Salisbury	Wicomico	(410) 742-5141
Bounds Funeral Home	705 East Main Street Salisbury, MD 21804	Salisbury	Wicomico	(410) 749-3281
Lewis N Watson Funeral Home	1618 West Road Salisbury, MD 21801	Salisbury	Wicomico	(410) 546-6937
Bennie Smith Funeral Home	917 West Isabella Street Salisbury, MD 21801	Salisbury	Wicomico	(410) 546-0626
Jolley Memorial Chapel	1213 Jersey Road Salisbury, MD 21801	Salisbury	Wicomico	(410) 749-6461
Zeller Funeral Home	1212 Old Ocean City Road Salisbury, MD 21804	Salisbury	Wicomico	(410) 749-5206
Stewart Funeral Home	821 West Road, Salisbury MD 21801	Salisbury	Wicomico	(410) 742-1297
Green Acres Memorial Park Inc.	1618 West Road Salisbury, MD 21801	Salisbury	Wicomico	(410) 341-6338
Burbage Funeral Home	108 Williams Street Berlin, MD 21811	Berlin	Worcester	(410) 641-2111
Holloway Funeral Home	107 Vine Street Pocomoke City, MD 21851	Pocomoke City	Worcester	(410) 957-0224
Bennie Smith Funeral Home	819 4th Street Pocomoke City, MD 21851	Pocomoke City	Worcester	(410) 957-0800
Burbage Funeral Home	208 West Federal Street Snow Hill, MD 21863	Snow Hill	Worcester	(410) 632-9991

Appendix E Mass Fatality Management Training

The United States Department of Health and Human Services Centers for Disease Control and Prevention *Public Health Preparedness Capabilities National Standards for State and Local Planning* recommends the following mass fatality management training.

General

1. Federal Emergency Management Agency (FEMA) Mass Fatalities Incident Response (G-386) – Emergency Management Institute
2. FEMA Emergency Support Function #8 – Public Health and Medical Services (IS-808)
3. National Mass Fatalities Institute:
 - Family Assistance and Behavioral Health Course, Responding to Active Shooter Incidents-Fatality Management (MFI 100,200,300 and 400)
4. Local and state mass fatality course offerings

Family Assistance

1. Providing Relief to Families after a Mass Fatality: Roles of the Medical Examiner's Office and the Family Assistance Center, Department of Justice's Office of Justice Programs, the Office for Victims of Crime:
<http://www.ojp.usdoj.gov/ovc>
2. Creating and Operating A Family Assistance Center: A Toolkit for Public Health: <http://www.apctoolkits.com/family-assistance-center/>
3. National Transportation Safety Board Training Center:
http://www.ntsb.gov/tc/sched_courses.htm
 - Family Assistance (TDA301)
 - Advanced Skills in Disaster Family Assistance (TDA405)
 - Mass Fatality Incidents for Medicolegal Professionals (TDA403)

Behavioral Health

1. Trauma, Death, and Death Notification: A Seminar for Professional Counselors and Victim Advocates (1996):
<http://www.ojp.usdoj.gov/ovc/publications/infors/death.htm>
2. Providing Relief to Families After a Mass Fatality: Roles of the Medical Examiner's Office and the Family Assistance Center, Department of Justice's Office of Justice Programs, the Office for Victims of Crime:
<http://www.ojp.usdoj.gov/ovc>
3. Light Our Way: A Guide for Spiritual Care in Times of Disaster for Disaster Response Volunteers, First Responders and Disaster Planners, Emotional and Spiritual Care Committee and the Light Our Way Task Force of National Voluntary Organizations Active in Disaster:
http://wwwldr.org/care/Light_Our_Way.pdf

Public Health Officials, Medical Examiners, and death care industry

1. Radiological Terrorism: A Tool Kit for Public Health Officials:
<http://emergency.cdc.gov/radiation/publichealthtoolkit.asp>
2. Guidelines for Handling Decedents Contaminated with Radioactive Materials (document and video):
<http://emergency.cdc.gov/radiation/pdf/radiation-decedent-guidelines.pdf>
3. Satellite Broadcast: Preparing for Radiological Population Monitoring & Decontamination:
<http://www.phppo.cdc.gov/PHTN/Radiological2006/default.asp>
4. The Medical Examiner and Coroner's Guide for Contaminated Deceased Body Management:
http://thename.org/index.php?option=com_docman&task=doc_download&id=13&Itemid=26

Appendix F Sample Forms

Initial Incident Assessment and Scene Recovery Checklist

Reference: *National Association of Medical Examiners Standard Operating Procedure for Mass Fatality Management 2010*

APPENDIX A
INITIAL INCIDENT ASSESSMENT AND SCENE RECOVERY
CHECKLIST

Location of Incident: County: City/Twp:		Best Access Route: Incident Command Post Identified: <input type="checkbox"/> Y <input type="checkbox"/> N If yes, location:
Type of Incident: <input type="checkbox"/> Transportation <input type="checkbox"/> Natural <input type="checkbox"/> Criminal <input type="checkbox"/> Work site <input type="checkbox"/> Other:	Type of Transportation Incident: <input type="checkbox"/> Aircraft <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Other: Capacity: Number of Passengers: Carrier/Company: Aircraft Model:	

Incident Commander: Name: Agency:	Presiding Law Enforcement Agency: Name: Agency:
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Contact #:	Contact #:
Identify County Emergency Management Director: Name: Agency: Contact #:	Identify County Emergency Planning Coordinator: Name: Agency: Contact #:
Identify Public Health Director: Name: Agency: Contact #:	Emergency Operations Center: Location: Contact numbers:

Scene Hazards	<input type="checkbox"/> Chemical Specify:	<input type="checkbox"/> Biological Specify:	<input type="checkbox"/> Radioactive Specify:	<input type="checkbox"/> Incendiary Specify:	<input type="checkbox"/> Scene Declared Safe By: Time:
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Field Safety	<input type="checkbox"/> Establish daily scene safety briefings
	<input type="checkbox"/> Request establishment of rest stations and food stations for scene workers.

	<input type="checkbox"/> Ascertain all scene workers are appropriately immunized (Tetanus, Hepatitis B, other immunizations, as deemed appropriate by Public Health)
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Scene Access	<input type="checkbox"/> Paved <input type="checkbox"/> No special equipment needed	<input type="checkbox"/> Paved access nearby <input type="checkbox"/> Access by regular vehicles <input type="checkbox"/> 4WD needed	<input type="checkbox"/> Difficult terrain <input type="checkbox"/> Special access vehicles required	<input type="checkbox"/> Excavation equipment required <input type="checkbox"/> Road Commission assistance required
Estimated Fatalities	<input type="checkbox"/> >5, <25	<input type="checkbox"/> >25, <50	<input type="checkbox"/> >50, <100	Specify Estimate:
Estimated Survivors	<input type="checkbox"/> >5, <25	<input type="checkbox"/> >25, <50	<input type="checkbox"/> >50, <100	Specify Estimate:
Hospitals Where Survivors Taken	<u>Hospital #1:</u>		Hospital #2:	
	<u>Hospital #3:</u>		Hospital #4:	

Condition of Remains	<input type="checkbox"/> Intact bodies	<input type="checkbox"/> <50% dismembered	<input type="checkbox"/> >50% dismembered
	<input type="checkbox"/> Charred	<input type="checkbox"/> Significant decomposition	<input type="checkbox"/> Facial trauma

Scene Security	<input type="checkbox"/> Request law enforcement to maintain scene security.
	<input type="checkbox"/> Consider requesting the air space be secured.
	<input type="checkbox"/> Establish an Identification System to limit individuals allowed into and out of the scene.
	<input type="checkbox"/> Establish a log to record the number of workers at the scene
	<input type="checkbox"/> Inform all workers that personal cameras may not be brought into or used at the scene.

Temporary Holding	Is a temporary holding site needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Location of Temporary Holding Site:

	<input type="checkbox"/> Assign Temporary Holding Site Leader: <input type="checkbox"/> Record contact information for Temporary Holding Site Leader <input type="checkbox"/> Ascertain use of Log for all remains placed into temporary holding site <input type="checkbox"/> Ascertain remains will not be stacked during holding or transport <input type="checkbox"/> Ascertain the Temporary Storage will remain locked at all times when not in use.
--	--

Transport to Incident Morgue	Is transport to incident morgue needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Assign Transportation Leader:
	<input type="checkbox"/> Record contact information for Transportation Leader
	Transporters to be used:
	<input type="checkbox"/> Funeral Directors
	<input type="checkbox"/> Other (Describe):
<input type="checkbox"/> Ascertain use of Chain of Custody for all remains being transported	
<input type="checkbox"/> Ascertain remains will not be stacked during holding or transport	
<input type="checkbox"/> Consider use of police escort for transports	

Equipment and Supplies	<p><input type="checkbox"/> Request scene recovery equipment be delivered to the scene</p> <p>Record to whom request is made:</p> <p>Date/time:</p> <p><input type="checkbox"/> Assign Equipment/Supply Officer</p> <p><input type="checkbox"/> Record contact information for Equipment/Supply Officer:</p> <p><input type="checkbox"/> Assign Scene Registrar to:</p> <p><input type="checkbox"/> Track used supplies</p> <p><input type="checkbox"/> Assure replenishment of supplies</p> <p><input type="checkbox"/> Record use of supplies for BILLING</p> <p><input type="checkbox"/> Contact NDMS/DMORT for acquisition and recording mechanisms</p>
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Search and Body Recovery	<input type="checkbox"/> Assign Body Recovery Team Supervisor: <input type="checkbox"/> Record contact information for Recovery Team Supervisor: <input type="checkbox"/> Meet with Recovery Team and Morgue Operations Supervisor to establish numbering system for remains recovered from the scene.
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DMORT Forms

Reference: *National Association of Medical Examiners Standard Operating Procedure for Mass Fatality Management 2010*

APPENDIX C

 VIP/DMORT Program Tracking Form		Incident _____
		PM Case #
Body Bag #	Presumptive	
Open Field #	SSN _____	DOB _____
RFID #	Last Name _____	First Name _____
Person performing station function must check and sign below when completed. "No" represents that this station function could not be performed.		
Processing Station: _____ Rep Initial _____ Section Rep. Signature _____		Date of Pathology Exam _____ Trackers Name _____
Admitting <input type="radio"/> Yes <input type="radio"/> No _____ Personal Effects <input type="radio"/> Yes <input type="radio"/> No _____ Photography <input type="radio"/> Yes <input type="radio"/> No _____ Body Radiography <input type="radio"/> Yes <input type="radio"/> No _____ Fingerprints <input type="radio"/> Yes <input type="radio"/> No _____ Anthropology <input type="radio"/> Yes <input type="radio"/> No _____ Pathology <input type="radio"/> Yes <input type="radio"/> No _____ Embalming <input type="radio"/> Yes <input type="radio"/> No _____ DNA <input type="radio"/> Yes <input type="radio"/> No _____ Dental Examination <input type="radio"/> Yes <input type="radio"/> No _____ Dental Photography <input type="radio"/> Yes <input type="radio"/> No _____ Dental Radiology <input type="radio"/> Yes <input type="radio"/> No _____ Exit Morgue <input type="radio"/> Yes <input type="radio"/> No _____		After Processing Location Identification Method <input type="checkbox"/> Anthropology <input type="checkbox"/> Radiographic <input type="checkbox"/> Dental Records <input type="checkbox"/> Fingerprints <input type="checkbox"/> Pathology <input type="checkbox"/> Personal Effects <input type="checkbox"/> Photography <input type="checkbox"/> DNA <input type="checkbox"/> Field Case Notes
Comments <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
This bag produced bag #'s: _____ <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		Photo's Number of Dental Photos _____ <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> Number of Personal Effects Photos _____ <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> Number of Specimen Photos _____ <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Created _____ VIP Program Provided thru the DMORT System		PM Info # _____

VIP/DMORT Program

Examining Pathologist Pathology Incident
PM Case # _____

Pg 1 of 3 Date of Exam _____

Bag # _____ Sex Male Female Unknown Condition of Remains _____

Est Race Caucasoid Asian Hispanic Est Race Other: _____
Race Negroid American Indian Unknown Import Pictures

Build Gracile Robust Height cm _____ Inches _____
 Intermediate Indeterminate Weight kg _____ Pounds _____

H e a i r	Hair Color	<input type="radio"/> Auburn <input type="radio"/> Black <input type="radio"/> Salt & Pepper	Hair Length	<input type="radio"/> Short <input type="radio"/> Long <input type="radio"/> Bald
	<input type="radio"/> Blonde <input type="radio"/> Gray <input type="radio"/> White	<input type="radio"/> Medium <input type="radio"/> Shaved <input type="radio"/> N/A		
	<input type="radio"/> Brown <input type="radio"/> Red <input type="radio"/> Other			
	Hair Accessory	<input type="radio"/> Extension <input type="radio"/> Hair Transplant	Hair Description	<input type="radio"/> Curly <input type="radio"/> Straight <input type="radio"/> Other
	<input type="radio"/> Hair Piece <input type="radio"/> Wig		<input type="radio"/> Wavy <input type="radio"/> N/A	
	Facial Hair	<input type="radio"/> Beard <input type="radio"/> Beard & Moustache <input type="radio"/> Moustache	Clean Shaven	<input type="radio"/> Goatee
	Facial Hair Color	<input type="radio"/> Blonde <input type="radio"/> Brown <input type="radio"/> Black <input type="radio"/> Gray <input type="radio"/> Red <input type="radio"/> Salt & Pepper <input type="radio"/> White		
	Facial Hair	<input type="radio"/> Clean Shaven <input type="radio"/> Beard & Moustache <input type="radio"/> Goatee <input type="radio"/> Sideburns <input type="radio"/> N/A		
	Hair Type	<input type="radio"/> Moustache <input type="radio"/> Beard	<input type="radio"/> Stubble <input type="radio"/> Lower Lip	
E y e	Eyes	<input type="radio"/> Blue <input type="radio"/> Green <input type="radio"/> Grey <input type="radio"/> Missing R <input type="radio"/> Glass R <input type="radio"/> Cataract	Optical	<input type="radio"/> Glasses <input type="radio"/> Contacts
	<input type="radio"/> Brown <input type="radio"/> Hazel <input type="radio"/> Blind <input type="radio"/> Missing L <input type="radio"/> Glass L			
N a i l s	Finger Nail Type	<input type="radio"/> Natural <input type="radio"/> Artificial <input type="radio"/> Unknown		
	Length	<input type="radio"/> Extra Long <input type="radio"/> Long <input type="radio"/> Medium <input type="radio"/> Short		
	Fingernail Color	<input type="radio"/> Bitten <input type="radio"/> Decorated <input type="radio"/> Mishapen <input type="radio"/> N/A		
	Toenail Color	<input type="radio"/> Decorated <input type="radio"/> Mishapen <input type="radio"/> Yellow/Fungus <input type="radio"/> N/A		

List manufacturer, serial numbers, and other identifying features:
Prosthetics _____

Teeth Present? Yes No Dentures Present? Yes No

S c a r s	<input type="checkbox"/> Scars (other than surgical) <input type="checkbox"/> Birthmarks <input type="checkbox"/> Deformities (non peri-mortem) <input type="checkbox"/> Cardiac	
	Description _____	
	Scars _____	
	Birthmarks _____	
Dormitories _____		
Cardiac _____		

S u r g e r y	<input type="checkbox"/> Gall Bladder <input type="checkbox"/> Laparotomy <input type="checkbox"/> Reconstructive	Other Surgery _____
	<input type="checkbox"/> Appendectomy <input type="checkbox"/> Caesarean <input type="checkbox"/> Open Heart _____	
	<input type="checkbox"/> Tracheotomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Other _____	
	Description _____	



VIP/DMORT Program

Examining Pathologist _____

Pathology _____

Incident _____

Pg 2 of 3

Date of Exam _____

Bag # _____ Sex Male Female UnknownTattoo(s) Yes No Unknown Photos? Yes No

Location Side Tatoo Description

Body Piercing(s)? Yes No Unknown

Body Bag # Location Side Quantity Piercing Description

Objects In Body

Other Object In Body

Pacemaker Prosthetic Devices Other
 Bullets Orthopedic devices

Wallet

Description _____

Contents _____

Purse

Description _____

Contents _____

Currency

Misc Items Found

Other Personal Effects

VIP/DMORT Program

	Examining Pathologist	Pathology Pg 3 of 3	Incident _____ Date of Exam _____	
Bag # _____		Sex <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	Specimen Wt _____	
Dimensions _____		Path Narrative:		
<hr/> <hr/> <hr/> <hr/>				
Additional head and neck exam remarks:				
<hr/> <hr/> <hr/> <hr/>				
Torso	<input type="radio"/> Viscera Identifiable	Torso Remarks		
<hr/> <hr/> <hr/> <hr/>				
External Genitalia		Internal Genitalia		
<input type="checkbox"/> Male	<input type="checkbox"/> Uncircumcised	<input type="checkbox"/> Testis Left	<input type="checkbox"/> Tubes Right	
<input type="checkbox"/> Female		<input type="checkbox"/> Testis Right	<input type="checkbox"/> Ovaries Left	
<input type="checkbox"/> Indeterminate		<input type="checkbox"/> Uterus	<input type="checkbox"/> Ovaries Right	
<input type="checkbox"/> Circumcised		<input type="checkbox"/> Tubes Left		
Extremity Remarks				
<hr/> <hr/> <hr/> <hr/>				
Expanded Condition of Remains:				
<input type="checkbox"/> Fresh	<input type="checkbox"/> Burned	<input type="checkbox"/> Cremains	<input type="checkbox"/> Specific Trauma	<input type="checkbox"/> Submerged (Grid #)
<input type="checkbox"/> Decomposing	<input type="checkbox"/> Charred	<input type="checkbox"/> Distinct Marks	<input type="checkbox"/> Floating (GPS)	<input type="checkbox"/> Scavenger Activity

VIP Program Provided thru the DMORT System



VIP/DMORT Program

Person Making Inventory Jewelry Inventory

Incident

PM Case #

Date of Exam

Body Bag # _____

#	Type Make	Band Material Face Color	Description	Inscription	A= Data not available B= Photo C= Other Info
WATCH					
<input type="text"/> <input type="text"/> <input type="text"/>					

#	Jewelry/Type Style	Material Color Stone Color	Size	Description	Inscription	A= Data not available B= Photo C= Other Info
JEWELRY						
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>						

Use this Space for More Info Regarding Jewelry:

<input type="text"/>

VIP Program Provided thru the DMORT System

	Person Making Inventory	Clothing	Incident _____
			PM Case # _____
			Date of Exam _____
Body Bag # _____	Sex _____		
CLOTHING INVENTORY:			
#	Clothing Items	Color	Description
			Size
Dry Cleaning Marks Description		Laundry Marks Description	
_____		_____	
Wallet: Description _____ Contents _____			
Purse: Description _____ Contents _____			
Currency _____ Misc Items Found _____ _____ _____			
Other Personal Effects _____ _____ _____			

VIP Program Provided thru the DMORT System

	Experiencing Radiologist	VIP/DMORT Program Radiology	Incident PM Case #	
		Date of Exam _____		
Bag # _____	Number of Images Taken: _____			
Radiology Technician: _____				
Radiologist Findings: Sex <input type="radio"/> Male <input type="radio"/> Unknown <input type="radio"/> Female possible <input type="radio"/> Est Age _____ <input type="radio"/> Female <input type="radio"/> Male possible				
Fractures:	<input type="checkbox"/> Cranium <input type="checkbox"/> Mandible <input type="checkbox"/> Torso <input type="checkbox"/> R Upper Arm	<input type="checkbox"/> R Forearm <input type="checkbox"/> R Hand <input type="checkbox"/> L Upper Arm <input type="checkbox"/> L Forearm	<input type="checkbox"/> L Hand <input type="checkbox"/> R Upper Leg <input type="checkbox"/> R Lower Leg <input type="checkbox"/> R Foot	<input type="checkbox"/> L Upper Leg <input type="checkbox"/> L Lower Leg <input type="checkbox"/> L Foot
Detailed Description of Fractures _____ _____ _____ _____ _____				
Other Radiology Findings (Prostheses, surgery, etc.) _____ _____ _____ _____ _____				

Reviewed by: _____

VIP Program Provided thru the DMORT System

 **Fingerprint Specialist**

VIP/DMORT Program
Fingerprinting

Incident _____
PM Case # _____
Date of Exam _____

Body # _____

Examiner 1 _____

Examiner 2 _____

Condition of Hands _____
(Burned,
mutilated, etc.)

Fingers Printed
(List Fingers Printed)

If not printed
why?

Fingerprint
Exam Notes

Footprint available ? Footprint Location
 Yes No

VIP Program Provided thru the DMORT System

VIP/DMORT Program
Examining Anthropologist **Anthropology** **Pg 1 of 2** **Incident** **PM Case #** **Date of Exam**

Bag # _____ Anthropology Condition of Remains: _____

Anthropology estimated information in this area.

Estimate age

Age narrow lower	Age narrow upper	95% Lower limits:	95%Upper limits:	Anthro Sex
_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female possible <input type="checkbox"/> Female <input type="checkbox"/> Male possible

Race / Skeletal	Skeletal Robusticity	Stature (in Cm)
<input type="checkbox"/> Caucasoid <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Negroid <input type="checkbox"/> American Indian <input type="checkbox"/> Unknown	<input type="checkbox"/> Gracie <input type="checkbox"/> Robust <input type="checkbox"/> Intermediate <input type="checkbox"/> Indeterminate	_____

Missing Parts	Unique Skeletal Features (Pathology, Healed Trauma, Non-metric Traits, Etc.)		
<input type="checkbox"/> Intact Body <input type="checkbox"/> Cranium <input type="checkbox"/> Partial Cranium <input type="checkbox"/> Mandible <input type="checkbox"/> Partial Mandible <input type="checkbox"/> Torso <input type="checkbox"/> Partial Torso <input type="checkbox"/> R Upper Arm <input type="checkbox"/> Partial R Upper Arm <input type="checkbox"/> R Forearm <input type="checkbox"/> Partial R Forearm <input type="checkbox"/> R Hand <input type="checkbox"/> Partial R Hand <input type="checkbox"/> L Upper Arm <input type="checkbox"/> Partial L Upper Arm <input type="checkbox"/> L Forearm	<input type="checkbox"/> Partial L Forearm <input type="checkbox"/> L Hand <input type="checkbox"/> Partial L Hand <input type="checkbox"/> R Upper Leg <input type="checkbox"/> Partial R Upper Leg <input type="checkbox"/> R Lower Leg <input type="checkbox"/> Partial R Lower Leg <input type="checkbox"/> R Foot <input type="checkbox"/> Partial R Foot <input type="checkbox"/> L Upper Leg <input type="checkbox"/> Partial L Upper Leg <input type="checkbox"/> L Lower Leg <input type="checkbox"/> Partial L Lower Leg <input type="checkbox"/> L Foot <input type="checkbox"/> Partial L Foot	<input type="checkbox"/> Intact Body <input type="checkbox"/> Cranium <input type="checkbox"/> Partial Cranium <input type="checkbox"/> Mandible <input type="checkbox"/> Partial Mandible <input type="checkbox"/> Torso <input type="checkbox"/> Partial Torso <input type="checkbox"/> R Upper Arm <input type="checkbox"/> Partial R Upper Arm <input type="checkbox"/> R Forearm <input type="checkbox"/> Partial R Forearm <input type="checkbox"/> R Hand <input type="checkbox"/> Partial R Hand <input type="checkbox"/> L Upper Arm <input type="checkbox"/> Partial L Upper Arm <input type="checkbox"/> L Forearm	<input type="checkbox"/> Partial L Forearm <input type="checkbox"/> L Hand <input type="checkbox"/> Partial L Hand <input type="checkbox"/> R Upper Leg <input type="checkbox"/> Partial R Upper Leg <input type="checkbox"/> R Lower Leg <input type="checkbox"/> Partial R Lower Leg <input type="checkbox"/> R Foot <input type="checkbox"/> Partial R Foot <input type="checkbox"/> L Upper Leg <input type="checkbox"/> Partial L Upper Leg <input type="checkbox"/> L Lower Leg <input type="checkbox"/> Partial L Lower Leg <input type="checkbox"/> L Foot <input type="checkbox"/> Partial L Foot

Anthro Sex _____
 Based On _____

Anthro Age _____
 Based On _____

Ancestry based on _____

Stature based on _____

Unique Skeletal Features _____

VIP/DMORT Program

 Examining Anthropologist Anthropology Incident _____
Pg 2 of 2 Date of Exam _____

Bag # _____ Anthropology Condition of Remains: _____

Condition of Remains / Comments

Anthropology Report

Cause of Death

Manner of Death

Signature of Section Leader _____

VIP Program Provided thru the DMORT System

DMORT Victim Identification Profile

Reference: National Disaster Medical System DMORT website:

<http://www.dmort.org/forms/index.html>

VIP Personal Information						Incident _____				
Page 1 of 8						Incident Date _____				
RM # _____										
Last	/	Suffix	/	First	/	Middle	Sex	If Female/Maiden Name	Age	
DOB MM/DD/YYYY	Race	SSN # / ID #		Birth City	State or Country		Birth Hospital			
Address	Apt #	City		State	Zip					
County	Country	Inside City Limits		Religious Preference						
Education: level completed: Elem/Second (0-12):			College	Degree Earned:						
Alias 1	Last	First	Middle	Alias 2	Last	First	Middle			
Phone (H)	Phone (W)	Phone (Cell)								
Status	<input type="radio"/> Is Married <input type="radio"/> Never Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Civil Union <input type="radio"/> Unknown								Date Wed _____	
Spouse	Last	Suffix	Maiden/birth Name	First	Middle		<input type="radio"/> Living	<input type="radio"/> Deceased	<input type="radio"/> Unknown	
Father	Last	Suffix		First	Middle		<input type="radio"/> Living	<input type="radio"/> Deceased	<input type="radio"/> Unknown	
Mother	Last	Suffix		First	Middle		<input type="radio"/> Living	<input type="radio"/> Deceased	<input type="radio"/> Unknown	
Informant	Last	Suffix	First	Middle			<input type="radio"/> Spouse	<input type="radio"/> Uncle		
	Address	City	State	Zip			<input type="radio"/> Father	<input type="radio"/> Aunt		
	Home Phone	Work Phone	Cell Phone	E-mail			<input type="radio"/> Mother	<input type="radio"/> Cousin		
							<input type="radio"/> Brother	<input type="radio"/> Employer		
							<input type="radio"/> Sister	<input type="radio"/> Friend		
							<input type="radio"/> Son	<input type="radio"/> Other		
							<input type="radio"/> Dtr			
Relationship:										
Other:										
Type of Initial Contact	Initial Contact Date _____									
OK to Contact Legal Next of Kin?	<input type="radio"/> Yes <input type="radio"/> No									
Address	Last	Suffix	First	Middle		<input type="radio"/> Spouse	<input type="radio"/> Uncle			
City			State	Zip		<input type="radio"/> Father	<input type="radio"/> Aunt			
Home			Work			<input type="radio"/> Mother	<input type="radio"/> Cousin			
E-mail	On Site/Cell Phone									
1 Contacts	<input type="checkbox"/> Additional Permanent Contact: <input type="checkbox"/> Additional Contact?									
	Last	Suffix	First	Middle		<input type="radio"/> Brother	<input type="radio"/> Employer			
	Address	City	State	Zip		<input type="radio"/> Sister	<input type="radio"/> Friend			
	Home Phone	Work Phone	Cell Phone			<input type="radio"/> Son	<input type="radio"/> Other			
							<input type="radio"/> Dtr			
E-mail	Type of Initial Contact _____ Initial Contact Date _____									

		VIP Physical Description Page 2 of 8						Incident _____ Incident Date _____	
		RM #	/	/	/	/	/	/	/
Last	Suffix	First	Middle	Age	DOB	Sex	Race		
Height Inches: _____ / Height cm: _____ Approx. Weight (Pounds): _____ / Weight Kilos: _____									
H h a i r o	Hair Color <input type="checkbox"/> Auburn <input type="checkbox"/> Brown <input type="checkbox"/> Gray <input type="checkbox"/> Salt & Pepper <input type="checkbox"/> Other <input type="checkbox"/> Blonde <input type="checkbox"/> Black <input type="checkbox"/> Red <input type="checkbox"/> White								
	Hair Length <input type="checkbox"/> Bald <input type="checkbox"/> Short < 3" <input type="checkbox"/> Male Pattern Baldness: _____ <input type="checkbox"/> Shaved <input type="checkbox"/> Medium <input type="checkbox"/> Long								
	Hair Accessory <input type="checkbox"/> Extensions <input type="checkbox"/> Hair Piece <input type="checkbox"/> Hair Transplant <input type="checkbox"/> Wig <input type="checkbox"/> N/A								
	Hair Description <input type="radio"/> Curly <input type="radio"/> Wavy <input type="radio"/> Straight <input type="radio"/> N/A <input type="radio"/> Other: _____								
	Facial Hair Type <input type="radio"/> Clean Shaven <input type="radio"/> Beard & Mustache <input type="radio"/> Goatee <input type="radio"/> Sideburns <input type="radio"/> N/A <input type="radio"/> Mustache <input type="radio"/> Beard <input type="radio"/> Stubble <input type="radio"/> Lower Lip								
E y e s	Facial Hair Color <input type="radio"/> Blonde <input type="radio"/> Black <input type="radio"/> Red <input type="radio"/> White <input type="radio"/> Facial Hair Notes: <input type="radio"/> Brown <input type="radio"/> Gray <input type="radio"/> Salt & Pepper <input type="radio"/> NA								
	Eye Color <input type="checkbox"/> Blue <input type="checkbox"/> Brown <input type="checkbox"/> Green <input type="checkbox"/> Hazel <input type="checkbox"/> Gray <input type="checkbox"/> Black <input type="checkbox"/> Other: _____								
	Optical Color/Description of Glasses lens: _____								
	Optical Lens <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> Implants <input type="checkbox"/> None <input type="checkbox"/> Desc. _____								
N a i s	Eye Status <input type="checkbox"/> Both Intact <input type="checkbox"/> Missing R <input type="checkbox"/> Missing L <input type="checkbox"/> Glass R <input type="checkbox"/> Glass L <input type="checkbox"/> Cataract								
	Fingernail Type <input type="radio"/> Natural <input type="radio"/> Artificial <input type="radio"/> Unknown Length <input type="radio"/> Extremely Long <input type="radio"/> Long <input type="radio"/> Medium <input type="radio"/> Short								
	Fingernail Color _____ Description _____								
	Characteristics <input type="checkbox"/> Bitten <input type="checkbox"/> Decorated <input type="checkbox"/> Misshapen <input type="checkbox"/> Yellowed/Fungus <input type="checkbox"/> N/A <input type="checkbox"/> Other								
T o e n a l i l s	Toenail Color _____ Toenail description _____								
	Characteristics <input type="checkbox"/> Bitten <input type="checkbox"/> Decorated <input type="checkbox"/> Misshapen <input type="checkbox"/> Yellowed/Fungus <input type="checkbox"/> N/A <input type="checkbox"/> Other								
	Body Piercing(s)? <input type="radio"/> Yes <input type="radio"/> No Photos? <input type="radio"/> Yes <input type="radio"/> No Photo Location _____								
#	Location	Side	Quantity	Description (include evidence of old piercings)			Photo		
1									
2									
3									
4									
5									
Tattoo(s)? <input type="radio"/> Yes <input type="radio"/> No Photos? <input type="radio"/> Yes <input type="radio"/> No Photo Location _____									
#	Location	Side	Tattoo Description						
1									
2									
3									
4									
5									

 RM # _____	VIP Medical History Page 3 of 8								Incident _____ Incident Date _____	
Last Suffix First Middle Age DOB Sex Race										
D Dentist _____ E Address _____ N Phone 1 _____ I See Dental Section For Additional Dental Information S T Additional Dental Information/2nd Dentist: _____				Dental Records Requested by DDS: _____				<input type="checkbox"/> Dental Work <input type="checkbox"/> Dentures <input type="checkbox"/> Both <input type="checkbox"/> Braces <input type="checkbox"/> Partials <input type="checkbox"/> Tooth Jewelry		
Some Initial Dental Records Received <input type="radio"/> Yes <input type="radio"/> No										
P Physician _____ H Address _____ Y City _____ State _____ Zip _____ I Phone 1 _____ Phone 2 _____ A Email _____								Practice Name _____ Physician Type _____ Reason Seen: _____		
								Records Requested <input type="radio"/> Yes <input type="radio"/> No Records Obtained <input type="radio"/> Yes <input type="radio"/> No		
P Physician _____ H Address _____ Y City _____ State _____ Zip _____ I Phone 1 _____ Phone 2 _____ A Email _____								Practice Name _____ Physician Type _____ Reason Seen: _____		
								Records Requested <input type="radio"/> Yes <input type="radio"/> No Records Obtained <input type="radio"/> Yes <input type="radio"/> No		
Medical Radiographs? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Medical Radiographs Location: _____								Potential Type of Radiographs - and dates taken if known: _____		
Old Fractures: Description: _____ <input type="radio"/> Yes <input type="radio"/> No										
Objects in Body: <input type="checkbox"/> Pacemaker <input type="checkbox"/> Bullets <input type="checkbox"/> Implants <input type="checkbox"/> Needles <input type="checkbox"/> Shrapnel <input type="checkbox"/> Other _____										
Surgery: <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Caesarean <input type="checkbox"/> Reconstructive <input type="checkbox"/> Other _____ <input type="checkbox"/> Appendectomy <input type="checkbox"/> Laparotomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Open heart _____										
Unique Characteristics		Description of: Scars, Operations, birthmarks, burns, missing organs, amputations, other special characteristics :								
<input type="radio"/> Yes <input type="radio"/> No		_____ _____ _____								
Prosthetic Location/Description Prosthetic(s) _____ <input type="radio"/> Yes <input type="radio"/> No _____										
Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Female, was she currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Female, was she pregnant during the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										

 RM #	VIP Jewelry Page 5 of 8	Incident _____ Incident Date _____																																																																																													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> </tr> <tr> <td>Last</td> <td>Suffix</td> <td>First</td> <td>Middle</td> <td>Age</td> <td>DOB</td> <td>Sex</td> <td>Race</td> <td></td> </tr> </table>												Last	Suffix	First	Middle	Age	DOB	Sex	Race																																																																												
Last	Suffix	First	Middle	Age	DOB	Sex	Race																																																																																								
WATCH: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">#</th> <th colspan="2">Type/ Make</th> <th rowspan="2">Band Material Watch Face Color</th> <th rowspan="2">Description</th> <th rowspan="2">Photo Available <input type="radio"/> Yes <input type="radio"/> No</th> <th rowspan="2">Inscription</th> </tr> <tr> <th>Style</th> <th>Stone Color?</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			#	Type/ Make		Band Material Watch Face Color	Description	Photo Available <input type="radio"/> Yes <input type="radio"/> No	Inscription	Style	Stone Color?	1																																																																																			
#	Type/ Make			Band Material Watch Face Color	Description					Photo Available <input type="radio"/> Yes <input type="radio"/> No	Inscription																																																																																				
	Style	Stone Color?																																																																																													
1																																																																																															
JEWELRY: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Jewelry/Type</th> <th colspan="2">Material Color/</th> <th rowspan="2">Size / Where Worn/ Frequently Worn?</th> <th rowspan="2">Description</th> <th rowspan="2">Photo Available <input type="radio"/> Yes <input type="radio"/> No</th> <th rowspan="2">Inscription</th> </tr> <tr> <th>Style</th> <th>Stone Color?</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Jewelry/Type	Material Color/		Size / Where Worn/ Frequently Worn?	Description	Photo Available <input type="radio"/> Yes <input type="radio"/> No	Inscription	Style	Stone Color?	1														2														3														4														5														6													
Jewelry/Type	Material Color/			Size / Where Worn/ Frequently Worn?	Description					Photo Available <input type="radio"/> Yes <input type="radio"/> No	Inscription																																																																																				
	Style	Stone Color?																																																																																													
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4																																																																																															
5																																																																																															
6																																																																																															
Other Commonly Carried Personal Effects _____																																																																																															
Gather this information only in the case of a Missing Person Report																																																																																															
Cell Phone Number _____ Cell Phone Type: _____ Service Provider: _____																																																																																															

RM #		Last	Suffix	First	Middle	Age	DOB	Sex	Race
CLOTHING:	Clothing Items			Color		Description			Size

Wallet: Description _____
 Contents _____

Purse: Description _____
 Contents _____

Pockets: Contents Left _____
 Contents Right _____

Other Commonly Carried Personal Effects _____

Gather this information only in the case of a Missing Person Report

Cell Phone Number _____ Cell Phone Type: _____ Service Provider: _____

 RM #	VIP Family Page 7 of 8						Incident _____ Incident Date _____	
	Last	Suffix	First	Middle	Age	DOB	Sex	Race
Potential Living Biological Donors All BIOLOGICAL Relatives of Missing Individual Such as: Mother/Father/Spouse/Sister/Brother/Children/Uncle/Aunt/Cousin								
To Add New Donor tab to last field of last Donor.								
	Last Name	First Name	Middle Name	Social Security/ Last 4	DOB	Sex	Relationship	
	Address	City	State	Zip	Phone 1	E-Mail		
	Last Name	First Name	Middle Name	Social Security/ Last 4	DOB	Sex	Relationship	
	Address	City	State	Zip	Phone 1	E-Mail		
	Last Name	First Name	Middle Name	Social Security/ Last 4	DOB	Sex	Relationship	
	Address	City	State	Zip	Phone 1	E-Mail		
	Last Name	First Name	Middle Name	Social Security/ Last 4	DOB	Sex	Relationship	
	Address	City	State	Zip	Phone 1	E-Mail		
	Last Name	First Name	Middle Name	Social Security/ Last 4	DOB	Sex	Relationship	
	Address	City	State	Zip	Phone 1	E-Mail		
	Last Name	First Name	Middle Name	Social Security/ Last 4	DOB	Sex	Relationship	
	Address	City	State	Zip	Phone 1	E-Mail		
	Last Name	First Name	Middle Name	Social Security/ Last 4	DOB	Sex	Relationship	
	Address	City	State	Zip	Phone 1	E-Mail		
Primary donor for Nuclear DNA Analysis An "appropriate family member" for nuclear DNA Analysis is someone who is biologically related to and only one generation removed from the deceased. The following are the family members who are appropriate donors to provide reference specimens, and in the order of preference (family members highlighted in bold print are the most desirable):								
1. Natural (Biological) Mother and Father , AND 2. Spouse and Natural (Biological) Children , AND 3. A Natural (Biological) Mother or Father and victim's biological children, OR 4. Multiple Full Siblings of the Victim (i.e., children from the same Mother and Father).								

**VIP Personal Information**

Page 8 of 8

RM #

Name _____ / _____ / _____
Last _____ First _____ Middle _____Location _____ Date _____ Interview Time _____
(MM/DD/YYYY)**Interviewer Info:**Interviewer Name _____
Full Name _____

Interviewing_Organization _____

Interviewer Home InformationInterviewer Address _____
Street, City State, Zip _____
Interviewer home phone _____
Interviewer cell phone _____
Interviewer work phone _____**Interviewer On-Site Information**Interviewer onsite address _____
Street, Hotel, Room # _____
Interviewer onsite phone _____
Interviewer onsite cell _____**Reviewer Info:**Reviewer Name _____
Reviewer Signature _____
Reviewing agency _____

Appendix G Equipment and Supply Considerations

The following information is a list of the equipment and supplies that may be necessary to effectively respond to a mass fatality incident. It is intended as a planning tool only and may not be an exhaustive list of necessary resources. These materials may be readily available through normal resource chains or it may be necessary to pre-identify and establish relationships with suppliers.

Administrative Supplies

Notepads/paper	Pencil sharpener
Sticky notes	Extension cords
Pens, pencils, markers, highlighters	Power strips
Stapler, staple remover	Surge protectors
Tape	Printer and copier
Duct tape	Copier paper
White out	Toner
File folders	Tables/desks
Paper clips	Chairs

Information Technology/Communications

Telephone equipment (hard line and cellular)
Incoming phone line(s)
Outgoing phone line(s)
Fax machine (dedicated line if possible)
Photocopy machine
Computers (Desk and lap top)
Internet access
Radios

Forms and Documents

Mass Fatality Management Plan (several hard copies)
Decedent information and tracking forms
Fatality tracking forms
Death certificates
Internal and external contact lists
Scene documentation forms

Fatality Processing Materials

Human remains pouches	Rakes (garden type)
Plastic zip-lock bags	Shovels
Waterproof marking pens	Hammers
Cloth evidence bags with wire tags	Face masks or respirators
Transfer cases or litters	Biohazard bags
Gridding supplies:	White bed sheets
GPS	Workman's cowhide leather gloves
Flags	Personal effects bags
Spray paint	Gloves, gowns and other PPE
Stakes, at least four feet in length	Tags (paper with strings)
Surgical masks	Morgue equipment (tools and instruments)
Photographic equipment	
Tents	

Other

Radiation/ HazMat detection equipment
Decontamination equipment
Portable X-Ray
Personal protective equipment (gloves, respirators, rain suits, helmets, boots, etc.)
Storage for equipment/supplies
Fatality storage facilities (pre-existing space or tents)

Appendix H Mass Fatality Management Plan Working Group

To coordinate and review the Maryland Mass Fatality Management Plan, the Office of Preparedness and Response organized a working group comprised of representatives from public health and partner organizations from the state and local level. The list of working group members is below.

Veronica Black	DHMH Office of Preparedness and Response
Barbara Brookmyer	Frederick County Health Department
Jim Bruzdzinski	State Funeral Directors Association
Meghan Butasek	Baltimore City Health Department
Lisa Chervon	Maryland Institute of Emergency Medical Services System
Beth Copp	Chester River Hospital
John Donohue	Maryland Institute of Emergency Medical Services System
Chas Eby (Chair)	DHMH Office of Preparedness and Response
Helen Espitallier	DHMH Vital Statistics Administration
Kathy Foster	Talbot County Health Department
Carrie Gonzalez	Dewberry
Isabelle Horon	DHMH Vital Statistics Administration
Bill Kelly	Montgomery County Health and Human Services
Ruth Maioran	Johns Hopkins School of Public Health
Jennifer Martin	Baltimore City Health Department
Ruth Mascari	Maryland Emergency Management Agency
Gary Poole	Shore Health System
Barbara Rosvold	Frederick County Health Department
John Veltri	Frederick Memorial Hospital
Ronn Wade	DHMH Anatomy Board
Gail Wowk	DHMH State Facilities
Ivan Zapata	DHMH Office of Preparedness and Response
Dawn Zulauf	DHMH Office of the Chief Medical Examiner

Law Enforcement Branch Briefing

COVID-19 Charles County IMT

April 22th, 2020

Buildings:

Charles County Sheriff's Office: District 1 Lobby is closed for scheduled remolding. The District 1 clerks have moved the CCDC Annex building in the same parking area and that lobby is open as normal

Maryland State Police: Restricted to public

Maryland Transportation Authority: Closed to Public

La Plata Police Department: Closed to the public

Natural Resources Police: Building Closed

Operations:

Charles County Sheriff's Office: Operations have gone to emergency schedule in accordance with a CCSO level 3 All-Hazards activation. Patrol operational periods are 12 hours from 0700-1900 and 1900-0700. All other operations sections running with normal services being provided from modified locations. Services provided have not been reduced or augmented as of now.

Maryland State Police: Operations as normal

Maryland Transportation Authority: Operations as normal

La Plata Police Department: Operations as normal; Doing screening in and screening out

Natural Resources Police: Operations as normal

Internal COVID-19:

Charles County Sheriff's Office:

- 5 sworn officer quarantined
- 0 officers isolated
- **0 correctional officer quarantined**
- 0 correctional officers isolated
- 5 civilian quarantined
- 1 civilians isolated

Maryland State Police: None local

Maryland Transportation Authority: None local

La Plata Police Department: 2 sworn officers quarantined

Natural Resources Police: 2 sworn officer quarantined

Crime Stats:

Crime continues to be down in all aspects.

TRU:

Charles County Sheriff's Office: Open and working; triage site for COVID-19 calls for service.

Maryland State Police: Open and working

Maryland Transportation Authority: Open and working

La Plata Police Department: Open and working

Natural Resources Police: Open and working

Call Restrictions:

Charles County Sheriff's Office: None

Maryland State Police: None

Maryland Transportation Authority: None

La Plata Police Department: None

Natural Resources Police: None

Governor's Order Violations since Emergency Orders Issued:

Violation sustained calls for service: 42

Warnings: 39

Charges later: 2

On-scene arrest: 1

Health Department Order Violations (Between 04/16/20 and 04/18/20):

Calls for Service

Founded: 5

Unfounded: 10

Dispositions

Warnings: 5 issued

Items of Note: (Not for redistribution)

None

*CHANGES IN RED

Intelligence Briefing 4-22-2020
COVID Charles County

Updated Infection Numbers: As of 1139 hrs.

Total worldwide: 2,594,724 **+93,568** since the 4-21-20 brief.

Worldwide increase of confirmed cases by 24-hour period over the last 10 days

4-11/12	4-12/13	4-13/14	4-14/15	4-15/16	4-16/17	4-17 to 19	4-19/20	4-20/21	4-21/22
85,648	69,285	134,855	65,338	80,985	99,539	164,125	74,806	80,717	93,568

Total fatalities worldwide: 179,778 **+7,968** since the 4-21-20 brief

Analysis note: The wild swings in worldwide confirmed case numbers and fatality numbers continue to illustrate the lack of consistent reporting channels. These number should not solely be used to gauge the scope and magnitude of the current situation.

Total confirmed cases in the US: 826,248 **+37,328** since the 4-21-20 brief

US increase of confirmed cases by 24-hours period over the last 10 days

4-11/12	4-12/13	4-13/14	4-14/15	4-15/16	4-16/17	4-17 to 19	4-19/20	4-20/21	4-21/22
28,520	28,326	54,634	27,062	38,764	31,493	63,794	24,499	29,134	37,328

Analysis note: The US case number increases have remained relatively unchanged for the last 10 days. However, this is likely not an indication of “flattening the curve.” As the data is reviewed, keep in mind we are reporting an additional 28 to 33,000 NEW cases each day. We have yet to see any dramatic decreases in diagnoses new cases.

Total fatalities in US: 42,458 **+2695** since 4-21-2020

Maryland Numbers: As of 1000 hrs. via <https://coronavirus.maryland.gov/>

Total confirmed cases in State in of MD: 14,775 **+582** since the 4-21-20 brief

Total tested in the State of MD: 61,754 **+2,303** over 4-21-20

Percent of those test that test positive: **23.9%**

Analysis note: Maryland percentage of positive test is now on par with PA, MA, IL, MI, CA and LA.

Total Fatalities in State of MD: 631 **+47** change since the 4-21-20 brief

Number of probable deaths: 67 (this is new statistic)

Total Ever Hospitalized: 3,325 Increase of 167 from 4-21-2020

Persons currently hospitalized. 1432 (new statistic)

First Responder Numbers in Charles County: As reported at 1230 4-20-2020

44 Quarantine: means exposed and they can't come to work. **+2 since last report**

7 Self Isolation: means sick or tested positive **-1 since last reported**

Weather:

Wed. 60-42 sun, Thursday 64-53 rain, Friday 66-46 rain

Local:

Stores were busy this am. Some paper products and disinfectant were available. Wholes and gaps remain in previously stated products.

Analysis note: Beef, poultry, and pork plants continue to close at an alarming rate. This will put pressure on the meat market and likely cause a run on store inventories as the press continues to cover these closures.

Nursing home and assistant living patients and staff make-up over **33%** of the total number of positive cases reported in Charles County.

Maryland Update:

Gov. press conf. at 1500 4-22-2020 RE: Laurel Region

Some barbershops begin to reopen

Gov. announces the procurement of 500,000 test kits for the state

Region:

Over 15,319 cases in the NCR as of 0500 4-22-2020,

27,611 cases in Maryland, DC, and Virginia as of 1100 on 4-22-2020.

DC releases a process for testing asymptomatic people

COVID FEAR: Woman pepper-sprays folks trying to ride elevator with her at a D.C. Wal-Mart:

<https://wjla.com/news/local/woman-pepper-sprays-customers-trying-to-ride-elevator-with-her-at-a-dc-wal-mart>

Inova lays off 400+ employees

Death total in the DMV passes 1000

DC believes they are flattening the curve

FBI bulletin: Endorsement of terrorist threat to hospitals

COG NCR briefing Wed. 10-1130

National:

USS Comfort leaving NYC

FBI bulletin on fraudulent 3M masks (see attached)

Director of CDC warns of the 2nd wave.

NY Gov. says "we are actually in a much better place."

The push to reopen the economy is adding to the national polarization and causing more people to lash out. Social media issues are increasing.

The cascading effects of the scope and length of this situation are reaching further than anyone imagined only weeks ago. Oil futures were negative yesterday.

5-year-old daughter of 2 Detroit first responders has passed away from complication of COVID-19. Official cause of is meningitis and swelling of the brain. Test positive for COVID last month. US Army boot camps have re-opened after 2 weeks

IRS warns of on-going fraud situation

Local critical infrastructure:

No outages or disruptions are reported or are appear to be likely as of today.

Predications/ Analysis:

- The length and scope of this situation have exposed large cracks in food supply chains, medical supply chains, fossil fuel industries, and other major portions of everyday life. Local leaders should begin a gap analysis and start the after-action process so they can create and modernize resiliency plans, local stockpiles, and coming up with other forward leaning solutions so when the next disaster occurs they are more self-sufficient and better prepared.
- While we have concentrated our efforts on peer support and helping our responders, a proactive approach to including families of first responders is quickly emerging. The command structure should consider a Family Support liaison or expand the Peer support branch.
- The increased discussions about opening the economy, added with the on-going conversation about health care in-equity and racial disproportionality of infections is causing increased polarization, angry, and hate. Social media is rampant with spirited discussions. It is only a matter of time before we begin to see emotions spill over into the public. The small protest we have witnessed thus far could pale in comparison to what is to come. LE should be reviewing plans, manpower, and boosting intelligence gathering to better prepare for potential situations.
- Protests over the continuing of stay at home orders, and business closures are becoming more prevalent and boisterous. Law enforcement should begin to make plans on how to track these groups and respond to events.
- First responder staffing and exposure issues will likely continue to increase. Priority messaging about PPE, manpower reduction strategies, and outside the box thinking should be continued and solutions expedited.
- FOIA and PIA requests for detailed records on infections in assisted living and nursing homes will increase as investigative reporting on this issue increases.
- Grocery stores could become a hotbed of fear and anxiety due to limiting numbers of patrons, assigning shopping days, mask requirements, and now limited meat supplies.
- As critical case in Charles County remain low (outside of nursing homes and assisted living homes), needs in other local jurisdictions are growing. Resources should be

prioritized and plans should be made to share/deploy critical resources, personnel, and/or facility space to meet the needs regionally.

- The longer this crisis continues the more likely we are to experience critical events that may not be related to the COVID crisis (incidents within the incident). Those in leadership positions need to be prepared to step into dual leadership/managerial roles at a moment's notice. This requires taking care of yourself and staying up on the latest tactics, strategies and knowledge.
- Planning for crisis recovery starts as soon as the crisis begins. Monday marks the 8th weeks of this crisis, 6th week of schools being closed. Partners and stakeholders should begin planning for what the return to the "new normal" looks like in their organization. Sharing of these plans will help each organization build more comprehensive processes.
- Over the weekend the US will likely eclipse 500,000 cases and 15,000 deaths. Md numbers will likely pass 5000 and 150 fatalities by Friday. These numbers will cause increased pressure to ratchet up rhetoric re: "stay at home orders" and could result in further sanctions and restrictions.
- As the confirmed case numbers continue to rapidly ascend the likelihood of jurisdictions issuing "travel bans" increases. Law enforcement should begin researching the constitutionality of these potential edicts and have plans in place for implantation and begin to develop a public communication strategy. Standardizing local "travel authorization documentation" should be explored by the lead jurisdiction having authority.
- Due to diverted attention, the international and domestic terrorism threat is rapidly increasing. Responders should be reminded to remain vigilant and of the DHS guidelines for spotting suspicion activities and terrorism indicators.
- As we enter into the reported peak of this situation communication, along with sharing of individual branch capability and capacity is more important now than ever. "We don't know what we are going to need to know until we need to know it."
- First responder organizations should begin surveying members for pre-existing conditions and other complicating medical conditions. Responders found to have pre-existing conditions should be placed in limited citizen contact roles.
- A review of the 179 countries that report COVID-19 cases, only two (South Korea and China) have somewhat "flattened the curve" of NEW infections. Both showed flattening roughly 30 to 45 days after the initial spikes. The initial spike in the US began around 3-18-2020.
- Reduced stability in the supply chain along with increased fear and anxiety can be expected with today's "stay at home order."
- After 3 weeks of social distancing and schools being closed non-english speaking communities within Charles County are likely feeling further isolated due to a lack of language specific communications. Direct and increased messaging to Spanish speakers is likely necessary.
- As mass transit continues to shrink in availability, plans should be made to ensure those who rely on it for essential supplies and trips have delivery resources.

- LE and EMS screening protocols should include questions about recent travel to NY, NJ, CT, and FL.
- Immediate attention is needed to direct companies and organization on the proper processes and appropriate contact to use (Donation Manager at the EOC) to donate PPE and cleaning materials to essential personnel
- The next 7 days will likely see a stabilization of a majority of the grocery supply chain. However, the potential for disruption moving forward continues to remain high.
- FOIA and PIA request from media and citizens groups will likely begin to increase the longer this event lasts. “New normal” processes need to be established as soon as possible.
- Lack of child care options will likely add to family stress. Additional resources, activity and options are needed.
- JIC staff should substantially amplify community resource communications
- As we enter the 2nd week of social distancing stress, anxiety, and fear will likely increase. Continuous reminders of patience and focusing on kindness will become increasingly important.
- Many stores restock overnight. Seniors and the vulnerable populations should be strongly encouraged to shop during the early morning hours when supplies are likely to be at their highest.
- As testing increased the confirmed cases in MD will increase. This will likely cause additional life restrictions.
- Supply chain issues will continue and likely increase as further life interruptions and travel restrictions are ordered. The possibility of violence increases as stress increases, especially at grocery stores.
- Commanders of responders and essential staff should have robust plans for potential quarantines and updated continuity of operations including plans for diminished manpower. Further, responder organizations should begin reviewing existing integration plans with the National Guard.
- Obtaining medical supplies and PPE will continue to be an issue for the foreseeable future. All services should use the command ordering process so orders can be tracked.
- The community of Charles County is showing increased signs of pulling together and assisting one another. The JIC should continue to encourage civility and increase positive press of good news stories occurring throughout our community.

“The most effective leaders in crises ensure that someone else is managing the present well, while focusing their attention on leading beyond the crisis toward a more promising future”

Respectfully submitted by Jason Stoddard



Charles County Volunteer Firemen's Association, Inc.

Post Office Box #21, La Plata, Maryland 20646

Serving Charles County

April 22nd, 2020

Re: Volunteer Fire/EMS Brief

Items Being Worked On:

- Reduction of Force Policy – *Information gathering occurring.*
- Station Health Screening Policy – *Completed*
- PPE Burn Rate / Inventory - *Completed*

Stations/Apparatus:

- No Contaminations issues at any Stations.
- No Apparatus with any contamination issues.
- No Service Deliverability Issues with Apparatus O.O.S.

Personnel - 26 Members across 3 Stations (6 Positive / 5 Negative):

- Fire Station 3 – 1 Member in 14 Day Isolation – Tested Positive 4/16/2020
- Fire / EMS Station 11 - 2 Members -2 Due to Family Members being Quarantined
 - o - 3 Members Due to potential exposure from another patient.
- Fire / EM Station 12 – 20 members due to a Positive Member in the Station (Currently 5 Positive/5 Negative)

Incidents/Call Volume:

- No Major Incidents to Report related to COVID-19
- Increase of Responses to SagePoint and Charleston over the past 9 days.
- Yesterday's EMS Call Volume was average, and Fire Call Volume was below average

56 Ems Related Incidents ----- 9 Fire Related Incidents

Other Information:

- Beginning to work on Distribution Plan for Returned N95 Mask after Decon.
- Pushed out information about Social Distancing in the Stations.
- New PPE Burn Rate Tracking tool created and set to start using today
- Continue to push out Peer Support Information.

Respectfully Submitted,

Mark A. Kaufmann, Jr
County Fire Chief, Charles County Maryland



Serving Charles County

Charles County **Volunteer Firemen's Association, Inc.**

Post Office Box #21, La Plata, Maryland 20646

Physical Address: 109 La Grange Avenue, La Plata, Maryland 20646
Administrative Services Office: 301-934-3581

Mass Fatality Management Plan (MFMP) - Covid 19 Update 4/8/20

Background: The Maryland Department of Health (MDH) Mass Fatality Management Plan (MFMP), last adopted in 2012, establishes a single, comprehensive framework for the management of fatalities in a mass fatality incident. The MFMP is implemented when the normal Maryland death management process capacity is exceeded or likely to be exceeded. The MFMP incorporates National Incident Management System (NIMS) concepts and is consistent with, and complementary to, the Maryland Emergency Operations Core Plan and the MDH Emergency Support Function #8: Public Health and Medical Services Operations Plan. The MFMP assigns roles and responsibilities to Maryland state government agencies and administrations within MDH and identifies the legal authorities of agencies to act in mass fatality management incidents.

Because of the unique characteristics of mass fatality incidents to which local and state agencies will be required to respond, the MFMP does not detail the specifics of how to respond to every aspect of an incident. Rather, the MFMP provides a framework in which responses are organized and decisions made. The MFMP is intended to be used in conjunction with detailed department and agency operating plans and procedures.

The successful implementation of the MFMP is contingent upon a collaborative approach with a wide range of organizations providing crucial support during emergency operations. The MFMP recognizes the significant role of the local health departments in coordination with local emergency management, law enforcement, fire and emergency medical services (EMS) departments, and hospitals in response to a mass fatality incident, while maintaining priority for the provision of services to the surviving victims.

COVID-19: The Covid-19 pandemic is a specific public health threat which may, based on multiple scientific projections and experiences in other States and Nations, result in large numbers of fatalities acutely or over an extended period of time. This may exceed the capabilities of the extant system of managing fatalities. The specific Covid-19 mass fatality plan calls first for maximizing the throughput and temporary holding capacity within the various agencies and organizations involved in death management within Maryland.

- For Funeral Homes this means, to the extent possible on a voluntary basis, expediting funerals services and maximizing the capacity to store remains pending funeral and burial.
- For crematoria this means maximizing the ability to meet stated demand for cremation through extension of hours and days of operation.
- For the Office of the Chief Medical Examiner this means maximizing the holding capacity at their Baltimore facility for the anticipated increase in OCME cases.
- For hospitals this means expanding, within their very limited space, the holding of decedents pending transfer to funeral homes or mortuaries.
- For the Maryland State Anatomy Board this means shortening the time that remains are held before being transferred for cremation in order to maximize the agency holding capacity.

Temporary Mortuary Affairs Center (TMAC): The experience of other States and Nations indicates that, despite these the aforementioned methods of increasing capacity, there may still be an excess of decedents that cannot be accommodated. This would become a public health crisis. To provide a dignified site for the deceased pending their final disposition the State has created a Temporary Mortuary Affairs Center (TMAC).

This center will hold remains that cannot be accommodated by the current extant mortuary management systems. The site will provide refrigerated storage capabilities of remains, careful documentation of cases, and coordinated transfers from the place of death to the TMAC and from the TMAC to Funeral Homes, Crematoria or to final disposition through the Maryland State Anatomy Board. The TMAC will provide a secure and dignified interim area of rest for the remains of those who cannot be promptly serviced by the existing system of mortuary affairs. At such time as mass fatality demand is no longer at risk of exceeding the extant capability of the Maryland mortuary system, the TMAC will be demobilized.

Charles County Public Schools Briefing 4-22-2020
COVID Charles County

48-hour Priorities:

- Maintaining instructional continuity
- Expanding and maintaining food service
- Expanding and maintaining WiFi service

Meals:

On Tuesday, 4/21/20CCPS served 5583 meals at the 11 meal distribution sites. This total was down -969 from Monday, 4/20/20. Westlake HS, St. Charles HS and JC Parks Elementary are still are the highest distribution sites.

Closure:

Charles County Public Schools (CCPS) now remains closed through May 15. All schools, buildings and centers will remain closed to the public.

Instruction:

Instructional packets have been distributed this week at our meal sites. Students are utilizing APEX, CCPS created online learning, Microsoft TEAMS and CCPS created learning packets to meet the continuity of learning requirements set forth by MSDE.

Friday, 4/24/20, is the last day for parents and students to request a laptop for their child.

Community Wifi:

All four sites are up and running and seeing use. CCPS in process of 3 other additional WiFi sites.

Misc:

Fairfax County PD arrested 30 men earlier this month in an online sting operation set up to identify and apprehend predators who use the internet to exploit children. The 30 men ranged in age 20-74. CCPS has sent out information from the FBI regarding internet safety approximately 4-5 weeks ago.

Respectfully submitted by Jason Stoddard and Michael Meiser