Mass-Fatality Surge & Family Assistance

By Thomas P. Russo, State Homeland News

The outbreak of tornadoes that rocked the Midwest and Southeast regions of the United States in 2011 illustrated not only how quickly disaster can strike but also how important it is for communities to be fully prepared to cope with such emergencies. The cooperative effort that followed demonstrated a willingness of neighbors to assist neighbors with response and recovery operations – but, more importantly, underscored the need for responses that are based on region-wide planning.

These realizations played directly into and supported the transition of the Hospital Preparedness Program (HPP) of the U.S. Department of Health and Human Services (HHS) from facility-level preparedness to a community-centric model. A number of region-wide healthcare coalitions already have formed, in fact, and brought together not only healthcare partners but also various allied disciplines representing neighbor jurisdictions.

The lessons learned from the 2011 tornadoes, coupled with the HPP-revised mission (region-wide capabilities), served as the impetus to: (a) expand the coastal South Carolina Region's coalition; and (b) focus greater attention on a critical planning element that earlier had received only cursory consideration. Fatality management, which is among the eight primary HPP target capabilities, served as a priority operational goal for the work of this regional coalition. Fatality surge planning could broaden the coalition's base by bringing together not only facility and jurisdiction representatives, but also various public- and private-sector partners, into a revitalized and more collaborative planning framework.

Training, Exercises & Evaluations

During the summer of 2011, hospitals discussed the need for mass-fatality planning at the region's healthcare coalition meetings. The topic came up due to coroners who had approached hospital emergency planners and asked if anticipated hospital expansion plans included the addition of morgue units – a need that becomes evident in light of the fact that, of three counties in the region, two had no morgue capacity at all, and the third had only enough capacity to accommodate 10 human remains. Throughout the region, therefore, coroners were dependent on hospital morgue resources in the event of disasters that resulted in a large number of fatalities.

One result of these discussions was that public health representatives, working in cooperation with area hospitals, started to reach out more directly to coroners and emergency managers throughout the region to begin serious talks about mass-fatality incidents. It was also determined by coalition partners that the local chapter of the American Red Cross (ARC) should be involved because of the major role the ARC has played, for many years: (a) in coping with aviation disasters; and (b) in providing family assistance. It became clear very quickly that no single jurisdiction possessed all of the resources needed to effectively manage a mass-fatality event. The logical conclusion, therefore, was that coping with such incidents would necessitate a regional response. In other words, regionalization is a core planning principle that should be fully integrated into future mass-fatality response and recovery operations.

In addition to writing an effective plan, a consensus emerged among the coalition members that an acceptable plan must also include training and exercises. It was the new emphasis on a comprehensive training, exercise, and evaluation program, in fact, that led the coalition to approach the local airport authority, which is required by the Federal Aviation Administration (FAA) to conduct a full-scale exercise (FSE) once every three years. Eventually, the workgroup was rounded out with inclusion of a regional air carrier and the Southern Baptist Disaster Relief organization, which has considerable experience in roles that support a Family Assistance Center (FAC). The outcome of this collaborative effort was a consensus on three primary objectives:

1. Write a Mass Fatality/Family Assistance Center (MF/FAC) plan;
2. Conduct a tabletop exercise using a mass-fatality scenario that activates family assistance; and
3. Carry out a full-scale exercise that activates mass-fatality situations and family assistance needs, as well as the assets required to support such activations.

Coalition members decided to start with a workshop that combined the two-day FEMA (Federal Emergency Management Agency) 386 Mass Fatality Incident Operations

Course – with a third day focused specifically on family assistance. Because few members fully understood the expectations for family assistance, it became critical to hear from state and federal partners. Before a plan could be written, members needed to know what the expectations of responding partners would be for a community that is suddenly responsible for the re-unification of families with their decedents.

The MF/FAC Workshop

The MF/FAC workshop was held 6-8 December 2011, with the first two days dedicated to the FEMA 386 course content and the third day devoted to the FAC component of mass-fatality responses. The specific goal for the third day was to identify the planning elements that attendees determined should be incorporated into a region-wide MF/FAC plan.

The coalition was successful in recruiting several members of the Disaster Mortuary Operational Response Team (DMORT), including a representative from the DMORT Family Assistance Center Team (FACT). The DMORTs are prominent among the hardest working components of the HHS's National Disaster Medical System.

More than 30 organizations were represented at the workshop by 82 participants – including representatives from government, non-government, and private-sector organizations and a broad range of social service agencies. Attendees were divided into six breakout groups that clustered agency personnel into response components that could carry forward into development of the MF/FAC plan. The six workgroups focused on the following broad (and sometimes overlapping) topic areas:

- Incident scene management (public safety, fire/rescue, EMS, law enforcement);
- Mortuary services (coroners, vital records, funeral directors);
- Family assistance (ARC, social service agencies, behavioral and spiritual care);
- Healthcare and hospital care (hospitals);
- Public information (public information officers representing county, city, ARC, and the private sector); and
- Resource management (county & state emergency management).

Each breakout group identified key planning elements that served as the basis for developing the MF/FAC plan. The plan was then written and circulated for review and comments. A core group met to incorporate comments and finalize the details of the plan.

Planning for an MF/FAC Exercise

The Homeland Security Exercise and Evaluation Program (HSEEP) guidance was used to plan an MF/FAC tabletop exercise. An exercise design team was established to assist with the exercise scenario, exercise design, and organization attendee list. At the first meeting (Initial Planning Conference), dates for both a Mid-Term Planning Conference (MPC) and a Final Planning Conference (FPC) were set and the exercise date was finalized.

The scenario agreed upon would be an off-site aviation accident that resulted in both mass casualties and mass fatalities. Objectives were discussed, along with documentation requirements – e.g., the writing of a Situation Manual and an After Action Report. The specific exercise purpose was:

> *[To] test the region-wide family assistance plan to coordinate and integrate local, state, and federal resources that could respond to the coastal region after the impact of a disaster that results in mass fatalities and that requires activation of a family assistance center to support response and recovery.*

The design strategy was to present participants with five modules that could guide them from the pre-incident stage through recovery with the establishment of the FAC. The exercise would begin with a commercial airliner in distress, continue with the public safety response, and conclude with a social service interagency response – identifying the required resources anticipated for recovery operations. A common theme throughout all of the modules would be the role of family assistance as defined by private-sector air carriers, with consideration of the responsibilities of the National Transportation Safety Board (NTSB) also incorporated. The intent would be to identify the expectations and capabilities of local community agencies and organizations to support and sustain fatality surge recovery.

Tabletops, Full-Scale Exercises & Beyond

The "First Alliance" MF/FAC tabletop exercise, held in April 2012, was attended not only by local responding agencies but also by some state agencies – augmented by "call-in attendance" by representatives of the Disaster Assistance team of the NTSB. After examining the casualty and fatality counts introduced in the scenario's modules, it was determined that, although hospitals probably could handle the trauma cases, the area's capability to handle burn patients was less than adequate – air assets would be required, therefore, to transport the patients who could not be treated locally. The morgue capacity and regional morgue storage capacity also were considered to be inadequate. Therefore, state morgue assets would be needed to support regional mortuary services.

The after-action report revealed a number of discrepancies between the region's family assistance plan and the plans provided by participating agencies. As a result, participants were encouraged to review their plans and incorporate various corrective improvements that had been recommended.

Currently, plans are underway for a full-scale exercise, scheduled for January 2014, that will build on the results of the April tabletop exercise. The healthcare coalition will continue to focus on its mass-fatality capabilities as well as various related aspects of fatality surge and family assistance operations. The roles played by individual agencies will be examined as they relate to rural areas of the region, where passenger rail service is a prominent transportation source. In addition, the role of family assistance will be explored in greater depth for noncommercial passenger incidents, where federal resources may not always be available to support such response operations.

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Taxis for the Sick

By Joseph Cahill, EMS

Every EMS (Emergency Medical Services) staff member learns a truism very early in his or her career: EMS is frequently used to provide basic transportation for people who are really not sick enough to need an ambulance and/or taken immediately to the emergency room. In fact, during the everyday operations of many resource-poor systems, ambulances deployed on "taxi ride" calls draw scarce resources away from those endangered by truly life-threatening emergencies. For that reason alone, local medical resources may well be stretched to and beyond their capacity during a local or regional crisis.

Another truism is that the general public has a limited understanding of the role played by EMS; regardless of the quality of the services reasonably available, there will always be at least some of those served who will never be satisfied. Fortunately, most U.S. cities and towns already have taken the opportunity, when available, to help shape public understanding, and individual expectations, by spreading the message that EMS and 9-1-1 calls are intended and should be used "for emergency purposes only."

Of course, the overarching mandate for most EMS systems within the United States is to provide lifesaving care – including, if and when needed, transportation to a hospital or other healthcare facility. However, a realistic and effective system goal would be: (a) to provide rapid EMS services, including transportation, to all callers who require that level of services; and (b) to provide a somewhat lower level of services (again, including transportation) to those who, insofar as can be determined, do not actually require the same "highest level" of services – and, therefore, do not monopolize the ambulances and other emergency resources available.

Some EMS systems – the one in San Antonio, Texas, is a good example – distribute vouchers that allow nonemergency patients to be transported to hospitals, clinics, or pharmacies via taxi. This practice is a relatively low-cost way to return ambulances to the 9-1-1 system as quickly as possible and make them available primarily for those with truly life-threatening illnesses and injuries.