A Tradition of Stewardship
A Commitment to Service

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HHSA EMERGENCY OPERATIONS PLAN (EOP) – APPENDIX 11

FATALITY MANAGEMENT PLAN

NAPA COUNTY HEALTH AND HUMAN SERVICES AGENCY (HHSA)

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1. INTRODUCTION

This plan establishes the Napa County Sheriff's Office, Coroner Division and Department of Public Health response in a Mass Fatality Incident. It describes authorities, assigns tasks, outlines responsibilities, and describes proper response activities.

As with all locations within the State of California, the threat of an incident in Napa County involving mass fatalities is constant. The susceptibility of Northern California to natural disasters and the ubiquitous threat of man-made disasters suggest that there are possibilities of such incidents within Napa County—incidents that could overwhelm the local response systems.

While the threat of mass fatality incidents is real, the routine local response is quite strong in Napa County. Similarly, for a county with a relatively small population base, the capacity for managing fatalities is also robust. Still, such significant events can threaten the ability to utilize available resources effectively or access supplemental resources efficiently.

1.1 PLANNING ASSUMPTIONS AND LIKELY TRIGGERS

The State of California Coroners Mutual Aid Plan defines a Mass Fatality incident as one "where more deaths occur than can be handled by local Coroner/M.E. Resources." While this will always be dependent on the particulars of any such event and is not determined simply by the numbers of fatalities involved. Historically, Napa County has been able to manage more than 10 fatalities in a 24 hour period with its normal processes.

The main purpose of a catastrophic mass fatality response plan is to facilitate the recovery, identification of the deceased, assist in the proper notification of families, and effect the final disposition in a timely, safe, and respectful manner while reasonably accommodating the religious, cultural, and societal expectations of the affected populations.

Those scenarios which are most likely to stress the local capacity and, thus, require implementation of a mass fatality response, involve either a sudden event resulting in an extraordinary number of fatalities or a prolonged, greater than normal death rate due to disease.

Most likely to occur in Napa are sudden events such as motor vehicle accidents with significant loss of life occurring suddenly, e.g., a fatal accident involving one or more tour buses, or building collapse due to earthquake. The sudden need to deal with the deaths of a large number of individuals, identify the bodies, notify the families, and manage the necessary recording of vital information may stress the available local resources beyond the capacity needed to complete the necessary tasks within a reasonable period of time. It is an incident like this that may trigger the implementation of a Mass Fatality Plan.

Napa County is also at risk for a prolonged communicable disease event. Indeed, an influenza pandemic of the magnitude of that which occurred in 1918 could stress every facet of emergency response including the county's ability to manage the tasks associated with mass fatalities. In such a circumstance, not only would the death rate significantly exceed the norm, but the available resources—i.e., personnel—would likely be impacted by widespread illness among the workforce, need to care for one's own family, and fear of contagion.

However, it appears that pandemic would be unlikely to overwhelm the county's routine ability to deal with fatalities, with a worst-case average rate of 10.46 deaths per week. A key feature of pandemic-based deaths is that all fatalities will not occur simultaneously. The timing of deaths will be distributed over a period of months. Using FluAid 2.0, the Centers for Disease Control's mortality and morbidity calculator for pandemic influenza, the following worst-case scenario is instructive: Using a county population of 160,000 with age breakdowns per the 2000 census, and using the CDC's national assumptions for death rates per 1,000, percentage risk by age, hospitalization rates per 1,000, and using the worst case figures of a 35% virus attack rate and a total maximum death count, the total mortality in Napa County would be 272. If this occurs over a span of six months (another "worse-case" assumption, as a pandemic may run longer than six months; the duration of the pandemic does not change the total mortality count in the FluAid model), this means an average of 10.46 deaths per week. This suggests that even a mass fatality event such as a pandemic is unlikely to overwhelm the county.

Some sudden events are unlikely in Napa County. For example, the likelihood of a major airline accident within Napa County is quite low, as there are no major airports within the county. Similarly, the kind of incident that could result in sudden, dramatic loss of life—e.g., the collapse of a high-rise building such as occurred in New York City in 2001—is highly unlikely in Napa County.

1.2 AUTHORITIES

The Coroner's legal authority is established pursuant to California Government Code §(s) 27471, 27491 et seq., 27504.1, California Health and Safety Code §(s) 7102. 102850, and other statutes as specified by applicable code(s).

More detailed descriptions of applicable codes, both State and Federal, are attached as an Attachment to this document. (Adopted from the State of California Mass Fatality Management Guide, published by the Governor's Office of Emergency Management).

1.3 ROLES AND RESPONSIBILITIES

Several different entities play important roles in the management of mass fatalities. These are listed below.

Coroner Division

Under California statute, the Coroner's Division of the Napa County Sheriff Department is responsible for the collection, identification and disposition of decedents during conditions of disaster or extreme peril.

First Responder

First responders may be required to assess any emergency or disaster situation for the existence of and number of casualties and make a determination of what assistance may be required. The primary concern of first responder should be the timely rescue of the living and search for survivors. However, attention must be given to the proper management of death scenes, preservation of evidence, and, of course, the proper and respectful handling of decedents.

Public Health

Public Health is responsible for the management of vital statistics collection and the prevention of the spread of communicable diseases. In collaboration with the coroner, the Public Health Officer can identify case definitions for mortality due to pandemic or similar circumstances, which can be used to facilitate the investigation of deaths and issuing of death certificates.

The Concept of Operations for the proper management of vital statistics in a Mass Fatality Incident is as follows:

- Healthcare facilities will designate a physician responsible for the signing of death certificates for decedents from their facilities.
- Healthcare facilities, to the best of their abilities, will make a health information specialist (i.e., medical records) available to the coroner for the management of determining cause of death by record review in cases in which the attending physician is unable to sign the death certificate.
- Public Health personnel will enter the information into the State's automated system, EDRS, which will generate a number that can be used in the creation of a burial permit (required for the disposition of remains).
- Public Health personnel will generate the burial permits.
- Deaths will be registered in the system within 7 days of death.
- In cases in which there are large numbers of deaths within a period of few days, Public Health can dedicate personnel and enter data up to approximately 40 records within a single day. Public Health will assign additional staff for greater demand.

Hospitals and Other Healthcare Facilities

The occurrence of mass fatalities, and thus the indicia of a mass fatality event, is most likely to be noted by health care facilities (if not by first responders). Health care facilities are responsible for alerting the coroner to indicia of event, e.g., suggestion of an increase in number of deaths beyond that recognized as usual or normal.

Hospitals are also responsible for having a plan for the management of mass fatalities. Plan elements should include:

- Identification of personnel responsible for the management;
- Local morgue capacity;
- Contingencies if the mass fatality event surpasses local morgue capacity;
- Provisions for physician signing of death certificates;
- Details for communication with coroner in cases in which death certificate cannot be signed;
- Provisions to store bodies and expand refrigerated storage for a temporary period to increase county capacity; and,
- Collaboration with the coroner to transport bodies as needed to other temporary storage sites, e.g., local mortuaries.

Hospitals are encouraged to review the guidelines for when the Coroner is to be called—in routine or emergency situations. The Coroner's Division's document, "Helpful Guidelines for Medical Staff in Determining When to Call the Coroner" is an Attachment in this document and has been shared with local hospitals and other healthcare facilities.

In order to support the efforts of the coroner to properly identify deceased and determine cause of death, the coroner may require hospital records for review. Hospitals are encouraged to make medical records staff available to work with the coroner office in order to facilitate this process. Additionally, hospitals should designate as part of their Mass Fatality Plan a physician named to be responsible for the signing of death certificates for the decedents of their institution.

Mortuaries

In addition to alerting the coroner to indicia of a mass fatality event, the mortuaries in Napa County play important roles in mass fatality response. Local mortuaries can expand capacity for temporary storage, if needed. (See Capacities section 2.2, below.) Local mortuaries will cooperate with the coroner to transport bodies to temporary storage or for disposition. Local mortuaries will maintain staffing to the extent possible in order to maintain disposition rate at or near capacity in order to meet needs during a mass event.

Additionally, Richard Pierce and the Inspiration Chapel are contracted to work as the primary transportation source for the Napa County Sheriff, Coroner's Division. In a mass fatality incident, this primary role will continue.

2. CONCEPT OF OPERATIONS

2.1 GENERAL

Napa County's concept of operations for mass fatality management is to utilize routine death processing mechanisms until such time as circumstances threaten to overwhelm those mechanisms, and then activate and implement the existing Fatality Management Plan as needed. Capacity would be where needed, on an as-needed basis. Triggers include a mass casualty incident or pandemic (see Planning Assumptions above). The County's overall capacity for fatality management can be expanded in the following ways:

- Storage capacity will be expanded first at the coroner's facility, secondly at Napa State Hospital, and thirdly at the California Veteran's Home-Yountville. Storage capacity may also be expanded at the three major mortuaries within the county: Richard Pierce & Inspiration Chapel, Treadway & Wigger, and Tulocay Cemetery.
- Transportation capacity will be expanded first via the Pierce Mortuary and secondly via use of other mortuary transportation resources and resources associated with the major healthcare facilities in the county. Sheriff's Department vehicles may be used as a last resort.
- Processing at mortuaries will be expanded to maximum capacity; if additional resources are required, mutual aid in neighboring counties will be sought.

This concept of operations rests on the following points:

- Most of the sudden death scenarios will be within the capacity of local resources or will be able to be organized under local resources and supplemented with mutual aid.
- The Coroner's office can utilize all deputized officers, having multiple teams in the field and a "receiving team" at the morgue. This includes 99 deputies—all of whom are available to be deputized for the management of deceased in an event – and about eight Extra Help deputies who may be utilized.
- Additionally, the Coroner's office plans to use CERT resources (non-deputized) to help run any Family Assistance Centers.
- Transportation of bodies will fall, to the extent possible, under the current contractual arrangement with Richard Pierce. Should there be greater transportation needs that can be handled by Richard Pierce, the Sheriff has vehicles which can be used for the transportation of bodies. The other two major mortuaries also have transportation resources that could be utilized.

2.2 CAPACITIES

The list below is a description of the current major facilities and mortuaries within the county, the status of their capacities are updated and maintained by HHSA PHD staff:

County Morgue

Queen of the Valley Medical Center

Napa State Hospital

St. Helena Hospital

California Veterans Home

Local Mortuaries

There are three large mortuaries in Napa County that account for the majority of the county's capacity for the transportation, storage, and disposition of deceased. The status of the capacities of these mortuaries are maintained by HHSA PHD staff.

Richard Pierce & Inspiration Chapel

Treadway & Wigger

Tulocay Cemetery

3. PROCEDURES

THE CORONER'S DIVISION RESPONSE WILL CONSIST OF FOUR MAJOR COMPONENTS:

Logistics-Identify and compile all necessary supplies and resources

Scene-Evaluation and Body Recovery

Morgue Facility- Body Identification and Processing – Determination of Cause and Manner of Death.

Family Assistance Center-Ante mortem Information – Take Care of Families

3.1 LOGISTICS

Personnel, Equipment and Supplies:

Designate Coroner's Division staff member(s) to handle logistics, notify required personnel, monitor supplies (log in and out), order supplies as necessary and arrange transport of supplies where needed. Required duties and supplies may include:

- Notification of off-duty personnel and personnel scheduling
- Transportation for personnel, i.e., cars, vans, etc.
- Transportation for bodies
- Refrigerated Trucks/Containers (if necessary) – for scene and/or morgue facility
- Protective Clothing – coveralls, gloves, boots, coats, hard hats, rain gear, etc.

- Body Bags – inventory and distribute/order as necessary
- Clear "zip-lock" baggies for personal effects
- Paint – for marking the exterior of body bags and recovery sites as necessary
- Flags – stakes (similar to irrigation flags) for marking location of body, body parts, etc.
- Toe tags – sufficient tags with "Sharpie" permanent pens (or similar) to permanently mark the tags
- Bio-hazard bags and boxes – for safe storage and disposal of biohazard debris
- Photographic equipment/film – to document the scene, body location, body parts, personal effects, etc. It may be necessary to enlist other agencies' equipment (survey equipment, etc.) for documentation purposes, depending on the nature of the scene
- Field report forms
- Clip on identification badges for all personnel
- Food and beverages for morgue personnel and recovery teams – this may be handled by OES/Red Cross personnel, but ensure teams are taken care of in this regard since they often follow the primary responders and EMS personnel and may be "forgotten"
- Cots/beds for staff members.

Recordation:

It is the responsibility of the Division on-duty command officer to ensure appropriate personnel (if the size of the event precludes the logistical officer/team from performing these duties) are assigned to provide an accurate recordation of all times, reported events, requests, personnel in and out, etc. A running log shall be maintained.

3.2 SCENE

Evaluation Team:

An evaluation team consisting minimally of two senior members of the Coroner's Division, i.e., the Unit Commander, sergeant, or Coroner investigator will go to the site of the mass fatality incident, to evaluate the following:

- Number of fatalities involved.
- Condition of the bodies, i.e., burned, dismembered, crushed.
- Difficulty anticipated in the recovery of the bodies and the types and numbers of personnel and equipment needed, i.e., structural stability of recovery area, the need for search and rescue teams, heavy equipment, etc.
- Location of the incident as far as accessibility and the difficulty that may be encountered in transporting bodies from the scene.
- Examination of the scene will be used to formulate a plan relative to documentation, body recovery and transportation.
- Number of personnel possibly needed to staff the morgue for identification, body examination/autopsy, evidence/property collection, notification, etc.
- Evaluate the scene for possible chemical, radiological, or biological hazards.
- Evaluate the need for remote fatality collection points.
- Evaluate the need for a family assistance center, i.e., are most of the victims local whereby the families would also be local and housing would not be a critical issue; is the incident one where the bodies are mostly from out of the particular area (such as an airplane disaster) and responding families would be in need of housing/transportation.

Note: In the event of multiple fatality sites several evaluation teams may be dispatched from the Coroner's Division at the direction of the Unit Commander to meet with local emergency response agencies and evaluate the individual scenes.

If the incident is of such magnitude that existing Coroner's Division personnel and equipment will be insufficient to manage the fatality recovery and processing, the local operations area, and the Office of Emergency Services (county) will be notified immediately. It shall be the responsibility of the preliminary evaluation team(s) to estimate resources needed and notify the designated emergency operations center. Additional resources available include but are not limited to the following:

- Utilization of law enforcement personnel for coroner duties under the ICS/SEMS model.
- Coroner mutual aid response by outside counties as directed by the Office of Emergency Services.
- Federal Disaster Mortuary Operational Response Team (DMORT) aid provided through FEMA as requested by the Office of Emergency Services.

Coroner's Division response will be coordinated with other allied agencies using ICS and SEMS guidelines and procedures.

Preliminary Organization:

Organize personnel and equipment prior to recording and moving bodies.

- If the body(s) or area is contaminated with radiological, biological or chemical agents, personnel equipped with and trained in the use of appropriate personal protective equipment must perform the recovery function.
- Arrange with logistics personnel for all necessary equipment for documentation and removal.
- Use departmental guidelines for necessary personal protective equipment (masks, gloves, etc.).

Body Recovery and Transport Team(s):

Body recovery team(s) shall document each recovery on the proper report form. The team should be comprised of the following personnel*:

- Coroner's Division investigator.
- Second Coroner's Division investigator-law enforcement, fire or other emergency services personnel may be utilized in this role if necessary.
- Scribe and photographer.

*This is an ideal composition. If Coroner's Division personnel are unavailable, local jurisdiction's Coroner Liaison, trained in coroner functions, will ensure properly trained personnel are assigned to this function.

Body transport team(s) should be comprised of a minimum of two personnel to transport decedents to the morgue or designated fatality collection point.

Body Numbering:

All numbers will be assigned at the scene. Use simple numbers, i.e., 1, 2, 3, . . . Body part numbers should be P1, P2, P3, . . . Personal effect numbers should be E1, E2, E3, . . .

In the event of multiple fatality scenes, a block of numbers may be assigned to each scene for tracking purposes, i.e., #1 - #100 for Napa area fatalities, #101 - #200 for Yountville area fatalities, etc. All cases will be assigned permanent case numbers at a later time. The Coroner's Division Unit Commander or designee will assign the appropriate numbering system. Body bags should be numbered with the appropriate number in a contrasting paint or marker color, on the exterior of the body bag for visibility.

Body Tagging/Marking:

Place an appropriately marked "toe tag" on the body *and* on the bag zipper. Personal effects recovered with the body should be packaged in marked clear "zip-lock" baggies (marked with the corresponding body or body part number) and placed inside the body bag with the body. Tags should minimally have the following information: Case number, Name, and Investigator.

Other information should be recorded on a 3x5 card which accompanies the body to the mortuary. That card should have the following information recorded:

- Name (if known)
- Race/Sex/Age (if known or approximate age)
- Hair/Eye Color
- Height/Weight/Build
- Location Recovered From
- Date/Time Recovered
- Recovery/Case No.

3.3 MORGUE FACILITY

Supervision:

A Coroner's Division member will supervise the morgue operation.

Security:

Morgue security will be strictly maintained. All assigned personnel will prominently display issued identification. Absolutely no unauthorized personnel will be allowed into the morgue facility.

If fatalities are the result of radiological, biological or chemical contamination and the bodies are contaminated, they will not be received into the central morgue without complete decontamination procedures being completed. In the event decontamination cannot be performed, contaminated bodies will be removed to and stored at a designated site with

appropriate storage facilities and security. Appropriate storage facilities and methods will be determined by the Coroner and designated Public Health officials.

Supplies:

Ensure that all necessary supplies are assembled or requested. This function is to be coordinated by the logistics personnel. Morgue facility supplies may include, but are not limited to the following items:

- Security – identification badges for all assigned personnel
- Protective Clothing – coveralls, gloves, shoe covers, masks, face shields, hats, etc.
- Morgue Supplies – autopsy tools, recovery vials and implements, blades, etc.
- Morgue photographic equipment
- X-Ray Supplies
- Office Supplies – pens, paper, etc.
- Office Equipment – copiers, computers, fax machine(s), etc.
- Refrigerated Trucks – steel walls/floors preferable

Records:

There must be dedicated Coroner's Division staff to assemble and maintain both antemortem and postmortem decedent records and ensure they are associated with the appropriate decedent's case.

Receiving:

A receiving team will be assembled to ensure accurate receipt of all bodies coming into the morgue facility or designated satellite fatality collection point. The number of the receiving team will be dictated by the nature of the event and number of anticipated decedents coming to the facility. A member of the Coroner's Division holding the rank of Coroner's Investigator or higher will supervise the receiving team.

Each body received shall be documented in the designated log-in book by date, time received, decedent name if known, body recovery number (number assigned in the field) person receiving the body and person delivering the body. The staff member(s) assigned to body tracking must know the location and final disposition of bodies at all times.

The receiving team is also responsible for maintaining a "matrix" display showing bodies in, place of recovery, their identification (if known) and their disposition. An example of a matrix that could be expanded (e.g., by use of butcher paper) and prominently displayed is attached as an Attachment.

Note: Three (3) login books should be used; one for bodies, one for body parts and one for disassociated personal effects (not attached to a body) recovered by Coroner's Division staff. Disassociated personal effects should be collected, documented and retained by the local police agency with jurisdiction over the scene and collected by Coroner's Division staff only as a "last resort" measure.

Morgue Staff:

Morgue staff requirements will be dictated by the nature and extent of the event. Morgue staff may be augmented by assigned law enforcement personnel, trained mortuary personnel, or other emergency responders as assigned. On-site morgue staff may include:

- Body Handlers – to move bodies
- Body Trackers – to escort the body and all associated paperwork from station to station in the order so intended – maintains integrity of body and documentation
- Forensic Pathologist – to perform autopsies and/or determine the cause of death
- Pathology Assistant – to assist the pathologist (trained Sheriff's Office personnel or other qualified personnel as identified by competent authority)
- Personal Effects Officer – to document and secure all personal effects
- Photographer – to photographically record the decedent as received and as required by forensic staff
- Photography Assistant – to assist the photographer in accurate recordation of photographs
- X-Ray Technicians
- Odontologists
- Forensic Anthropologists

MORGUE FACILITY – Stations

Anatomical Charting/Personal Effects/Clothing:

If evidence is to be collected, a law enforcement officer may also be present at the receiving station to take custody of the evidence. The personal effects and clothing should be collected, inventoried and bagged with the appropriate case number. All personal effects and clothing should be placed in a secure area with a designated person in charge of the area. The following procedures should be followed:

- Photographs – photographs should be taken before clothing is removed. The case number shall be displayed in each photograph.
- Clothing and Personal Effects– clothing and personal effects shall be described and recovered according to accepted procedure.

Note: All paperwork generated at this station should be given to the "tracker" and placed in the case file to go with the body to the next station.

Fingerprints:

Fingerprint specialists should attempt to print all bodies. Fingers should only be removed on non-viewable bodies at the discretion of the Coroner or designee. If fingers are removed they should be placed in a sealed bag with the case number and placed back with the body after processing.

Photography:

Full body photographs shall be taken of each body with the case number displayed in each photograph.

X-Ray/Radiology:

Type and number of x-rays will be determined depending on the type of incident. All x-rays should be given to the "tracker" to go with the body through the rest of the stations.

Dental:

Odontology exams are to be conducted as necessary or as required by statute. Jaws are only removed on non-viewable bodies or at the direction/discretion of the Coroner or designee. All records, charts, etc. become part of the case file.

Autopsy:

The forensic pathologist and assigned pathology assistant shall perform an autopsy to the extent deemed appropriate and necessary.

Optional Stations:

- Anthropology
- X-Ray Examination Area

3.4 FAMILY ASSISTANCE CENTER

A member of the Coroner's Division must be in charge of the initial setting up of the Family Assistance Center due to the Coroner's statutory responsibility to identify decedents and notify next-of-kin. Additional personnel may be recruited from the Law Enforcement Chaplains Association and local mortuary association due to their expertise in dealing with decedents and families of decedents and supplemented with other personnel as necessary.

Site selection is important to ensure it is away from the disaster scene while still accessible to responding family members and near motels/hotels that may be needed by responding family members. The Family Assistance Center should be large enough and have sufficient parking to comfortably accommodate the anticipated number of persons utilizing its services. The site should also lend itself to both parking lot and building security.

Required Components of Family Assistance Center:

Below are examples of the organizations/services necessary for the operation of and available to the Family Assistance Center:

- Coroner's Division/General Administration – for interviewing responding family members and collection of antemortem records, family information and death notification.
- American Red Cross/Salvation Army – for family support, transportation, housing, supplies, equipment, volunteer coordination.
- Napa County and local cities office(s) of social services, family assistance, etc.
- Security – parking lot, outside check points, inside check points, family escorts
- Food Service – for families and staff.

- Communications – telephones/cell phones/fax machines for families and Family Assistance Center staff.
- Mental Health – family support, staff support, assisting with death notification.
- Medical – family care, staff care, assisting with death notification.
- Religious Support – family support, staff support, assisting with death notification.
- Site Support – custodial, site maintenance.
- Transportation

LOCAL JURISDICTION RESPONSIBILITIES/REQUIREMENTS

Local jurisdictions (cities) will provide coroner liaison personnel to assist in body recovery, transport and/or handling as necessary pursuant to ICS/SEMS guidelines.

The "Mass Fatalities Plan of Operations" does not supersede local jurisdictions mission to investigate any criminal act associated with the mass casualty/fatality event. Pursuant to Government Code §(s) 27491, the Coroner and local law enforcement will cooperate in the investigation of death(s) suspected to be the result of a criminal act.

Procedures and resource lists shall be reviewed and updated annually.

4. ATTACHMENT A: GOVERNMENT CODES

Statute or Code	Title	Authority
Health and Safety Code, §102850	Coroner: Notification of Death	A physician and surgeon, physician assistant, funeral director, or other person shall immediately notify the coroner when he or she has knowledge of a death that occurred or has charge of a body in which death occurred under any of the following circumstances: (a) Without medical attendance. (b) During the continued absence of the attending physician and surgeon. (c) Where the attending physician and surgeon or the physician assistant is unable to state the cause of death. (d) Where suicide is suspected. (e) Following an injury or an accident. (f) Under circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another. Any person who does not notify the coroner as required by this section is guilty of a misdemeanor.
Health and Safety Code § 102855	Coroner: Duty to Investigate	The coroner whose duty it is to investigate such deaths shall ascertain as many as possible of the facts required by this chapter.
Health and Safety Code § 102860	Coroner: Duties, Re: Certificate	The coroner shall state on the certificate of death the disease or condition directly leading to death, antecedent causes, other significant conditions contributing to death and other medical and health section data as may be required on the certificate, and the hour and day on which death occurred. The coroner shall specifically indicate the existence of any cancer, as defined in subdivision (e) of Section 103885, of which he or she has actual knowledge. The coroner shall within three days after examining the body deliver the death certificate to the attending funeral director.
Health and Safety Code § 102870	Coroner or Medical Examiner: Dental Examination	a) In deaths investigated by the coroner or medical examiner where he or she is unable to establish the identity of the body or human remains by visual means, fingerprints, or other identifying data, the coroner or medical examiner may have a qualified dentist, as determined by the coroner or medical examiner, carry out a dental examination of the body or human remains. If the

Statute or Code	Title	Authority
		coroner or medical examiner with the aid of the dental examination and other identifying findings is still unable to establish the identity of the body or human remains, he or she shall prepare and forward the dental examination records to the Department of Justice on forms supplied by the Department of Justice for that purpose. (b) The Department of Justice shall act as a repository or computer center, or both, with respect to dental examination records and the final report of investigation specified in Section 27521 of the Government Code. The Department of Justice shall compare the dental examination records and the final report of investigation, if applicable, to records filed with the Violent Crime Information Center (Title 12 (commencing with Section 14200) of Part 4 of the Penal Code), shall determine which scoring probabilities are the highest for purposes of identification, and shall submit the information to the coroner or medical examiner who submitted the dental examination records and the final report of investigation, if applicable.
Health and Safety Codede § 103450	Court Procedure to Establish Fact of Death	(a) A verified petition may be filed by any beneficially interested person with the clerk of the superior court in and for (1) the county in which the birth, death, or marriage is alleged to have occurred, (2) the county of residence of the person whose birth or marriage it is sought to establish, or (3) the county in which the person was domiciled at the date of death for an order to judicially establish the fact of, and the time and place of, a birth, death, or marriage that is not registered or for which a certified copy is not obtainable. (b) In the event of a mass fatalities incident, a verified petition may be filed by a coroner, medical examiner, or any beneficially interested person with the clerk of the superior court in and for (1) the county in which the death is alleged to have occurred, or (2) the county in which the person was domiciled at the date of death for an order to judicially establish the fact of, and the time and place of, a death that is not registered or for which a certified copy of the death certificate is not obtainable. (c) In the event of a mass fatalities incident, a single verified petition with respect to all persons who died may be filed by a coroner or medical examiner with the clerk of the superior court in and for the county in which the mass fatalities incident occurred for an order to judicially establish the fact of, and the time and place of, each person's death that is not registered or for which a certified copy of the death certificate is not obtainable.

Statute or Code	Title	Authority
Health and Safety Code, § 103451	Mass Fatalities Incident, Definition	(a) For purposes of this chapter, "mass fatalities incident" means a situation in which any of the following conditions exist: (1) There are more dead bodies than can be handled using local resources. (2) Numerous persons are known to have died, but no bodies were recovered from the site of the incident. (3) Numerous persons are known to have died, but the recovery and identification of the bodies of those persons is impracticable or impossible. (b) The county coroner or medical examiner may make the determination that a condition described in subdivision (a) exists.
Health and Safety Code, § 103466	Court Procedures: Mass Fatalities Incident	Notwithstanding Section 103465, upon the filing of a petition for a determination of the fact of death in the event of a mass fatalities incident, the clerk shall set a hearing no later than 15 days from the date the petition was filed. The petitioner shall make a reasonable effort to provide notice of the hearing to the known heirs of the deceased up to the second degree of relationship. Failure to provide the notice specified in this section shall not invalidate the judicial proceedings regarding the determination of the fact of death.
Health and Safety Code § 103490	Certified	(a) The State Registrar shall send certified copies of the court order delayed certificate to the local registrar and the county recorder within the area in which the event occurred and in whose offices copies of records of the year of occurrence of the event are on file. However, if the event occurred outside the state, a certified copy shall be sent only to the county recorder of the county in which the petitioner resides. (b) In the event of a mass fatalities incident, the State Registrar, without delay, shall send certified copies of the court order delayed death certificate to the local registrar and the county recorder of the county in which the incident occurred and in whose offices copies of records of the year of occurrence of the incident are on file. The State Registrar, without delay, also shall send a certified copy of the court order delayed death certificate to the spouse or next of kin of the decedent, if there is no spouse, provided the spouse or next of kin's name and address information are included in the court order or on the application form submitted by

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		the spouse, next of kin, coroner, or medical examiner. However, if the incident occurred outside the state, a certified copy shall be sent only to the county recorder of the county in which the decedent was domiciled at the date of death.
Federal Government Code, US Public Law 93-288	Federal Government	Provides authority to respond to emergencies and provide assistance to protect public health; implemented by Federal Emergency Management Act.
USC Title 42-264	Federal Government	Provides the U.S. Surgeon General the authority to apprehend and examine any individual(s) reasonably believed to be infected with a communicable disease for purposes of preventing the introduction, transmission, or spread of such communicable disease only: 1. if the person(s) is moving or about to move from state to state. 2. if the person, upon examination, is found to be infected, he may be detained for such time and in such manner as may be reasonably necessary.
USC Title 42-139 Sec. 14503	Federal Government	Liability protection for volunteers—No volunteer of a non-profit organization or governmental entity shall be liable for harm caused by an act of omission of the volunteer on behalf of the organization or entity.
California Government Code § 27491	Coroner Duties	It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden, or unusual deaths; unattended deaths; deaths wherein the deceased has not been attended by a physician in the 20 days before death; deaths related to or following known or suspected self-induced or criminal abortion; known or suspected homicide, suicide, or accidental poisoning; deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent; deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, or where the suspected cause of death is sudden infant death syndrome; death in whole or in part occasioned by criminal means; deaths associated with a known or alleged rape or crime against nature; deaths in prison or while under sentence; deaths known or suspected as due to contagious disease and constituting a public hazard; deaths from occupational diseases or

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		occupational hazards; deaths of patients in state mental hospitals serving the mentally disabled and operated by the State Department of Mental Health; deaths of patients in state hospitals serving the developmentally disabled and operated by the State Department of Developmental Services; deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another; and any deaths reported by physicians or other persons having knowledge of death for inquiry by coroner. Inquiry pursuant to this section does not include those investigative functions usually performed by other law enforcement agencies. In any case in which the coroner conducts an inquiry pursuant to this section, the coroner or a deputy shall personally sign the certificate of death. If the death occurred in a state hospital, the coroner shall forward a copy of his or her report to the state agency responsible for the state hospital. The coroner shall have discretion to determine the extent of inquiry to be made into any death occurring under natural circumstances and falling within the provisions of this section, and if inquiry determines that the physician of record has sufficient knowledge to reasonably state the cause of a death occurring under natural circumstances, the coroner may authorize that physician to sign the certificate of death. For the purpose of inquiry, the coroner shall have the right to exhume the body of a deceased person when necessary to discharge the responsibilities set forth in this section. Any funeral director, physician, or other person who has charge of a deceased person's body, when death occurred as a result of any of the causes or circumstances described in this section, shall immediately notify the coroner. Any person who does not notify the coroner as required by this section is guilty of a misdemeanor.
California Government Code § 27491.1	Coroner Duties Continued	In all cases in which a person has died under circumstances that afford a reasonable ground to suspect that the person's death has been occasioned by the act of another by criminal means, the coroner, upon determining that those reasonable grounds exist, shall immediately notify the law enforcement agency having jurisdiction over the criminal investigation. Notification shall be made by the most direct communication available. The report shall state the name of the deceased person, if known, the location of the remains, and other information received by the coroner relating to the death, including any medical information of the decedent that is directly related to the death. The report shall not include any information contained in the decedent's medical records regarding any

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		other person unless that information is relevant and directly related to the decedent's death.
California Government Code § 27491.2	Examination and Identification of Body; Cause of Death Inquiry; Removal	(a) The coroner or the coroner's appointed deputy, on being informed of a death and finding it to fall into the classification of deaths requiring his or her inquiry, may immediately proceed to where the body lies, examine the body, make identification, make inquiry into the circumstances, manner, and means of death, and, as circumstances warrant, either order its removal for further investigation or disposition or release the body to the next of kin. (b) For purposes of inquiry, the body of one who is known to be dead from any of the causes or under any of the circumstances described in Section 27491 shall not be disturbed or moved from the position or place of death without permission of the coroner or the coroner's appointed deputy. Any violation of this subdivision is a misdemeanor.
California Government Code 27491.3	Control of Premises Where Body Found; Death Due to Traffic Accident; Anatomical Donor Card	(a) In any death into which the coroner is to inquire, the coroner may take charge of any and all personal effects, valuables, and property of the deceased at the scene of death or related to the inquiry and hold or safeguard them until lawful disposition thereof can be made. The coroner may lock the premises and apply a seal to the door or doors prohibiting entrance to the premises, pending arrival of a legally authorized representative of the deceased. However, this shall not be done in such a manner as to interfere with the investigation being conducted by other law enforcement agencies. Any costs arising from the premises being locked or sealed while occupied by property of the deceased may be a proper and legal charge against the estate of the deceased. Unless expressly permitted by law, any person who enters any premises or tampers with or removes any lock or seal in violation of this section is guilty of a misdemeanor. (b) Any property or evidence related to the investigation or prosecution of any known or suspected criminal death may, with knowledge of the coroner, be delivered to a law enforcement agency or district attorney, receipt for which shall be acknowledged. (c) Except as otherwise provided in subdivision (d), any person who searches for or removes any papers, moneys, valuable property or weapons constituting the estate of the deceased from the person of the deceased or from the premises, prior to arrival of the coroner or without the permission of the coroner, is guilty of a misdemeanor. At the scene of any death, when it is immediately apparent or when it

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		has not been previously recognized and the coroner's examination reveals that police investigation or criminal prosecution may ensue, the coroner shall not further disturb the body or any related evidence until the law enforcement agency has had reasonable opportunity to respond to the scene, if their purposes so require and they so request. Custody and control of the body shall remain with the coroner at all times. Reasonable time at the scene shall be allowed by the coroner for criminal investigation by other law enforcement agencies, with the time and location of removal of the remains to a convenient place to be determined at the discretion of the coroner. (d) A peace officer may search the person or property on or about the person of the deceased, whose death is due to a traffic accident, for a driver's license or identification card to determine if an anatomical donor card is attached. If a peace officer locates such an anatomical donor card which indicates that the deceased is an anatomical donor, the peace officer shall immediately furnish such information to the coroner having jurisdiction. "Peace officer," as used in this subdivision, means only those persons designated in Sections 830.1 and 830.2 of the Penal Code.
California Government Code § 27491.55	Delegation of Jurisdiction; Another county; Federal Government; Conditions	In any case where a coroner is required to inquire into a death pursuant to Section 27491, the coroner may delegate his or her jurisdiction over the death to an agency of another county or the federal government when all of the following conditions have been met: (a) The other agency has either requested the delegation of jurisdiction, or has agreed to take jurisdiction at the request of the coroner. (b) The other agency has the authority to perform the functions being delegated. (c) When both the coroner and the other agency have a jurisdictional interest or involvement in the death.
Emergency Services Act, § 8607	Standard Emergency Management System (SEMS)	(a) By December 1, 1993, the Office of Emergency Services, in coordination with all interested state agencies with designated response roles in the state emergency plan and interested local emergency management agencies shall jointly establish by regulation a standardized emergency management system for use by all emergency response agencies. The public water systems identified in Section 8607.2 may review and comment on these regulations prior to

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		adoption. This system shall be applicable, but not limited to, those emergencies or disasters referenced in the state emergency plan. The standardized emergency management system shall include all of the following systems as a framework for responding to and managing emergencies and disasters involving multiple jurisdictions or multiple agency responses: (1) The Incident Command Systems adapted from the systems originally developed by the FIRESCOPE Program, including those currently in use by state agencies. *Governor's Office of Emergency Services 2006 59* (2) The multiagency coordination system as developed by the FIRESCOPE Program. (3) The mutual aid agreement, as defined in Section 8561, and related mutual aid systems such as those used in law enforcement, fire service, and coroners operations. (4) The operational area concept, as defined in Section 8559. (b) Individual agencies' roles and responsibilities agreed upon and contained in existing laws or the state emergency plan are not superseded by this article. (c) By December 1, 1994, the Office of Emergency Services, in coordination with the State Fire Marshal's Office, the Department of the California Highway Patrol, the Commission on Peace Officer Standards and Training, the Emergency Medical Services Authority, and all other interested state agencies with designated response roles in the state emergency plan, shall jointly develop an approved course of instruction for use in training all emergency response personnel, consisting of the concepts and procedures associated with the standardized emergency management system described in subdivision (a). (d) By December 1, 1996, all state agencies shall use the standardized emergency management system as adopted pursuant to subdivision (a), to coordinate multiple jurisdiction or multiple agency emergency and disaster operations. (e) (1) By December 1, 1996, each local agency, in order to be eligible for any funding of response-related costs under disaster assistance programs, shall use the standardized emergency management system as adopted pursuant to subdivision (a) to coordinate multiple jurisdiction or multiple agency operations. (2) Notwithstanding paragraph (1), local agencies shall be eligible for repair, renovation, or any other nonpersonnel costs resulting from an emergency. (f) The office shall, in cooperation with involved state and local agencies, complete an after-action report within 120 days after each declared disaster. This report shall review public safety response and

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		disaster recovery activities and shall be made available to all interested public safety and emergency management organizations.
Penal Code §830.35 (c)	Coroners and Deputy Coroners; Peace Officers; Limitations	The following persons are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest pursuant to Section 836 as to any public offense with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of that offense, or pursuant to Section 8597 or 8598 of the Government Code. Those peace officers may carry firearms only if authorized and under terms and conditions specified by their employing agency. (c) The coroner and deputy coroners, regularly employed and paid in that capacity, of a county, if the primary duty of the peace officer are those duties set forth in Sections 27469 and 27491 to 27491.4, inclusive, of the Government Code.
Civil Code § 1714.5		No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are defined in Section 8558 of the Government Code, shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.

5. ATTACHMENT B: MORGUE TRACKING MATRIX

Case #	Name	Cause of Death	Sex/Age	Autopsy?	Toxicity Report	City of Death	Mortuary	Disposition

6. ATTACHMENT C—CONTACT LIST

County Coroner	**(707) 253-4256**
Health Care Facilities:	
St. Helena Hospital	(707) 963-6254
Queen of the Valley Medical Center	(707) 252-4411
Napa State Hospital	(707) 253-5664
Veterans Home	(707) 944-4601
Funeral Homes/Morturaries:	
Richard Pierce and Inspiration Chapel	(707) 226-7444
Treadway & Wiggers	(707) 226-1828
Tulocay Cemetery	(707) 252-4727

7. ATTACHMENT D: WHEN TO CONTACT THE CORONER

GARY L. SIMPSON

SHERIFF-CORONER

NAPA COUNTY SHERIFF'S OFFICE

CORONER DIVISION

1535 AIRPORT BLVD

NAPA, CA 94558

(707) 253-4256 • FAX (707) 259-8177

www.napasheriff.ca.gov

HELPFUL GUIDELINES FOR MEDICAL STAFF IN DETERMINING WHEN TO CALL THE CORONER

When is the Coroner called?

Generally, the Coroner must be called when the cause of death is in question and an investigation and/or autopsy must be performed to document the cause of death. The Coroner does not necessarily need to be involved in "natural" deaths where a physician is able to document the cause. *However, the Coroner must be called when the death occurs during or shortly after a procedure, even if the cause in known.* A telephone call is placed to either the NSO Coroner Division (253-4256) or Napa Dispatch (253-4451) by a doctor or nurse. Specific information, such as whether or not an attending physician will sign for cause(s), age of the Decedent, present medical history, and pre-made funeral arrangements should be reported. The Coroner's Office will determine at a later time whether or not an autopsy needs to be performed for cause of death. Often, even if a primary physician cannot sign for cause, the Coroner's Office utilizes medical records and a pathologist review. This is referred to as a **CORONER'S CASE.**

Duties of the Coroner

The Coroner's Office is a division that falls under the Napa County Sheriff's Department and consists of Sheriff's Deputies working as Coroner Investigators. All Deputy Sheriff's are also

Deputy Coroners. The Deputy Coroner arrives at the site of death before the body can be moved so that the scene and circumstances can be investigated and documented. The Deputy Coroner will establish the identity of the Decedent, inspect the body, physical position, and environment. They will interview witnesses, take photographs, search for wills/other legal documents, and request medical records.

California Government Code 27491 instructs the Napa County Coroner to inquire into and determine the circumstances, manner, and cause of the following:

- All sudden, violent, or unusual deaths.
- Unattended deaths.
- Deaths where the deceased has not been seen by a physician for at least 20 days.
- Deaths related to or following known or suspected self-induced or criminal abortion.
- Known or suspected homicide, suicide, or accidental poisoning.
- Deaths that occurred as a result of an accident or injury, whether prior or recent.
- Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, alcoholism, drug addiction, strangulation, or aspiration.
- SIDS (Sudden Infant Death Syndrome).
- Deaths due to criminal means.
- Deaths that occur while the subject is in custody
- Deaths due to contagious disease.
- Deaths due to an occupational disease or exposure.
- Deaths that occur at the Napa State Hospital or involving a Napa State Hospital patient at another hospital or care facility.
- Deaths under such circumstances as to afford reasonable grounds to suspect the death was caused by the criminal act of another.

Nothing should be removed or changed on the decedent's body unless approved by the Coroner, or until the case is released by the Coroner. This includes, but is not limited, to any and all medical intervention devices and/or clothing. The decedent's body should not be removed to another location unless approved by the Coroner (this could include a patient who expired in the ER and having to be moved to accommodate an influx of patients). The decedent's body should also not be released to a funeral home, especially outside of Napa County, unless approved by the Coroner. If changes are made, evidence may be compromised, and questions raised by physicians, families, and attorneys may not be able to be answered by the Coroner.

Medical Records

Pursuant to **California Civil Code Section 56.10 (b) (8)**, *"When requested in the course of an investigation by the Coroner's Office…medical records shall be disclosed to the Coroner without delay upon request…"* Hospitals and medical/care facilities are required to provide copies of any and all medical records pertaining to the decedent, which typically includes history and physicals, recent surgeries and visits. **This is also in compliance with HIPPA requirements, 45 C.F.R. Section 164.512 (g).**

Decedent Property

Pursuant to **Government Code Section 27491.3,** the Coroner may take charge of personal effects at a death scene. This includes clothing, dental appliances, and any valuables such as a purse, wallet, jewelry, and money.

Notification

Death notification can be made to next-of-kin by doctor, nurse, or care staff via telephone or in-person. If the Coroner's Office is involved in notification, we attempt personal contact if at all possible.

Organ Donation

The Coroner's Office supports the Uniform Anatomical Gift Act, as specified in **Chapter 3.5 of the Health and Safety Code**. The Coroner's Office works closely with local eye and tissue donor services for the recovery of organs and tissues involving Coroner cases. The Coroner's Office is fully aware of the importance of organ and tissue transplants and the need to balance these programs with the decedent's wishes, desires of next-of-kin, and the mandates of this office.

Special attention is given to Coroner cases where homicide and suicide are known or suspected. This is due to law enforcement involvement and the potential of subsequent litigation. In these cases, the Coroner's Office must ensure the circumstances, manner, and cause of death are determined prior to the release of the decedent to an organ and tissue donor recovery organization.

Important telephone numbers

Napa Police/Fire Dispatch (707) 253-4451

Napa County Coroner (707) 253-4256

Law Enforcement Chaplain (707) 257-7260