

Devon • Cornwall • Isles of Scilly



Local Resilience Forum

Human Diseases
EXCESS DEATHS
EMERGENCY PLAN

June 2009

DOCUMENT INFORMATION

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Document Name	Devon, Cornwall, Isles of Scilly Local resilience Forum (LRF), Human Diseases Excess Death Emergency Plan
Purpose	The aim of this plan is to outline the existing arrangements in place within Devon County and the, Unitary Authorities of Torbay, Plymouth, Cornwall and the Isles of Scilly (hereafter referred to as Devon and Cornwall) to manage the deceased. It may also provide additional support to the Mass Fatalities Plan should it be activated. In addition this plan will identify issues arising from excessive deaths caused by a pandemic or similar event and look to provide solutions and options to facilitate the process.
Nature of document	The subject of this document is event driven. It is intended to identify pinch points in the overall delivery process with options and guidelines to address these. Pre planning to address some of the issues in advance of an initial occurrence warning is to a degree hampered by geographical and financial restraints. This should be resolved as an event occurs and information as to potential fatality rates become clearer. Work streams will continue to address the Tactical and Operational requirements at individual local authority level to deliver in partnership.
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Location of Document	PDF Version linked to LRF Website: www.dcisprepared.org.uk . This plan is available electronically from the DCC Emergency Planning Service.

<p><u>Acknowledgements:</u> London Resilience Team. Stockport Contingency Planning Service. Wiltshire and Swindon LRF Home Office Government Office South West (GOSW)</p>	<p><u>Referred Documents:</u> Home Office 'Framework for planners preparing to Manage Deaths' (version1.1) DoH Aug08- Pandemic influenza: guidance on the management of death certification and cremation certification GOSW- Planning for Excess Deaths Cabinet Office Guidance 'Contingency Planning for a Possible Influenza Pandemic' (July 2006). LRF - Pandemic Influenza Plan LRF – Mass Fatalities Plan LRF – Combined Agency Emergency Response Protocol (CAERP).</p> <p>Also see useful links at Appendix 12</p>
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FOREWORD

Dealing with the consequences of mass fatality incidents requires the dedication of numerous agencies. These agencies are committed to ensuring that the deceased and the bereaved receive sensitive and dignified treatment, in accordance with the ideas projected in the quotes below:

“Show me the manner in which a nation or community cares for its dead and I will measure with mathematical exactness the tender sympathies of its people, their respect for the laws of the land and their loyalty to high ideals.”

(Gladstone, William. 1871)

“All persons involved with the bereaved will be mindful of the following recommendations:

- Provision of honest and accurate information at all times at every stage
- Respect for the deceased and the bereaved
- A sympathetic and caring approach throughout
- The avoidance of mistaken identification”

(Clarke, Lord Justice, 2001, para 34:1)

“The care with which our dead are treated is a mark of how civilised a society we are. Much goes on for understandable reasons behind closed doors. For this reason there is a special responsibility placed on those entrusted with this work and the authorities that supervise it to ensure that the bodies of the dead are treated with the utmost care and respect. That is what bereaved and loved ones are entitled to expect and what society at large demands.”

(Haddon-Cave, Charles, 2000)
Representing the Marchioness Action Group

This plan has been produced by Devon, Cornwall and Isles of Scilly Local Resilience Forum (LRF) as part of the multi-agency response to the threat of pandemic influenza. Influenza pandemics are natural phenomena which have occurred 3 times in the last century (*Lessons learnt from development of current Swine Flu Pandemic will be updated upon review*). No country can expect to escape the impact of a pandemic entirely and it poses a unique local, national and international challenge.

Although it is very likely that an influenza pandemic will occur at some point, it is impossible to forecast its exact timing. It is imperative that all agencies have arrangements in place to respond as and when the event occurs

Despite their variability, previous pandemic events provides a valuable source of planning information and experience recognising that much has changed since the last pandemic in 1968.

Past pandemics have varied in scale, severity and consequence, although in general their impact has been much greater than that of even the most severe winter 'epidemic'. There have also been material differences in the age groups most affected, the time of year they occurred and the speed of spread, all of which influenced their overall impact.

Although little information is available on earlier pandemics, the three that have occurred in the 20th century are well documented. The worst (often referred to as 'Spanish Flu') occurred in 1918/19. This caused serious illness with an estimated 20-40 million deaths worldwide (with peak mortality rates in people aged 20-45 years) and major disruption.

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Section 1

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Section 1

Introduction

The Government judges that one of the highest current risks to the UK is the possible emergence of an influenza pandemic. That is, the rapid worldwide spread of influenza caused by a novel virus to which people would have no immunity, resulting in more serious illness than that caused by seasonal influenza.

The risk of an Influenza Pandemic scores very highly on both National and Regional Risk Registers with an estimated likelihood and potential impact which has necessitated detailed regional and national planning.

Whilst this plan focuses on dealing with deaths from an influenza pandemic it will provide a generic template for a response to a range of incidents likely to cause multiple or excessive deaths. It should be read in the context of the Devon and Cornwall (LRF) Pandemic Influenza Plan which is also reflected within the LRF Community Risk Register (www.dcisprepared.org.uk).

The overriding principle being, that if we can demonstrate resilience against the outcomes of pandemic influenza we will be adequately prepared for most emergencies.

The Cabinet Office Guidance 'Contingency Planning for a Possible Influenza Pandemic' (July 2006) makes reference to the requirement for:

Co-ordinated multi-agency planning for handling excess deaths, including surveying local capacity at relevant stages of the process from death to burial or cremation.

1.1 Aim

The aim of this plan is to outline arrangements in place within Devon Cornwall and Isles of Scilly to manage excess deaths caused by a flu pandemic. In addition the plan will identify issues arising from excessive deaths caused by a pandemic or similar event and look to provide solutions and options to facilitate the process.

It may provide additional support to the LRF Mass Fatalities Plan should it be invoked.

1.2 Objectives

The key objectives are to describe how the multi-organisation response will be activated, managed and delivered including:-

- Translate national planning assumptions for a variety of clinical attack and case fatality rates to Devon and Cornwall LRF
- Apply the national influenza pandemic excess death management assumptions.
- Roles and responsibilities of each organisation
- Pronouncing life extinct

- Certification of death
- Coronial Issues
- Recovery of bodies and transportation
- Storage of bodies – mortuary arrangements
- Arrangements for the registration of deaths
- Identification and release of the deceased to families
- Cemetery and crematory arrangements

Any procedures that are put in place as a result of a pandemic will **endeavour to** respect the dignity of the deceased, and the humanitarian needs of the friends and family. This plan should be read in conjunction with each organisation's Business Continuity Plan's, Pandemic Flu Plan's and the LRF Mass Fatalities Plan

1.3 Key Legislation

The Public Health Act 1936 (s.198) makes provision for a local authority to provide a mortuary for the reception of dead bodies before interment and a post-mortem room for the reception of dead bodies during the time required to conduct any post-mortem examination ordered by the coroner. Ministers can enforce this if required.

The Coroners Act 1988 (s.24) makes provision for coroners to pay the fees and allowances necessary for inquests, including to persons summoned to attend as witnesses and to medical practitioners carrying out post-mortem examinations.

The Coroners Act 1988 (s.27) makes a number of provisions for the fees and disbursements paid by the Coroner in the course of his duties under the provisions of the Act to be reimbursed by the relevant local authority. Where a coroner's jurisdiction falls between two or more districts, the expenses should be apportioned between those councils.

The Civil Contingencies Act 2004 gives central government wide ranging powers for use in an emergency. It places a legal obligation upon emergency services and local authorities (defined as "Category 1 responders" under the Act) to assess the risk of, plan, and exercise for emergencies, as well as undertaking Business continuity Management

1.4 Planning Assumptions for Pandemic Influenza

Normal mortality rate

Total deaths in the UK are normally around 12,000 per week. -----

The total deaths per annum in Devon Cornwall and Isles of Scilly – average 18,134 (**Fig 1**), which equates to approx 349 deaths per week (this figure will be affected by seasonal variations).

Excess deaths

Based on Government figures the following table (**Fig 2**) is a realistic assumption for influenza attack rates and excess deaths in Devon Cornwall and Isles of Scilly. The attack rate figure of **50%** combined with **2.5%** death rate (as reasonable worst case scenario) is considered to be the appropriate benchmark for planning purposes. This will give an overall planning assumption figure over the 15 week period of **20,366** excess deaths.

During a pandemic the total deaths are likely to gradually rise to the peak of an influenza wave, and then gradually decline (**Fig 2A**). There is the potential, in the more severe scenario, for as many deaths to occur over 15 weeks of a pandemic as normally occur in one year.

The pandemic may strike in one, two or more waves resulting in similar fatality figures but spread over extended period of time, prolonging impact on the bereavement process.

Mortality rates are likely to vary considerably between different age groups but the mortality age profile remains unknown until the new virus strain emerges.

Treatment with antiviral drugs could reduce both the extent and severity of the illness and possibly reduce the peak incidence.

[(**Fig 2B**) is included to give an example of varying % death rates across a clinical attack rate of 50% within the LRF Group and uses local resident population figures from 2007.]

Transient Population

The figure of **20,366** (Fig 2) takes no account of the potential transient population (Second homes and overnight stay tourists) There is no indication available as to the mindset of this group, would they continue with their visit, stay at home or in the belief it may be better to leave a crowded city, head for the perceived fresh green areas of the country. For the purpose of the present planning assumption transient population is not included, but we are aware this could put a further strain on the response and further transport and storage issues would have to be addressed, potential figures will be included in preparation of the Tactical / Operational planning.

Figure 1

Mortality Rates 2004 - 2006 Inclusive

	Area	Cornwall	Isles of Scilly	Devon	Plymouth	Torbay	Total
Year							
2004		5756	26	8266	2422	1783	18253
2005		5853	9	8303	2393	1823	18381
2006		5655	22	8073	2347	1671	17768
Total		17264	57	24642	7162	5277	54402
Average		5755	19	8214	2387	1759	18134
<i>(per week)</i>		<i>111</i>	<i>0.4</i>	<i>158</i>	<i>46</i>	<i>34</i>	<i>349</i>

Figure 2

**Devon and Cornwall –
Pandemic Influenza figures**

Total Population	1,629,300	Year 2004-6 average death rate 18,134 per annum			
Clinical attack rate		Excess Deaths			
Population %	Population Number	0.4%	1%	1.50%	2.50%
25%	407,325	1629	4073	6110	10,183
35%	570,255	2281	5703	8554	14,256
50%	814,650	3259	8147	12,220	20,366

These figures will be additional to the normal deaths which equate to 349 week.x 15wks = 5235

Figure 2A

EXCESS DEATHS WEEKLY PROJECTIONS - Resident Population @ 1,629,300

PANDEMIC WEEK		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
PERCENTAGE*		0	0	1	3	11	22	21	14	10	8	5	3	2	1	1

REASONABLE WORST CASE		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Devon Cornwall and isles of Scilly LRF - approx		0	0	204	611	2,240	4,481	4,277	2,851	2,037	1,629	1,018	611	407	204	204

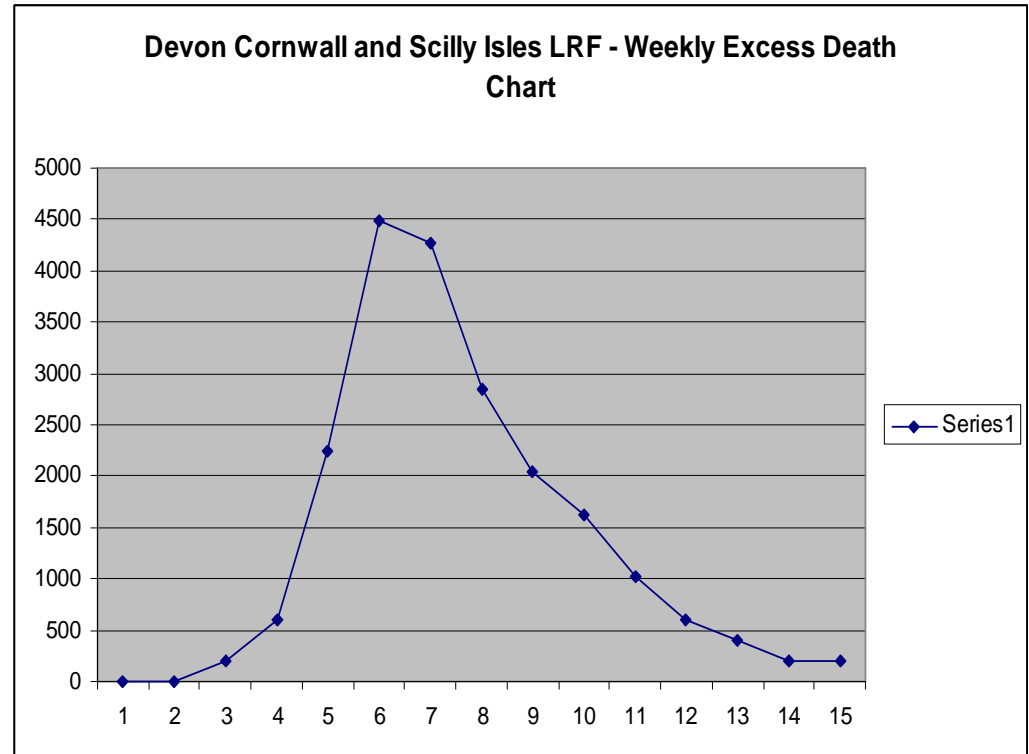


Figure 2B (Local Resident Population Figures in 2007 per LRF Group)

**Devon and Cornwall –
Pandemic Influenza figures**

Total Population	1,683,303	Excess Death example @ Clinical Attack rate of 50%			
		0.4%	1%	1.50%	2.50%
Devon County	763,099	1526	3815	5723	9539
Torbay	140,802	281	704	1056	1760
Plymouth	260,722	522	1304	1955	3260
Cornwall (inc's lofS at approx 2,200)	519,400	1039	2507	3896	6493

1.5 Management of Deceased

Deaths can occur in the community or in hospital, and can be categorised as;

Expected: Cause of death known and not reportable to Coroner

Expected : Reportable to Coroner.

Unexpected : Cause of death unknown - Sudden death.

Unexpected : Suspicious death.

Further description on these types of deaths is covered within Section 3 and at Appendix 1.

Process tables for Community Death at **Figure 3** and Hospital Deaths at **Figure 4**.

1.5.1 Coronial Forms

See **Figure 5** for Flowchart. (and Fig 5A to changes on Cremation Form numbering)

When the Coroner is not involved or is satisfied that no action is required and issues a form A , the Registrar of Births, Deaths and Marriages will issue an authority for the burial or cremation of the deceased.

When the Coroner orders a post-mortem but is satisfied that no inquest is required, either the Coroner will issue an authority for the cremation or the Registrar will issue an authority for a burial.

When an inquest is held, the Coroner will issue the authority for either a burial or cremation.'

1.5.2 Deceased Unidentified

In most of the situations described above the deceased will be identified, usually by the relatives or a person who knows them. If not then other agencies will become involved such as the Police or Social Services to try and identify the deceased. In an emergency situation and where there is possibly a large number of unidentified bodies, the Coroner could convene an identification commission to deal with identity. In any event, each body which remains unidentified will be labelled with a body label and / or with a unique number.

If the identity of the deceased is unknown or no known next of kin or family this may increase timescales for burials or cremations.

If appeal is made and is unsuccessful and no family either (a) comes forward or (b) is found the local authority is required to make appropriate arrangements. In extreme circumstance the LA might make arrangements for a funeral and follow up an appeal at a later stage. Decisions would need to be taken in collaboration with other services routinely involved eg. police, faiths groups

1.5.3 Deaths Abroad (Outside of the British Isles)

Deaths will be registered in accordance with the regulations of the country where the death occurred. If the body is then brought back to this country the Coroner whose jurisdiction the body is brought to has to be advised. If satisfied to identity and it is natural causes the Coroner will take no further action. If not satisfied the Coroner that the deceased has died from natural causes they will order a post mortem examination following which a decision will be made as to whether an Inquest will be required. If the funeral is a cremation then the Coroner will issue a cremation form whether he has opened an Inquest or not.

1.5.4 Outside England and Wales

If the funeral is a burial, on production of satisfactory evidence, the registrar in the sub-district where the burial is to take place will issue a Certificate of No Liability.

1.5.5 Funerals

It is usually the deceased's family who would be responsible for arranging and payment of a funeral. Where no person accepts responsibility for the disposal of the person or management of the estate or in cases where the family refuse to arrange the funeral, it is the responsibility of the Local Authority (Community deaths) or Hospital Trust (Hospital deaths) to arrange for disposal.

MANAGEMENT OF FATALITY PROCESS – HOSPITAL DEATHS

FIGURE 4

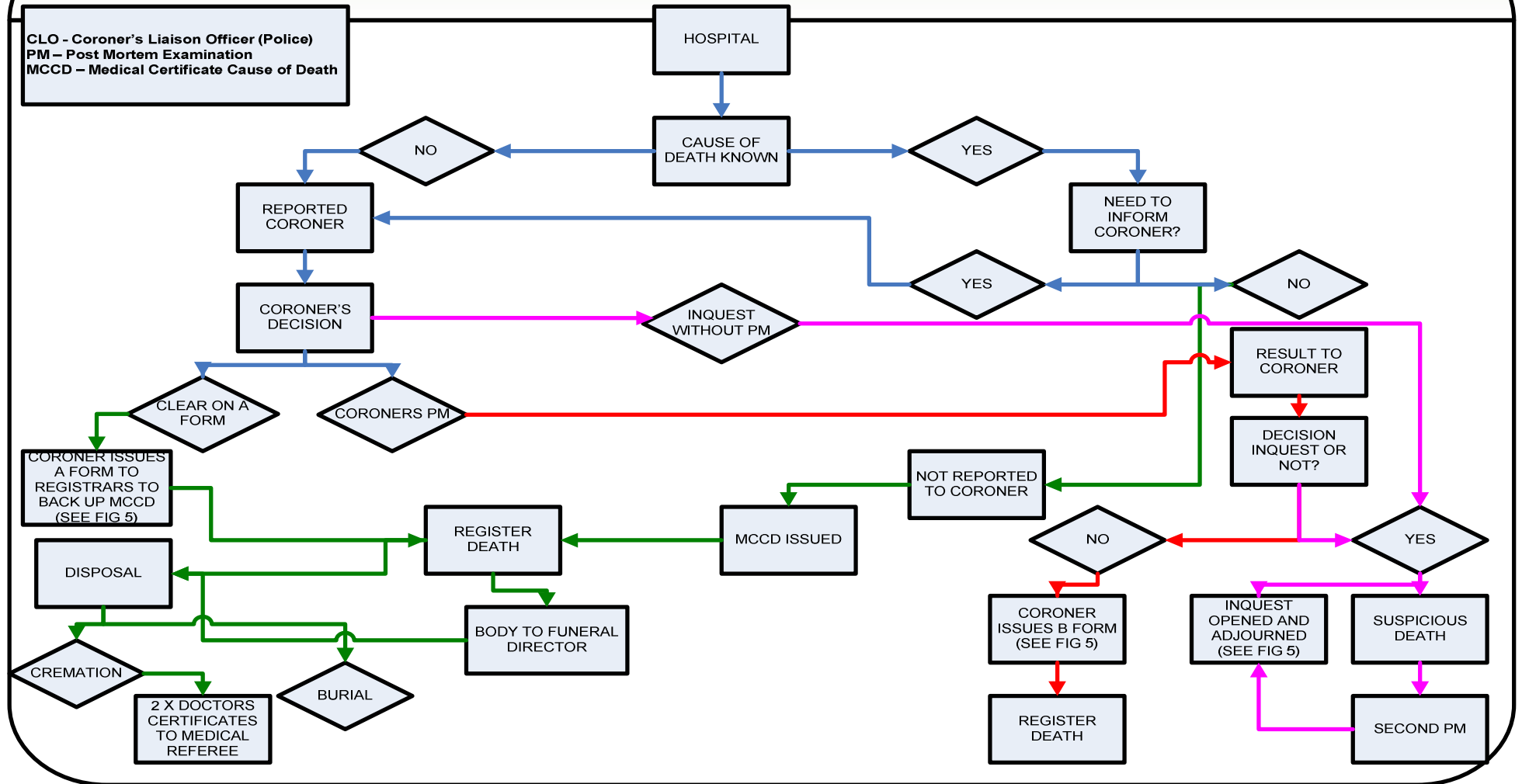


FIGURE 5

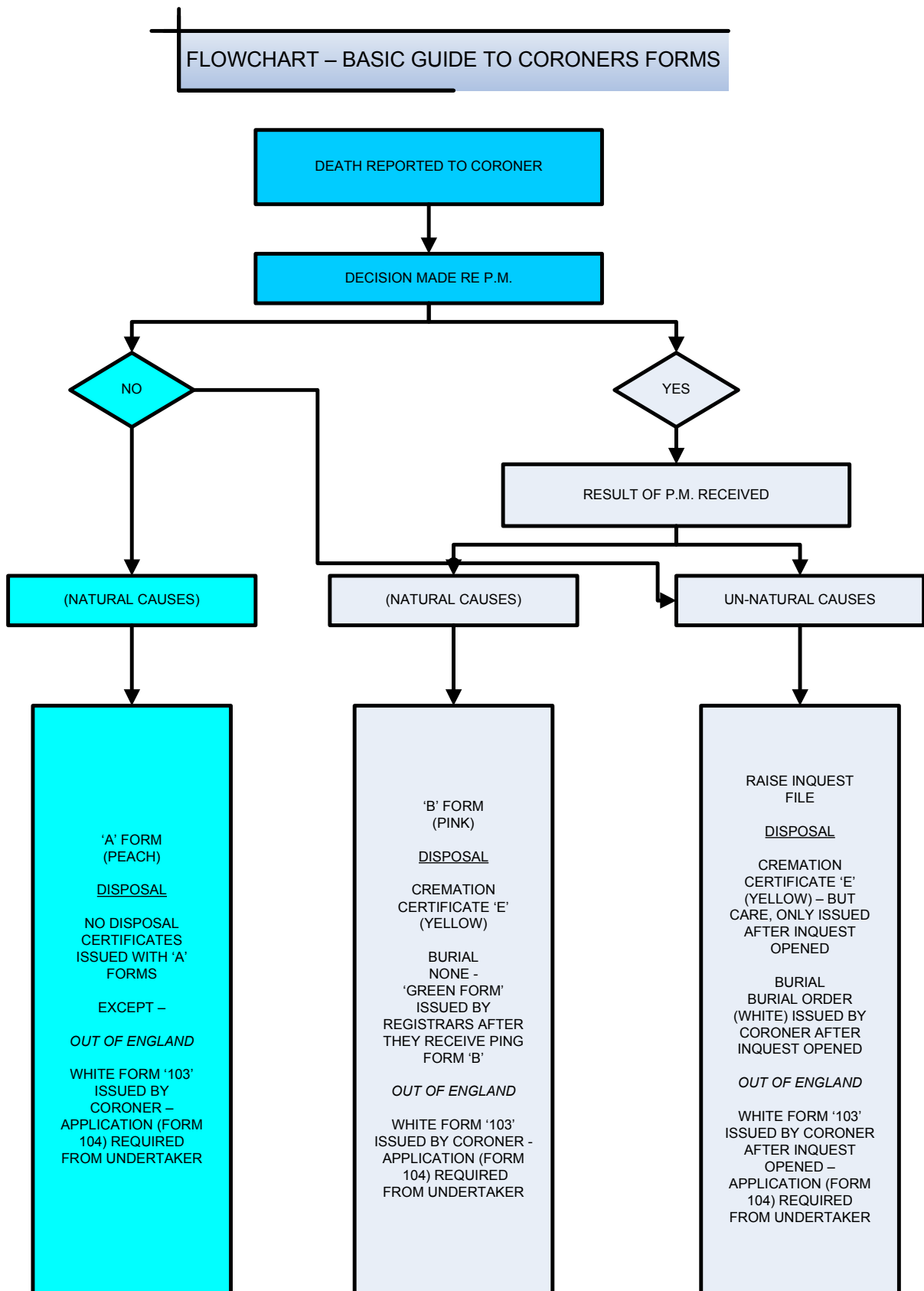


Figure 5A

Note: Cremation Forms have changed to :

Old Form	New Form	Comment
A – Application	1	
B – First Doctors Medical	4	
C – Second Doctors Medical	5	
F – Medical Referee	10	Or 12 or 13 depending on whether usual adult death 10, or Body Parts 12 or Stillborn 13.
Coroners Certificate E (yellow)	6 (white)	

1.6 Summary - Influenza Pandemic Planning – Handling Excess Deaths

To facilitate the co-ordinated multi-agency planning for handling excess deaths, it will be necessary to consider local capacity at relevant stages of the process from death to burial or cremation. Current capacity within each organisation is referred to in Section 3 and Appendix 5 (cemetery, crematorium and mortuary capacities and location).

The following table summarise the plan and identifies some of the potential impacts on capacity at each stage and lists possible mitigating measures. (see also Section 4 - Action through Phases and Further Information)

Stage	Process	Potential impacts	Possible mitigating measures	Lead Agency
Death	Pronounce life extinct Cause of death certification	<ul style="list-style-type: none"> • requirement upon primary care resources if death occurs at home • limited availability of GPs/hospital doctors 	<ul style="list-style-type: none"> • raise public awareness of what to do after a death • consider wider use of locum services/recently retired GPs • collective certification • use of nurses or other identified professionals to pronounce life extinct, issue cause of death • consider using Police Body Labelling System 	PCT
Identification	Body Label & Identification	<ul style="list-style-type: none"> • requirement of D&C Police attendance if requested by GP • Limited availability of personnel 	<ul style="list-style-type: none"> • Increase training for assistance in collection of deceased • Identify 'trained' team with sole task of attending community deaths 	Police
Removal of body from home or hospital	Personnel and appropriate transport.	<ul style="list-style-type: none"> • Limited supply of trained personnel/transport 	<ul style="list-style-type: none"> • consider training of substitute/additional staff or volunteers • Contracts with external companies (would require extra resources) • raise public awareness about procedures for DIY removals • Use of alternative vehicles for multiple collections 	Funeral Directors

Mortuary storage	Suitable mortuary facilities	<ul style="list-style-type: none"> • capacity of existing mortuary facilities 	<ul style="list-style-type: none"> • provision of temporary mortuary facilities – use of Community Hospital mortuaries / wards. Followed by Acute if required. • Funeral directors storage capacity • Make use of alternative buildings – possible contract with Community Resilience • Identify other internal sites. 	NHS Acute / Foundation Trust/Local Authority
Cremation certification (I)	Certification by medical referee	<ul style="list-style-type: none"> • other pressures upon GPs/hospital doctors 	<ul style="list-style-type: none"> • consider options for easing pressures on GPs for cremation certification 	PCT/NHS Acute / Foundation
Cremation certification (II)	Confirmation medical referee	<ul style="list-style-type: none"> • other pressures upon GPs/hospital doctors 	<ul style="list-style-type: none"> • consider 'centralising' this task at one location • consider recruitment of recently retired GPs 	PCT/NHS Acute / Foundation
Post-mortem examinations	Qualified pathologist to conduct post – mortems with adequate facilities & resources	<ul style="list-style-type: none"> • availability of pathologists/post-mortem facilities and supporting staff 	<ul style="list-style-type: none"> • decrease number of post mortems where possible • Consider Post Mortem for purpose of confirming believed cause of death only. 	NHS Mortuary Coroner
Coroner authorisation	Issue of Certificate for Cremation or Order for Burial	<ul style="list-style-type: none"> • availability of coroner to issue certificate 	<ul style="list-style-type: none"> • consider extended opening hours • IT solutions and Home working • Postpone inquests • Recruit retired coroners • Appoint legal/medical staff as temporary coroners 	Coroner
Death Registration	Death recorded Certificates issued Authority for disposal	<ul style="list-style-type: none"> • availability of Registrars and premises • supply of statutory 	<ul style="list-style-type: none"> • consider extended opening hours • Reallocate registrars to areas with high demand • Designate registrars across borders for 	Registration Service

Death Registration Continued		<ul style="list-style-type: none"> stock access to IT systems Suitable premises 	<ul style="list-style-type: none"> shared resource Identify non critical staff & train as registrars in advance to authorise when required Utilise staff with previous registration experience 	
Embalming*	Trained personnel	<ul style="list-style-type: none"> availability of Embalming equipment Suitable of suitable premises capacity of premises and speed of process 	<ul style="list-style-type: none"> increase supply inventory consider alternative personnel, e.g. recently retired, etc. recruit and train additional personnel/volunteers Alternate to coffins Decrease amount of embalming 	Funeral Director
Funeral service	Funeral director, clergy, coffin, appropriate location and transport	<ul style="list-style-type: none"> availability of church cemetery or crematorium chapel availability of clergy and trained staff supply of coffins, vehicles, fuel, etc. Faith Issues 	<ul style="list-style-type: none"> increase inventory stocks of coffins locally consider extended opening hours/availability of churches and cemetery/crematorium chapels Limit funeral service Restrict attendance Use of lay officials 	Funeral Directors / Multi- Faith
Cremation**	Trained personnel and appropriate transport Time slot availability at crematorium	<ul style="list-style-type: none"> capacity of crematorium/speed of process availability of trained personnel availability of fuel/power car parking capacity for mourners 	<ul style="list-style-type: none"> expand surge capacity of crematorium by extended hours of operation consider training of additional/substitute personnel restrict length of service 	Crematorium / Funeral Directors / Local Authority

Interment	Trained gravediggers and capacity at cemetery/churchyard	<ul style="list-style-type: none"> • availability of trained personnel and capacity • availability of machinery and fuel 	<ul style="list-style-type: none"> • Parish empowerment. • Pre-digging of graves at early stage. • identify and train additional/substitute personnel including provision of documentation as an aid. • Source appropriate specialist machinery • Identify additional capacity at cemeteries. • Use of communal graves. • Identify new site/s 	Cemeteries / Funeral Directors / Local Authority.
<p>* Bodies for interment may be embalmed and placed into temporary interment sites pending later burial</p> <p>** Families may opt for cremation first and a funeral service later.</p>				

Section 2

ACTIVATION, COMMAND & CONTROL PROCEDURES

Section 2

Introduction

Due to the potentially large numbers involved in a pandemic, the drain on resources across the all of the partner agencies will create exceptional circumstances falling outside of the normal business continuity arrangements.

It will take a managed and co-ordinated operational response to deal with the deceased alone. Each individual local authority or silver group should put into place an Excess Death Management Team (EDMT) (para 2.3) within their own Emergency Centre structure to control a systematic delivery of functions across their Local Authority. This may run within the overall pandemic response or sit separately, either way it will take its media and overall strategic lead from the one source (Strategic Coordination Group - SCG).

The local authority EDTM's will agree that one of the authorities will act as the lead EDTM responsible for co-ordinating the overall activity within the LRF area. This will provide a means of maintaining an overview of the LRF's response and delivery and will also facilitate the possible sharing of resources and good working practices. However each individual EDTM will participate and report to the LRF SCG which remains the single point of contact (SPOC) for the Regional response.

The response will take its format from the LRF CAERP (Combined Agencies Emergency Response Protocol) document and follow the standard principles of Gold (Strategic), Silver (Tactical) and Bronze (Operational) as with any major incident.

It should be recognised that the activation of the EDTM is situation driven, it relies on the information and intelligence available that identifies the potential Clinical Attack Rate and probable excess death rate, this will allow for a measured and coordinated use of resources.

2.1 Activation & Alerting Procedure

Upon the notification of an influenza outbreak and the subsequent activation of the UK Pandemic Influenza Plan (**UK Alert Level 1** – Cases outside the UK) the following actions will be considered.

(Good practice learnt from initial swine flu outbreak in Mexico 2009. Local Authority Emergency Planning Departments should review plans and liaise with partner agencies as a pre awareness exercise on first site of information that may require advanced work towards pinch point areas)

- I. Excess Death Management Team (EDMT) – Local Authority led, tactical group based on the lines of Silver and reporting up to the SCG (see membership Section 2.3) will be formed as soon as possible (subject to the expected clinical

attack rate v anticipated death rate) to discuss current situation and available information on mortality predictions. The EDMT will sit throughout all Phases (**Figure 6/6A**) and be key in delivering and co-ordinating at local levels

- II. Organisations in receipt of the plan will confirm contact numbers and their current situation to Emergency Planning Service
- III. GP Surgery's and Hospitals will monitor the situation as per normal procedures and link into national data.
- IV. If the characteristics of the virus can be identified from patterns outside the UK, insert the clinical attack rate and mortality rate into *Figure 2* in this plan - This will give an indication of what the area / authority could expect in terms of illness and death rate
- V. Members will continue to monitor situation outside the UK.

Once an outbreak is identified within the UK (**UK Alert Level 2-4**) the following actions will be considered

1. The Excess Deaths Management Team will convene immediately and agree regular timetable of meetings.
2. GP's and Hospital keep Coroner & EDMT informed of changing situation.
3. Funeral Directors – monitor capacities and report daily to 'nominated' funeral Director who will report to EDMT.
4. Individual Authorities within the LRF – identify their temporary storage options (subject to mortality predictions)
5. Multi Agency (LRF, Regional & National) Public information strategy needs to be considered. (See LRF Pandemic Influenza Plan)
6. Consider extending body labelling system to all deaths outside hospital.

2.2 Command and Control

Multi agency partnership approach, Local Authority led and working under the auspices of the overall Flu Pandemic Response group.

There will be delivery at both LRF level (Strategic Coordination Group (SCG)) and for the Individual Local Authority Groups within the Excess Death Management Team/s (EDMT), to ensure the coordinated response

2.2.1 Strategic Coordination Group (SCG) (Gold)

The response to the Pandemic Flu (Excess Deaths) will require all of the co-ordination skills developed by partners in responding to other major incidents. The overall principles of such a response are found within the CAERP.

The distinct difference with Pandemic Flu is the potential scale of the disaster, the lack of pre-determined information as to who, when and where individuals will be affected and how Business Continuity Plans will stand up to the challenge.

The Strategic Co-ordinating Group will be responsible for providing and maintaining the strategic lead, overview, the co-ordinated media response and the link through Government Office South West to Central Government (see 2.3.2).

They will be responsible for communicating both up and down the chain.

It is important that this group supports and ensures that the Silver and Bronze processes are in place, being delivered and identified pinch points addressed.

It is likely that the Local Authority will take the lead in this response and as such should provide the location, off site conferencing facility and secretariat as required.

2.3 Excess Death Management Team

EDMT will convene to discuss the impacts of the incident on the fatality process and provide the tactical and operational response to manage delivery. All members will report to EDMT with updates on impacts affecting their own business.

Local Authority will chair meetings of this group agreeing a suitable time table.

Consideration should be given to the EDMT LRF Lead / Chair being appointed from the Local Authority most or first affected by the outbreak or as a mutually agreed appointment by the LRF members.

Membership will include representation from the following organisations:

<p>Local Authority Lead / Chair</p> <ul style="list-style-type: none"> • Emergency Planning (Secretariat) • Registration Services • Health and Safety • Environmental Health • Adult & Social Care Services • Procurement <p>H.M Coroner</p> <p>D & C Police</p> <ul style="list-style-type: none"> - Contingency Planning Officer - Coroners Officer <p>PCT</p> <ul style="list-style-type: none"> - Director of Public Health nominated representative (who will also cover GP issues) <p>NHS Acute / Foundation Trust</p> <ul style="list-style-type: none"> - Mortuary - NHS Trust to identify others <p>Funeral directors</p> <p>Nominated 'lead'</p> <p>Cemeteries and Crematoria</p> <p>Nominated 'lead'</p>	<p>If requested:-</p> <p>Multi Faith / Communities Group</p> <p>Strategic Health Authority</p> <p>Health Protection Agency</p> <p>Children & Young Peoples Services</p> <p>Voluntary Sector (inc Bereavement Services)</p> <p>Other agencies as necessary</p>
<p>Members of the group will be responsible for disseminating information back to their own organisation.</p>	

2.3.1 EDMT – Operational Support

This group will be formed to provide the administrative function, staffing is likely to be provided by the local authority, but may rely on partnership support. The role in conjunction with CCP (Para 2.3.2), is to ensure correct delivery through all aspects of the process from initial information of the deceased through to disposal.

This function is essential in maintaining all aspects of the movement and storage of a deceased to ensure continuity as any mistake in identity would be unacceptable.

The system employed will mirror current emergency centre or incident room procedures and subject to event is likely to include, a system of receiving, indexing, allocating, auditing and supervision

The formation of the EDMT operational support and processes involved are considered to be part of the Tactical and Operational delivery, included in current ongoing partnership work.

2.3.2 Central Coordination Point (CCP)

The Central Coordination Point sits within the EDMT Operational Support they will liaise with all agencies (hospital mortuary, temporary storage area, HM Coroner, Police, and Funeral Directors etc.) involved in the management of excess deaths across the LRF.

It will be a focal point where information is collated and disseminated, enabling the Excess Death Management Team and Coroner to keep abreast of the changing situation. They will feed back to the LRF SCG (2.3.1) to ensure the Strategic overview is maintained.

Figure 6 (See 6A for Explanation of Phases)

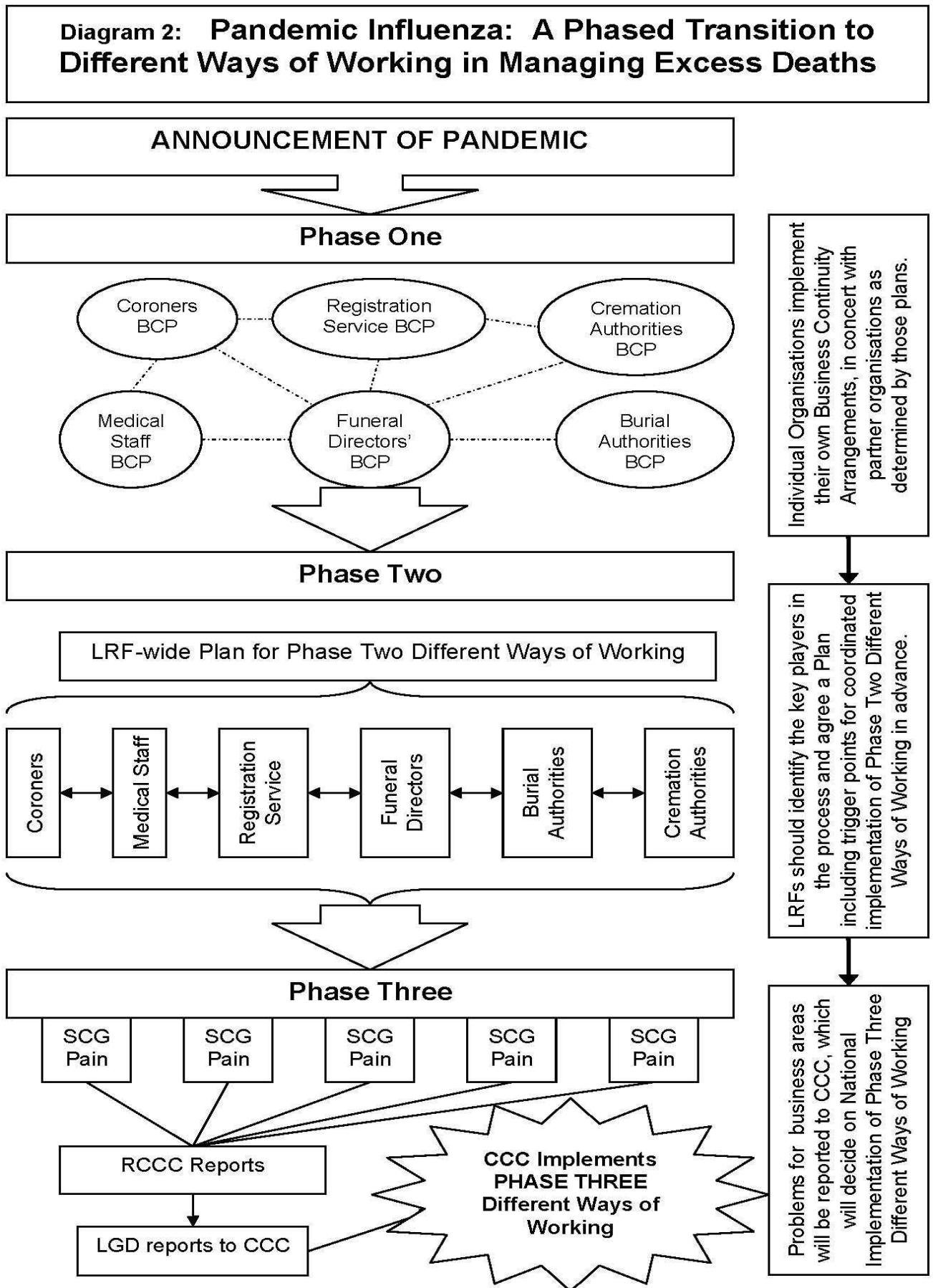


Figure 6A (as below)

Overview of Suggested Different Ways of Working
PHASE ONE
<p>On announcement of a pandemic, organisations will enter: <u>Phase One – Business Continuity</u></p> <p>It is recognised that there will be particular strains on staff resources due to the additional workload combined with staff absences (of up to 35%). Therefore the reliance on robust business continuity planning is paramount to the continuance of 'near to normal' delivery for as long as possible. A brief summary of key business continuity measures that should be implemented is laid out below.</p> <p>GPs, PCTs, NHS, Acute Foundation / Trusts – considerations: retired GPs, pooling of GP resources etc.</p> <p>Registration Service – considerations: Pooling of staff across counties and borders, increase part time hours, identify retired registrars, extended opening hours, additional venues for registrar duties, rationalisation of work processes, list of non statutory registration services which can be postponed until after the pandemic period, identify marriage or civil partnership celebrations which couple may choose to postpone. Seek Home office instruction regarding postponement of citizenship ceremonies</p> <p>Funeral Directors – considerations: Pooling of resources including cars/drivers, extensions to working pattern, additional staff resources including embalming technicians, stockpiles of coffins/continuity of coffin supplies.</p> <p>Coroners – considerations: Prioritisation of completion of disposal certificates over inquests, identification of retired/part time coroners who can return to work/work additional hours, additional deputies, pooling of resources between districts, redeployment of support staff from other LA functions.</p> <p>Cremation/burial authorities – considerations: Mutual aid agreements/pooling of resources, scaling up of grave digging – how this will be done, any restrictions, health and safety considerations.</p>
PHASE TWO
<p>'Business as usual' will be maintained for as long as possible, however the LRF areas is considered likely to enter into <u>Phase Two - Non-statutory working</u> (where business continuity measures (phase 1) are not sufficient) at a trigger point agreed by the Excess Deaths task & finish group.</p> <p>Collection of the deceased - considerations: If normal and business continuity collection arrangements fail, what emergency provisions will be put in place (note that Govt is unlikely to impose any restrictions on internal travel)?</p> <p>Encoffining - considerations: How quickly and in what quantity can coffins be acquired, if coffins cannot be provided what alternatives are offered? Local/regional/national suppliers?</p>

Registration Service - considerations alternative receiving methods for MCCDs (medical certificate cause of death), cease any local coroner requirement to report any death which occurs within 24 hours of hospital admission.

Funerals - considerations: Reduction to length of service, reduction to car service, limits to choices of type of service and choices of time/day of service (can there be weekend/night services?). Limits on attendees (close family only/no attendees?), limits on venues or changes to venue (home services, faith issues?).

Cremation/burial - considerations: Limits to choice of burial/cremation (faith issues?), limits/reduction/ceasing of graveside services/commitments (faith issues?). Group burials - family/chosen trench, unrelated individuals/no choice to trench, permanent burial, temporary burial, plot markings.

Mortuary capacity - Emergency body storage to be implemented (note that HO guidance states that temporary mortuary facilities are explored as a last measure)

- At/for NHS facilities (those who die at hospital or in ambulances on the way to hospital)
- Public/LA managed (those who die at home/elsewhere)

Planned options for emergency body storage- considerations: type of storage (demountable, inflatable, containerised etc), facility supplier, capacity, location of facility, body racking/trolleys/hoists, ventilation and chilling/freezing, facility shrouding.

Other considerations are water supply, power, foul sewer, body labelling, staffing – from where/volume of staff required/security and Human Tissue Licensing if autopsy required.

PHASE THREE

The General Register Office (GRO) is exploring changes to legislation which might be required to assist registrars in coping with excess deaths. The GRO suggest that phase three becomes available at WHO Phase 6 (UK Alert Level 3 & 4). Phase Three is split into two sections:

Phase Three (Section One):

Requirement to receive the original, signed MDCC (Medical Certificate Cause of Death) or coroners forms will be relaxed. Legislation maybe changed to allow information for a death or still birth to be provided by telephone where the LA have advised that face to face registration is inappropriate. Legislation will be amended to allow still births to be registered more than 3 months after a child has been still born.

Phase Three (Section Two):

- I. Provision will be made to extend the list of those who may act as qualified informants to include a funeral director when authorised by the family of the deceased to act on their behalf.
- II. The legal requirement for a registrar to refer a death to the coroner if a medical practitioner who has certified the cause of death and attended the deceased during their final illness and has not seen the deceased after death nor within 14 days prior to death will be relaxed to 28 days.
- III. Provision will be made to allow a registered medical practitioner who has not attended the deceased during their final illness to provide a medical certificate of cause of death (MCCD) for those who appear to the best of their knowledge and belief to have died of pandemic influenza.

Ministers will need to decide whether or not to make Orders required to amend the law in the light of the pressures on services brought about by a pandemic.

2.4 Phase 3 Working *(further to Fig 6A above)*

The indications on changing working practices at Phase 3 create a number of variables and assumptions which will require legislative change and training support to adapt from normal working practices.

SCG has to make a request of RCCC to implement Phase 3 working, a proforma is available on the UK Resilliance site and copy of detail reqired is enclosed at Appendix

2.5 Flu Pandemic Reporting Requirements.

A '**Battle Rhythm**' is to be agreed and set .

This will set a required daily time line for the gathered information from the partners across the LRF to report the current situation within their own organisations and their response and delivery to the ongoing situation.

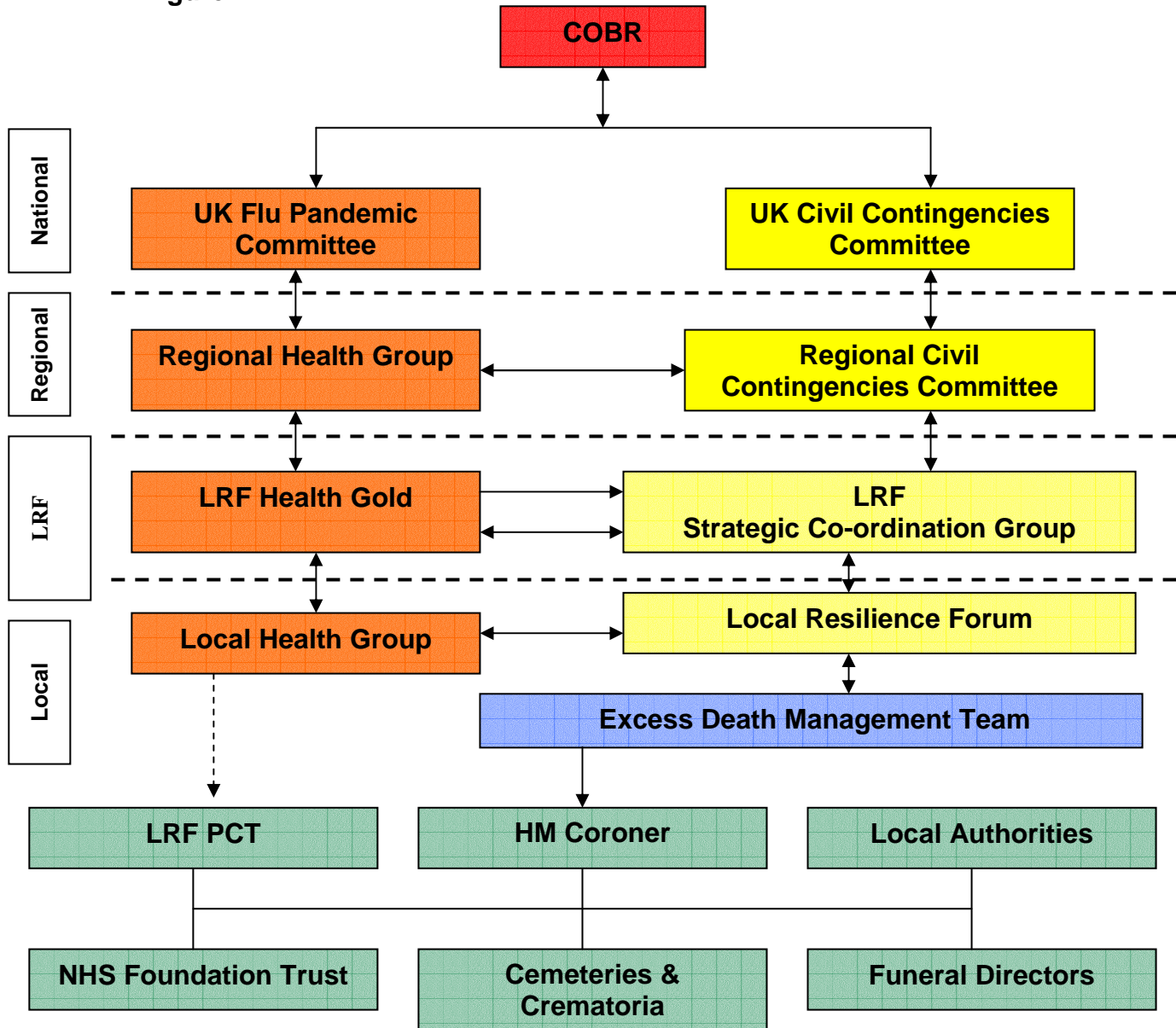
This information will be co-ordinated through the CCP in good time for the SCG pm meeting and submission to Government Office.

2.6 Devon Cornwall and Isles of Scilly (LRF), National & Regional Command and Control

During a pandemic it should be noted that co-ordination will take place at LRF, Regional and National levels (*Fig 7*) . The LRF Excess Death Management Team will be required to communicate with the Local Resilience Forum; whose role is to have strategic overview of issues affecting the LRF as a whole and will be able to make multi-agency decisions.

(Also refer to LFR Pandemic Influenza Flu Plan).

Figure 7



2.7 Trigger Points

It is most likely that an influenza pandemic will not start within the LRF but rather will be seen to be spreading from elsewhere and gradually impact on the UK and Counties.

It is therefore necessary for each organisation within this plan to recognise and set out clear trigger points which enact certain policy changes on operational activities.

Listed below are trigger point levels with general descriptions to enable each organisation listed in the plan to detail their own criteria.

<p>Indication of potential pandemic outbreak WHO levels increasing. National and International media interest.</p>		<p>Normal procedures apply; Department of Health and World Health Organisation monitor reports on pandemic flu. Each agency monitors their daily business. Excess Death and Business Continuity Plans should be reviewed and work considered to addressing the potential pinch points</p>
<p>Phase One.</p>		<p>UK Pandemic Flu Plan activated (UK Alert Level - 1), Excess Death plan activated. Organisations managing fatalities, no supply or resource issues.</p>
<p>Phase Two.</p>		<p>Warning will apply when demand approaches capacity (e.g. mortuary spaces, coroner's inquests, funeral bookings, hospital deaths, death registrations etc).</p>
<p>Phase Three.</p>		<p>Fatalities across the LRF continue to rise and demand exceeds capacity. Disposal failure is evident due to lack of capacity, staff, fuel, coffins; temporary storage options need to be considered (see Appendix 2)</p>

Organisations will be required to notify the CCP / EDTM immediately of any changes to their alert status. This will enable swift action by the LRF Management to recognise demands in the process and if required make changes to operational policy.

Section 3

Roles & Responsibilities

This section should be read in conjunction with a general description of organisational roles and responsibilities during emergencies, as laid down in the LRF Combined Agency Emergency Response Protocol (CAERP).

Identified pandemic issues, possible mitigating measures and pinch points to consider when assessing phases are included where required.

3.1 Death Certification – Doctors / GP's

If the death occurred at a private residence, including private or local authority administered residential home, the usual G.P. (Doctor) of the deceased will be called. Many doctors use the services of a 'deputising service' when they are busy or off duty. If the death occurs at night or during a holiday period a 'locum' doctor may attend in place of the deceased usual G.P. (see Doctor on call system).

The attending doctor will examine the deceased to establish that death has actually occurred (pronounce life extinct) and will make a note of the date, time and place of the death. If it is the deceased own G.P. who attends at this time, and if the G.P. has attended the deceased within the previous 14 days and can positively certify the actual cause of death, then a medical certificate cause of death (MCCD) will be issued.

It is the responsibility of GP's within the LRF area to attend the deceased and identify the cause or probable cause of death. It is the Registration Office who will issue the actual Death Certificate.

If the doctor is unable / unwilling or unavailable to certify cause of death the death is reported to the coroner's office for further investigation.

If the death is reportable, but the coroner is satisfied that the doctor can issue, then the Coroner instructs the issue of an "A" form to the registrars to cover the doctors MCCD.

The same procedure applies to deaths occurring in hospitals but it is the hospital doctor, rather than the deceased's own G.P. who will issue the MCCD, direct or through the Hospital Bereavement Office.

If the Coroner has authorised a post-mortem and the result is natural causes, he issues a "B" form to the Registration Office to advise of the cause of death and may issue a Form E for cremation.

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Expected Deaths *(further detail attached at Appendix 1)*

The majority of expected deaths take place at hospitals, patient's homes and in residential or nursing homes.

Where an expected death has occurred and it has been verified then the body may be removed with the agreement of the next of kin to the hospital mortuary or a recognised funeral home (or other appropriate place) within the jurisdiction of HM Coroner.

If there are circumstances where the usual GP could be unavailable then it is recommended that a patient who is expected to die should be formally handed over to a partner or deputy.

Hospital deaths not reported to the coroner will be released to Funeral Director (or deceased's family member), in line with their local arrangements.

Unexpected Deaths *(further detail attached at Appendix 1)*

If a GP is contacted in or out of hours regarding the sudden death of a registered patient in their own home, residential or nursing home the doctor will attend, confirm death and report the death to the coroner either personally or via the police. During Office hours the GP can refer to coroner for 'A' form clearance and the body can then be removed by a Funeral Director. If Form A is not issued, police will deal as below.

Out of Office hours, the Police identify, complete Form 195 and use a body labelling system to provide continuity, before removal by Funeral Director to the Hospital Mortuary after which it is referred to the coroner.

Pandemic Issues around death certification

- Insufficient doctors to pronounce life extinct and certify death
- Insufficient legally authorised persons to perform task
- Clear guidance is required from Central Government on issuing of death certificates at a local level

Possible mitigating measures

NB mitigating measures are for consideration and may require central government approval.

- Consider business continuity arrangements of GPs.
- Ensuring liaison through the Primary Care Trust (PCT) and Director of Public Health.
- Consider using Police body labelling system.
- Extend MCCD issuing for Doctor on call system GP's
- Consider other health professionals to pronounce the death (life extinct).
- Consider how an MCCD could be issued by a GP following diagnosis remotely i.e. telephone
- Collect bodies once pronounced dead for one or more doctors/ medical referee to pronounce life extinct en masse and complete necessary documents.
- Provision for uncertified deaths.
- If the person's death does not meet any of the criteria for needing to be reported to a coroner, then the person could be moved to a holding area soon after being pronounced dead.

Doctor on call system – Out of Hours Service

Doctor on call system provides cover from 6.30pm - 8am during weekdays and 24hrs on weekends for those patients with urgent needs that cannot wait until their GP practise is open.

Doctor on call system GP's can only confirm that life is extinct and do not sign medical certificate stating cause of death.

Medical practitioners will / may be able to issue MCCDs for those who have died from pandemic influenza where they have not been in medical attendance of the deceased at phase 3 following legislative change.

Pinch points to be considered when assessing phases.

- Normal service provided during and out of hours
- Delay in immediate attendance by a doctor (or other health professional in respect of pronouncing life extinct.
- 12hrs + delay in attendance by a doctor
- 24hrs + delay in attendance by a doctor
- Failure of doctor to attend and issue MCCD

NB Organ donation is dealt with prior to death by an organ donation co-ordinator and their standard protocols should be followed.

3.2 Identification and Body Labelling System – D&C Police

Providing there are no suspicious circumstances, once life has been pronounced extinct the body can be moved. *(further detail attached at Appendix 1)*

In the event of a sudden death, a police officer will attend scene, obtain details and search the body for any unusual marks. The officer will remove valuables from the body to leave with the family, complete Form 195, then attach a body label in place around the wrist of the deceased before resuming patrol.

Staff in the Police Operations Control Room will contact either the next available rota undertaker, or one nominated by the family, to attend the address. The nominated or rota undertaker will remove the body to the relevant mortuary for that coronial area. The body label will enable continuity within this process.

OCR staff contact the relevant hospital mortuary to advise the intended arrival.

Pandemic Issues

- Insufficient police staff to attend properties identify and label bodies

Possible mitigating measures

- Increase training for assistance in the collection of deceased.
- Multiple collection of bodies
- Identify specialised 'trained' team(s) to attend community deaths

Pinch points to be considered when assessing phases.

- Normal service provided.
- Delay in immediate attendance by a Police Officer.
- Undue delay in attendance by a Police Officer.

3.3 Transportation of bodies - Funeral Directors (See Appendix 9)

The transportation of the deceased occurs on a number of occasions

- community to hospital mortuary
- community to funeral directors
- hospital to funeral directors
- funeral directors to disposal

Once the doctor has attended and issued a MCCD or the police have attended and labelled the body the deceased will require transportation to either Hospital Mortuary or Funeral Directors. This role is usually carried out by Funeral Directors.

Pandemic Issues

- Insufficient vehicles to collect deceased and maintain service
- During peak hours 9-5, limited availability for collection
- Insufficient staff 'trained' undertakers/staff to carry out removals
- No capacity in mortuary or funeral directors to deposit deceased.
- Decomposition.
- Family transporting own deceased

Possible mitigating measures

- Increase capacity for on call funeral directors rota
- Increase training for assistance in the collection of deceased and welfare considerations.
- Multiple collection of bodies
- Temporary storage facility with drop off and collection
- Deployment of non-specialist vehicles, consider including Local Authority, Partner Agencies and Volunteer organisations.

Pinch points to be considered when assessing phases.

- Normal service provided.
- Delay in immediate attendance by funeral directors.
- Undue delay in immediate attendance by funeral directors
- Insufficient storage facilities for deceased.
- Failure to provide or adhere to a co-ordinated approach to disposal.

3.4 Mortuary arrangements (Acute / Foundation Trusts and Funeral Directors)

Mortuary facilities are mainly provided by the five Acute / Foundation Trusts (although some capacity may be available in some PCT-run community hospitals). Most autopsy examinations are instigated by Her Majesty's Coroner. Mortuaries are used as storage prior to collection by Funeral Directors for disposal.

In addition, for non-hospital deaths and where there are no suspicious circumstances, bodies are usually held by funeral directors. Funeral Directors have limited mortuary storage available.

Pandemic Issues

- Insufficient capacity to meet demand
- Specialist role of staff
- Health focal point
- Supplies of formaldehyde and other chemicals needed for embalming

Possible mitigating measures

- Business continuity as far as practical and maintain non influenza deaths
- Consider transfer of non essential services to support mortuary business
- Liaise with partners to deal with critical issues
- Utilise out-buildings for additional storage *
- Consider temporary storage with Local Authority identified premises *.
- Consider embalming or freezing to slow de-composure rate.

(NHS Acute, Foundation and PCT Hospital premises with Mortuaries, Funeral Directors with Mortuary Storage Facilities and potential identified *premises are within work streams to collate essential detail – Address / Contacts / Mapping / Floor Plans and potential for additional storage.)

Pinch points to be considered when assessing phases.

NHS Mortuary capacity across the LRF is approximately 450. Capacity in the mortuary is monitored twice daily, trigger points will be implemented and EDMT updated..

Extract from LRF Flu pandemic Plan:

The NHS is well accustomed to dealing with an increase in seasonal deaths. These are catered for under the 'Health' 'winter pressures' arrangements and are well practiced, with all organizational plans being reviewed annually before the seasonal increase in activity.

During an Influenza Pandemic the expected 'excess deaths' will be far greater and will be on top of any seasonal increase. Business Continuity plans are being reviewed to deal with immediate in house storage and mortuary expectations.

Other pinch points and assistance with partnership working is covered within the LRF Influenza Pandemic 'Excess Death' plan which has been written specifically to deal with the expected numbers from an Influenza Pandemic and the subsequent impact on the Coroner, Registration and burial services.

- Normal storage facilities coping.
- Demand exceeds normal storage facilities or arrangements..
- Failure to provide excess storage facilities on time.
- Failure to provide suitable trained staff to delivery in a co-ordinated and continuity approach.
- Pinch points occurring in other areas that have a storage knock on effect..
- Failure to provide an adequate throughput causing additional health and safety issues.

3.5 Registration of Death – Registration Offices

Registration Services are provided by the local authorities and come under the governance of the local authority or General Register Office. The services are run across two county councils and two unitary authorities. There is some capacity to cope with increases in death registration particularly when other non critical services are delayed. There is likely to be more capacity in the counties by increasing the hours of part time offices and utilising part time staff.

Cremations or burials cannot take place until a registrar or coroner issue an authority for the funeral to take place. A registrar would normally issue a certificate for burial or cremation after registering a death but may issue a certificate for burial before registration on production of an MCCD. Deaths should be registered within five days except where an inquest is to be held. Death is registered by a qualified informant ie. A relative, a person who was present at the death, the occupier or inmate of a house or institution where the death occurred, a person who found the body or is in charge of the body or a person who is arranging the funeral.

How increased death registration might be managed has been considered by the General Register Office and local authority representatives. They broadly consider that registrars will be able to manage pressures. However, this is dependent on the severity of the pandemic wave and services may become overwhelmed quickly. It is essential that local authorities consider how to provide resources to support proposed ways of working differently, identify and train additional staff at the earliest opportunity. During a period of excess deaths consideration should be given to exploring the possibilities of invoking emergency powers.

Pandemic Issues

- Specialised role
- Focal point for public to register deaths
- Capacity of 'trained' staff
- Failure of MCCD issuing result in failure to authorise funeral to proceed

Possible mitigating measures

- Employment of extra staff to act as deputy registrars – and provision of necessary training;
- Contact between registration districts to explore potential for interchange of staff to cover absenteeism;
- Extension of opening hours, incorporation of shift working, and moving to a seven day working week; with agreement, rationalising work processes - prioritising death services, cancelling non statutory services and where possible deferring activity on births, marriages, civil partnerships, historic certificate provision and citizenship ceremonies;
- Publicity of arrangements for death registration will be through media, local press, websites, and notices.
- Additional document / registration stationary stocks held

It is likely that further work will be required locally to determine appropriate ways of signposting the bereaved to bereavement and other support. Local authorities may choose to lead local networking. Local bereavement services will want to consider how advice and support is given.

It will be important for DWP/Pensions to have business continuity arrangements in place to ensure that they have capacity to cope with increased requests for support. Liaison with other local service providers about the payment for funerals will be necessary.

Pinch points to be considered when assessing phases.

- Normal service provided.
- Registration services being processed with spare capacity identified.
- Registration services being processed with little spare capacity.
- Delays in processing statutory registration services.
- Significant delays in processing statutory registration services
- Failure to train or provide additional staffing to provide registration services.
- Pinch points occurring in other areas that have a knock on effect.
- No change in government procedures to assist system
- Failure to provide or adhere to a co-ordinated approach

3.6 HM Coroner

Role

A death is usually reported to the Coroner if it is sudden or unexpected or if the doctor is unable to issue a death certificate. The Coroner is then responsible for satisfying identification criteria, establishing the cause of death and considering whether to order a post mortem and/or hold an inquest.

All sudden, unexplained or otherwise suspicious deaths are reported to the Coroner. It is the Coroner's duty to determine the medical cause of the death (see section 1.5).

Reporting of Deaths

Deaths are usually reported to the Coroner by the police or by a doctor called to the death if it is sudden. But a doctor will also report a patient's death if unexpected. In other cases, the local Registration Office may make the report.

Whenever the death has been reported to the Coroner, the registration office must wait for the Coroner to finish his or her inquiries before the death can be registered.

The Coroner may decide that death was quite natural and that there is a doctor who can sign a form saying so. In this case the Coroner will advise the registrar.

To assist his/her judgement, the Coroner may ask a pathologist to examine the body. If so, the examination must be done as soon as possible. The Coroner or his/her staff will, unless it is impracticable or cause undue delay, give notice of the arrangements to, amongst others, the usual doctor of the deceased, and any relative who may have notified the Coroner of his or her wish to be medically represented at the examination. If the examination shows the death to have been a natural one, there may be no need for an inquest and the coroner will send a form to the registrar of deaths so that the death can be registered by the relatives and a certificate of burial issued by the registration office. If the person is to be cremated, the certificate may be issued by the coroner.

Pandemic Issues

- Significantly increased numbers of deaths reported
- Impact of pandemic on Coroner's staff levels
- Coroners should identify what their priorities will be during the pandemic – the requirements of investigating unnatural, violent or sudden and unknown deaths will need considering alongside any increased reporting of natural deaths.
- Out of England orders may need to be issued.

Possible mitigating measures

- Inquests will be opened and adjourned to allow for other business to be given priority and are not resumed until after the pandemic has passed.
- The completion of disposal certificates will be prioritised over inquests
- In the absence of the Coroner – Deputy Coroners are appointed, as Acting Coroners for the duration of the pandemic
- Part time coroners may requested to work full time for an agreed fixed term
- Training issues to be considered in advance.
- Pool resources with other neighbouring authorities
- Consider employing recently retired coroners
- IT solutions for home working and faxed certificates, use of despatch driver
- Hospital to coroner administration process streamlined by IT solution.
- Develop paper based systems should IT fail.

Pinch points to be considered when assessing phases.

- Normal service provided.
- Increase in reportable deaths with little spare capacity for Coroners and Deputies to deal with.
- Administration work restricted with no listing of inquests.
- Excess reportable deaths with no spare capacity for Coroners and Deputies to deal.
- Administration work suspended with failure to conduct inquests.
- No change in government procedures to assist system

3.7 Coroners Officer (CO) – D&C Police

The primary role of the CO is to administer the police reporting system in respect of sudden deaths and prepare inquest files for HM Coroner.

- act as a central reference and liaison point between HM Coroner, police officers investigating sudden deaths, relatives of the deceased and bereavement counsellors
- if required, interview and take statements from witnesses and relatives of the deceased in sudden deaths of an unnatural, suspicious or criminal nature where HM Coroner orders an inquest
- prepare inquest files for submission to HM Coroner
- attend sudden death scenes, arrange identification of the deceased and witness post mortem examinations (when necessary)
- attend Coroners Court in order to give evidence at inquests when called to do so.

Pandemic issues

- Insufficient capacity to meet demand
- Specialist role of staff

Possible mitigating measures

- Training of further officers and/or support staff.
- Co-ordinate an attending officer to complete elements of the role

Pinch points to be considered when assessing phases.

- Normal service provided.
- Coroners Officers duties completed with spare capacity identified.
- Coroners Officers duties completed with little spare capacity.
- Delays in completing Coroners Officers duties.
- Significant delays in completing Coroners Officers duties.
- Failure to train or provide additional Coroner Officers to provide the role.
- Pinch points occurring in other areas that have a knock on effect.
- Failure to provide or adhere to a co-ordinated approach

3.8 Funeral Directors

Funeral directors by the nature of the profession play an important role in the community by supporting families through their time of need.

Their role is to:

- Safeguard the deceased person until final disposition, including embalming and restorative work.
- Completion of documentation
- Assisting the deceased family or person organising the funeral through the bereavement process (this may be restricted during the pandemic).
- Arrange and provide an orderly series of events that finalise the funeral by liaising with clergy, crematorium, cemeteries, registrar etc.
- Final disposal of the body.

Pandemic Issues

- During a pandemic funeral directors can expect to handle an additional 12 months work within a 15 week period
- Resources restrictions – staff, coffins, other supplies
- Reduced staffing levels due to pandemic
- Focal point for community suffering bereavement
- Some faith groups have single nominated Funeral Directors due to religious requirements.

Possible Mitigating Measures

- Increase working hours, seven day week operation
- Pool resources if possible with other business
- Employ additional staff to act under supervision of existing staff
- Staff roles adapted and only carry out essential services (e.g. the deceased are taken to the chapel; no car service is offered; those attending funerals are met at the chapel)
- At the chapel, funeral staff will seek to support burial and cremation staff by taking on agreed duties at the chapel, crematorium and cemetery – this is to assist cemeteries and crematoria to deploy their own staff in other essential duties.
- Restrict choices of types and sizes of coffins – this will ensure manufacturers can increase their capacity to supply and demand
- Discuss with Faith groups alternative options
- Request those who arrange the funeral have basic shorter services at the chapel, or memorials are held at other venues / times (as faith leaders will have funerals, burials/ cremations as their main priority & families may travel from other areas) (e.g. at home or appropriate place of religious worship).

Funeral Directors will need to work with Registrars to ensure next of kin or executor of the deceased estate provides the right information in a timely way. They will work with those managing cemeteries and crematoria and faith representatives (where required) to plan funerals. Funeral Directors will need to liaise with those arranging the funeral to explain why choices are being restricted and request collaboration.

Funeral Directors have standing admin policies that prohibit them from collecting the bodies from the community or an institution until satisfied that an MCCD has been issued or life has been pronounced extinct and arrangements for Coronial procedure are in place.

Embalming

Embalming is a process whereby temporarily preserving human remains to forestall decomposition and make it suitable for display at a funeral. The three goals of embalming are preservation, sanitization and presentation (or restoration) of a dead body to achieve this effect.

It can take up from 1-3hrs to embalm a body.

Specific Issues relating to Embalming:

- Availability of human and physical resources - Trained persons
- Self employed profession
- Embalming equipment
- Locations
- Capacity of embalmers, speed of process
- Dangers – Health & Safety

Precautionary advice has been issued to Funeral Directors via guidance DVD and leaflet.

Pinch points to be considered when assessing phases.

- Normal service provided.
- Failure to provide or adhere to a co-ordinated approach.
- Insufficient staff and resources to deal with excess deaths, from collection and storage through to eventual disposal.
- Pinch points occurring in other areas that have a knock on effect.

3.9 Religious Services and Multi Faith Issues. (See Appendix 1)

The Salvation Army acts as a contact point for the diverse faith communities across the LRF area.

Community and Religious groups will play an important part both during the pandemic and in the recovery period.

Religious and ethnic groups often have specific directives about how bodies are managed after death and these needs must be considered as part of pandemic planning.

Jews, Hindus, Muslims, all have specific directives for the treatment of bodies for funerals. The wishes of the family will provide guidance, however if no family is available local religious or ethnic communities can be a contact for information.

As a result of these special circumstances, some religious groups maintain facilities such as small morgues, chapels of rest and other facilities, which are generally operated by volunteers. These groups need to be contacted to ensure these facilities and volunteers are prepared to deal with pandemic issues. Religious leaders should be involved in planning for funeral management, bereavement counselling and communications.

Faith representatives will need to consider their capacity to cope and sustaining pastoral duties during the pandemic. They will want to consider if supporting those in their communities who have suffered loss can take priority over their responsibilities (See Guidance for faith communities www.communities.gov.uk). Voluntary organisations such as CRUSE have trained staff to provide support and should be considered.

Multicultural issues around death and dying

Working with cultural diversity requires knowledge and sensitivity. Family members will often prefer to be asked about their customs and religious requirements around death and dying.

It is vital to establish what is important to the person receiving palliative care regardless of culture or creed in order for their needs to be met.

Do not assume that because a person has declared that they are of a specific faith that they will necessarily adhere to all the associated customs. There will be many variations and interpretations.

Variety of issues will present see **Appendix 1** for the specific dying and death customs.

Pandemic Issues

- Faith organisations may be restricted in their practices
- Religious ceremonies will increase
- Faith groups nominate single Funeral Directors to perform all services.

Possible Mitigating Measures

- Encourage faith groups to prepare for an influenza pandemic
- Encourage faith groups to analyse their faith practises and rituals to ensure they adhere to the principles of infection control during influenza pandemic
- Pre pandemic information.
- Reduce Service times
- Extend opening hours
- Consider alternative locations for services.

Pinch points to be considered when assessing phases.

- Normal services provided by and from within faith group. Capacity to increase pastoral care available from within the group
- Normal services provided from within the faith grouping with close supervision of membership /community looking for signs of illness. Little if any capacity to increase available pastoral care beyond the faith group
- Normal services disrupted by demand for pastoral care. Services reduced to minimum required to meet the requirements of the faith group. Utilising retired clergy, lay personnel and shared working amongst congregations/communities as available
- All available capacity being utilised on pastoral care for sick/dying & funerals/burials/cremations. No capacity for other duties beyond public services. Utilising services of other agencies as available

3.10 Cemeteries and Crematoria

It is a local authority responsibility to provide facilities for disposal of bodies. Cemeteries and Crematoria are operated by District and Unitary Councils across the LRF area, or may be provided by the private sector. Cemeteries may also be attached to Churches. (nb.. Not all lower tier Authorities operate cemeteries and/or crematoria)

(List of facilities and capacity information to be developed within the Local Authorities, Tactical and Operational planning)

Cremations

Cremation can only take place after the deceased's nearest surviving relative or executor has completed an application to cremate (Form A). A doctor who attended the deceased during their last illness must also complete a medical certificate (Form B). A second medical certificate (Form C), confirming cause of death, must be completed by a separate doctor who has seen and examined the deceased and spoken to the first doctor. *(Note: See Figure 5A re changes to Cremation Forms)*

When completed forms A, B, C are taken to the crematorium and checked by a medical referee who can then sign Form F giving authority to cremate. If a post mortem or inquest were necessary the coroner certifies cremation through Form E.

The table shows the average maximum number of cremations that can be completed per day per crematoria.

No. of shifts	No. of cremators in operation		
	1	2	3
1 (8 hrs)	5	10	16
2 (16 hrs)	11	21	32
3 (24 hrs)	16	32	48

Pandemic Issues

Cemeteries

- Pressure on spaces
- Pressure on capacity to dig graves
- Staff absence

Crematoria

- Staff absence
- Limited capacity to store coffins on site
- Large Increase in numbers of cremations required
- Restricted number of qualified staff (at least one must be present at all times)
- Availability of urns for the containment of deceased ashes.
- Cremated remains need to be collected promptly as there is limited storage on site

Pandemic Mitigating Measures

Cemeteries

- Maintain basic requirement of allowing individual marking of graves
- Extend opening hours and working days, with agreement of staff
- Redeploy staff, train volunteers in management and physical aspects of operating cemeteries
- Identify additional workforce in and special contractors– excavate additional graves, manual labour etc
- Arrange maintenance and inspection of equipment – ahead of periods of peak usage.
- Consider stockpiling of resources and equipment
- Consider brown or green field sites for additional grave yards.
- Liaise with funeral director staff, allowing staff normally required for committals to be redeployed elsewhere
- Encourage funeral services to be held in local places of worship
- Reduce committal time slots
- Stock graves
- Collective burial (see Appendix 3)

NB – The LGA recommends that local service providers should aim for most of the burials and cremations to take place within six days of death registrations during a pandemic.

Crematoria

- Reduce and simplify services with no involvement from crematorium staff or offer no chapel/services at all at crematorium site
- Extend opening hours and working days, with agreement of staff – consider shift working (two shifts); round-the-clock working unrealistic
- Redeploy staff, train volunteers in management, technical and physical aspects of operating crematorium
- Delay maintenance and inspection of equipment
- Consider stockpiling of resources and equipment

- Liaise with funeral director staff, allowing staff normally required for committals to be redeployed elsewhere
- Encourage funeral services to be held in local places of worship
- Reduce committal time slots
- Consider additional support from neighbouring crematorium and pooling resources.
- It is likely that the storage of coffins at the crematorium will impede efficient operation. Coffins should therefore arrive 'just in time' and be disposed of as efficiently quickly as possible.
- Maintain stock of various cremated remains containers

Pinch points to be considered when assessing phases

Cemeteries:

- Normal burial service maintained.
- Reduced Service, with back log building.
- Normal burial service maintained, utilising additional resources.
- Advanced preparation of single site graves.
- Excess death requirements likely to exceed capability for normal burial
- Advanced preparation of group burial site graves.
- Variation to normal burial procedures.

Crematoria :

- Crematorium and booking operating as normal, extra capacity available if needed.
- Crematorium and booking operating as normal procedures utilising spare capacity.
- Change to crematorium procedures invoked to cope with extra demand (See possible mitigating measures (above)).
- Excess demand, outweighs adapted procedures.

3.11 Role of Emergency Services.

3.11.1 Devon & Cornwall Police

The Police have specific responsibilities relating to emergencies which involve fatalities; these are dealt with in Home Office Guidance dealing with fatalities in emergencies and the LRF Mass Fatalities Plans. General organisational roles and responsibilities are detailed in CAERP.

The general role of the Police's is to investigate sudden deaths for which a doctor's certificate as to the cause of death cannot be issued.

In addition to attending deaths in the community, the Police will also be required to:

- Assist with 'life-critical' processes e.g., NHS supplies including vaccine distribution
- Chair and support the SCG in coordinating the response of the GM Resilience Forum (Lead Local Authority Chief Executive as deputy)

- Provide a location for the SCG
- Provide a public order response
- Provide advice to PCTs & Local Authority on mass vaccination issues such as traffic and people management, public order issues
- Maintain core business as far a possible.

3.11.2 Devon and Somerset Fire and Rescue Service

The Fire Service role in the bereavement process is limited as documented in the LRF Pandemic Flu Plan. FRS will:

- Support the decisions taken by the Strategic Coordinating Group in so far as the exigencies of the service allow.
- Strive to maintain maximum front line operational service delivery at all times.
- Provide a delegate to the Strategic Coordination Group and Gold Control, as required.
- Provide an alternative Gold fallback facility if requested.
- remain open to approaches to undertake new responsibilities in support of the community at large during the pandemic.

3.11.3 South West Ambulance Service

The ambulance service may be requested to attend members of the public who are seriously ill and require hospital treatment.

If the ambulance service arrive at scene and the person dies in their care or is already deceased. They will offer their condolences give some advice and leave. The deceased will remain the care of a relative or friend until other support e.g. doctor, police or undertaker arrives.

Paramedics can provide a diagnosis of death if the deceased is in their own home, over 18 and there are no suspicious circumstances. Following this they would contact their control room who would notify the Police.

3.12 Local Authorities

The main local authority roles in response to excess deaths during a flu pandemic have been outlined in the sections above covering death registration, HM Coroner functions, and cemeteries / crematoria.

They will also take the lead in formation and delivery of the processes required by the Excess Death Management Team (*Discussed at S2.3*).

In addition there will be roles for:

3.12.1 Environmental Health

The environmental health team is responsible for providing measures to control the spread of infectious disease; maintain reasonable standards of health and hygiene; waste disposal; advise on health matters.

If a temporary mortuary or body storage area is required an Environmental Health Officer would be required to provide the following:

- Arrange for safe disposal of contaminated liquid waste, which would otherwise enter the mains drainage system.
- Liaise with the appropriate Waste Disposal Authority and Environment Agency, to organise the safe disposal of: Solid wastes; 'household' waste; contaminated waste; waste requiring autoclaving; clinical sharps and radioactive waste
- Advise mortuary or body storage manager on all Health & Safety matters in the facility
- Advise on and supervise cleaning of emergency facility and associated equipment prior to return to normal use.
- Advise on environmental health matters as necessary, including clean up of incident site, vehicles used for transportation, (refrigerated containers/vehicles if used).
- Ensure police and Excess Death Management Team are kept informed of all possible environmental health issues

3.12. 2 Bereavement Services / Environmental Health / Adult Services

Local Authorities have a statutory duty to bury or cremate the body of any person who has died within their boundaries, in any case where it appears to the authority that no suitable arrangements have been made, or are being made other than by the authority. The following quotations are from Section 46 of the Public Health (Control of Diseases) Act 1984:

Local Authorities must:

- Arrange for burial or cremation in cases where nobody else is prepared and able to undertake the necessary action.
- Undertake the burial or cremation of anyone who, immediately before their death, was being provided with accommodation by arrangement with the Council.
- Not cremate a body where they believe that this would be against the wishes of the deceased person. Bear in mind the religion and culture of the deceased.
- Observe any statutory requirements regulating the burial, cremation or anatomical examination of the body of a deceased person.

An authority may recover from the estate of the deceased person expenses incurred.

3. 13 Environment Agency:

The Environment Agency will be actively involved during the tactical and operational preparation, with assessing proposed disposal sites and storage facilities and support the processes during a pandemic to ensure that adequate provisions are made not to cause undue harm to the environment.

Section 4

Further Information

Section 4 Further Information

4.1 Bereavement Support

Signposting/agencies for provision of support should be considered. Funeral Directors will normally do this as part of their routine business. Mismanagement of the dead has consequences for the psychological well being of survivors, the rights of survivors to see their dead treated with dignity and respect, requires practical guidance and technical support. Voluntary agencies such as CRUSE can provide invaluable assistance. Otherwise provision may be through local authority Social Care Services and partner agencies.

4.2 Public Information Guidance

The appetite for information on how the deceased are being treated should not be underestimated. It is likely to become a focus of media reporting at local, regional and national levels.

Public information strategy will be led by Health and developed at Strategic Coordination Group (SCG) level, as documented in the LRF Pandemic Flu plan.

Media representation should be considered on the Excess Deaths Management Team.

4.3 Infection Control. Health and Safety / Welfare

It is important to note that there is no real risk of infection from bodies of people dying from the virus. The most important protection is personal hygiene and hand washing. See Pandemic Flu – A guide to Infection Control, issued by HM Government.

H&S Risk assessments should be completed and employed for those working with the deceased by the employing agency. Consideration will also be given to welfare needs and issues and the tactical and operational planning will reflect accordingly.

4.4 Finance

Finance will be a key consideration for all organisations. The resource implications of all components of this plan should be carefully considered at a time when revenue could be drastically affected.

Key areas include:

- Staff
- Equipment
- Communications

Costing for services which are reduced in time and resources e.g. (Crematorium, funeral services, etc)

4.5 Protection of Property

(Legislative Power for Local Authorities to deal with deceased property)

National Assistance Act 1948, Part IV Section 48

- This act also gives the Local Authority “the power at all reasonable times to enter any premises, and deal with any moveable property, in any way which is reasonably necessary to prevent or mitigate loss or damage
- The Local Authority can assume a “nearest relative” function. This means that the Local Authority assumes the duties of the relative, either because they refuse to assume any responsibility or where the Local Authority establishes its right over existing relatives to act in the best interests of the individual concerned.

Section 5

Appendices

- Appendix 1 Management of Deceased
- Appendix 2 Faith issues
- Appendix 3 Emergency / Temporary Mortuary Storage
- Appendix 3 MOU for PCT Provision of Mortuary Equipment
- Appendix 4 Collective Burial
- Appendix 5 Existing capacity for dealing with deceased Template
- Appendix 6 Mass Fatalities Arrangements
- Appendix 7 South West (RRF) Mass Fatalities Arrangements
- Appendix 8 Key Organisation Contacts Template
- Appendix 9 Funeral Director Information & Contacts Template
- Appendix 10 Useful links & Documents
- Glossary of terms
- Abbreviations

APPENDIX 1

Management of Deceased. (Referred to within Sections 1.5 and 3.1)

Community Deaths

- **Expected, Cause of death known (not reportable to the Coroner)**

This is where a doctor treated the patient during the last illness, seen the patient in the last 14 days or they have treated the patient during the last illness or they have seen them after death. If it is natural causes and there is no reason for the doctor to report the death to the Coroner he or she will sign a *Medical Certificate of Cause of Death (MCCD)*. This enables the death to be registered with registrar. The body can be removed to the Funeral Directors chapel.

- **Expected – reportable to the Coroner**

This is where a doctor has been treating the patient and has seen the deceased in the last 14 days or after death, but the cause of death is unnatural or circumstances are such that the doctor may choose to report the death to the Coroner.

In some cases the Coroner may be satisfied that he does not need to take any further action and will instruct the doctor to issue a MCCD and issue a Coroner's "A" Form to the registrar. The body can be removed to the Funeral Directors chapel.

In some cases the Coroner may wish to make further enquiries or order a post-mortem examination to establish the cause of death. The Police or a Coroner's Officer will establish identity, affix a Label (also referred to as 'body label') to identify the deceased and the location found to provide continuity, then organise the body to be removed to the mortuary via the Police on call funeral director rota. Once a result is received the Coroner will decide whether to open an Inquest or issue a "B" Form to the registrar to enable the death to be registered.

The Registrar of births, deaths and marriages has a duty to report a death to the Coroner if the deceased was not attended by a medical practitioner during his/her last illness; where a duly completed MCCD is not available; where the deceased was seen by the medical practitioner neither after death or in the 14 days prior to death; where the cause of death appears unknown; where the registrar believes the death to have been caused by violence, neglect, abortion or attended by suspicious circumstances; where the death appears to have occurred during an operation or before recovery from the effect of anaesthetic; or where the death appears to have been due to industrial disease or industrial poisoning.

- **Unexpected – cause of death unknown - Sudden death**

If a death is unexpected and the cause is unknown or unnatural it is usual for the Coroner to be involved. The doctor or paramedic certifying life extinct will call the Police who will establish identity, affix a Label to identify the deceased and the location found to provide continuity, then organise the body to be removed to the mortuary and report the death to the Coroner via the Coroner's Officer. The Coroner will usually order a post-mortem examination to establish the cause of death. Once a result is received the Coroner will decide whether to open an Inquest or issue a "B" Form to the registrar to enable the death to be registered.

- **Unexpected – suspicious deaths**

Suspicious deaths are reported to the Coroner by the Police and usually involve specialist forensic post-mortem examinations. There can be delays releasing a body in these cases as there may be a need for a second post-mortem examination to take place on behalf of anyone who might be charged with a serious offence such as murder.

Hospital Deaths

- **Expected – cause of death known - not reportable to the Coroner**

This is where a doctor has treated the patient during the last illness has seen the patient in the last 14 days or seen them after death. If it is natural causes and there is no reason for the doctor to report the death to the Coroner he or she will sign a MCCD which enables the death to be registered with the registrar. This will usually be issued to the family via the Hospital Bereavement Office.

- **Expected – reportable to the Coroner**

This is where a doctor has been treating the patient but the cause of death is unnatural or circumstances are such that the doctor chooses to report the death to the Coroner

In some cases the Coroner may be satisfied that he does not need to take any further action and will instruct the doctor to issue a MCCD and issue a Coroner's "A" Form to the registrar.

In some cases the Coroner may wish to make further enquiries or order a post-mortem examination to establish the cause of death. As the death occurred in hospital the body would already be in the mortuary. Once a result is received the Coroner will decide whether to open an Inquest or issue a "B" Form to the registrar to enable the death to be registered.

The Registrar of Births, Deaths and Marriages also has a duty to report a death to the Coroner under circumstances previously described under Community Deaths.

- **Unexpected – cause of death unknown - Sudden death**

If a death is unexpected and the cause is unknown or unnatural it is usual for the Coroner to be involved. The doctor treating the patient in hospital will report the death directly to the Coroner via the Hospital Bereavement Office and the Coroner's Office. The Coroner will usually order a post-mortem examination to establish the cause of death. As the death occurred in hospital the body would already be in the mortuary. Once a result is received the Coroner will decide whether to open an Inquest or issue a "B" Form to the registrar to enable the death to be registered.

- **Unexpected – suspicious deaths**

Suspicious deaths are reported to the Coroner by the Police and usually involve specialist forensic post-mortem examinations. There can be delays releasing a body in these cases as there may be a need for a second post-mortem examination to take place on behalf of anyone who might be charged with a serious offence such as murder.

APPENDIX 2

Faith Issues

Faith Issues - Also see Devon Cornwall and Isles of Scilly LRF Mass fatalities Plan and Home Office - Needs of Faith Communities in Emergencies.

Salvation Army are providing the link to Multi-Faith Groups and sit within the Mass fatalities Group.

Guidelines

These guidelines are intended to help health and social care staff, particularly if no immediate family members are available.

If at all possible the views of the individual or family concerned should be sought.

Atheist/Humanist or Agnostic

Atheists do not believe in God or in life after death, while an agnostic neither believes nor disbelieves. The families may or may not object to an organ donation. The funeral could be held at a crematorium, cemetery chapel or green burial ground and the service may be taken by a member of the family or a humanist minister. The minister would spend some time talking to the congregation about the deceased and would probably read some poetry and then listen to some music. It is very unlikely that an incumbent of a church would allow an atheist/humanist burial in a churchyard.

Baha'i Faith (mainly Iranian)

Dying

There are no special religious requirements for Bahá'ís who are dying, but They may wish to have a family member or friend to pray and read the Bahá'í scriptures with them.

Death Customs

While there is no concept of ritual purity or defilement relating to the Treatment of the body of a deceased person, there are a few simple and specific requirements relating to Bahá'í burial and the Bahá'í funeral service, which the family will wish to arrange: - the body is carefully washed and wrapped in white silk or cotton – this may be done by family members or by others, according to the family's preference;

- the family may choose to allow others to observe the preparation of the body;
- a special burial ring may be placed on the finger of a Bahá'í aged 15 or over;
- the body is not cremated but is buried within an hour's travelling time from the place of death;
- unless required by law, the body should not be embalmed;
- it is buried in a coffin of as durable a material as possible;
- and at some time before interment a special prayer for the dead, the only specific requirement of a Bahá'í funeral service, is recited for Bahá'í deceased aged 15 or over.
- While it is preferable that the body should be buried with the head pointing towards the Point of Adoration, this is not an absolute requirement, and may be impossible in some cemeteries without using two burial plots. This is a matter for the family.

Buddhism

Dying

Many Buddhists wish to maintain a clear mind when dying. 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 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.

Death Customs

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 post-mortems. 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 coloured 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.

Chinese Culture

Dying

All family members gather at the bedside. A Chinese Christian pastor is called to pray for and to counsel the dying person. In the UK this practice is also common among Chinese with no religious convictions or who are traditional Confucian/Taoist. Buddhists call for a priest/monk from a Buddhist association or temple with links to Taiwan or Hong Kong.

Death Customs

After death, undertakers handle the deceased. Some undertakers in areas with long established Chinese populations (e.g. Merseyside) are accustomed to Chinese needs such as embalming and the deceased being fully dressed in best clothes including shoes and jewellery. In such areas some cemeteries have a Chinese section. Burial or cremation may take place a week after the person has died. Friends and relatives visit the bereaved family, usually in the evenings prior to the funeral when gifts of money or flowers are given and help offered. Sweets are offered to visitors when they leave.

If the deceased is the head of the family, all children and their families are expected to observe a period of mourning for about a month. Headstones may have a picture of the deceased. If the deceased is a child, parents usually do not want to visit the mortuary. A sibling or close relative would be asked to identify the body in the mortuary.

Christian

Dying

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 the Sick (which used to be called Extreme Unction). The Sacrament of the Sick is not limited to those who are dying, but is part of the healing ministry of the Church. Other Christians may ask for prayer for healing with the laying on of hands.

Death Customs

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.

Christian Scientist

Dying

There are no specified last rites. Such issues are an individual/family decision.

Death Customs

Questions relating to care of the body should be answered by the individual's partner/ family. In general, Christian Scientists request that, whenever possible, the body of a female should be prepared for burial by a female. The individual's family should answer questions relating to post mortem examinations.

Hinduism

Dying

Most fatally ill Hindus would prefer to pray with a *mala* (rosary). A Hindu will appreciate being with someone, preferably of the same sex.

Death Customs

It is preferred if all Hindu bodies can be kept together after death. 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 where 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. Post mortems 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

Dying

Many humanists will want to have family or a close friend with them if they are dying, or the support of another caring individual. Some may appreciate the support of a secular counsellor or a fellow humanist. 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 belief in god or an afterlife.

Death Customs

No specific requirements. The choice between cremation and burial is a personal one, although cremation is more common. Most will want a humanist funeral, and crosses and other religious emblems should be avoided. However, since many humanists believe that when someone dies the needs of the bereaved are more important than their own beliefs, some may wish decisions about their funeral and related matters to be left to their closest relatives.

Jain

Dying

If death is certain and there is nothing to benefit by staying in the hospital, the Jain would prefer to spend the last moments at home. Ideally, the subject would wish for mental detachment of all desires and concentrate on the inner self. Family members or others would assist by reciting text or chanting verses from the canon. As much peace and quiet should be maintained as possible.

Death Customs

There are no specific rituals in Jain philosophy for this event. Bodies are always cremated and never buried except for infants. Cremation must be performed as soon as practicable, even within hours if possible, without any pomp. Many Jains still pursue Hindu customs as a family preference. All normal practises of UK undertakers are acceptable if handled with respect. The family normally provide the dress and accessories for the preparation and final placement in the coffin.

Japanese (Shinto)

Dying

Dying Japanese will wish to meditate.

Death Customs

Generally Japanese would prefer cremation to burial. Funeral services are administered according to Buddhist rites

Jehovah's Witnesses

Dying 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.

Death Customs

An appropriate relative can decide if a limited post mortem is acceptable to determine cause of death.

The dead may be buried or cremated, depending on personal or family preferences and local circumstances.

Jewish

Dying

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*.

Death Customs

The prompt and accurate identification of the dead is particularly important for the position of a widow in Jewish law. Post mortems 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

Mormon - Church of Jesus Christ of Latter - day Saints

Dying

Members may request a priesthood blessing. A quiet private place is appropriate for the blessing

Death Customs

The Church takes no position on post mortem examinations. 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.

Muslim

Dying

If a Muslim is terminally ill or dying, the face should be turned towards Makkah. 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).

Death Customs

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). Post mortems are acceptable only where 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 a 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 Makkah.

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.

Sikh

Dying

The dying person will want to have access to the Sikh scriptures where possible.

Death Customs

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

Pagans

Death Customs

Most Pagans believe in reincarnation. The emphasis in funerals is on the joyfulness for the departed in passing on to a new life, but also consolation for relatives and friends that the person will be reborn. Disposal of the body may be by burning (cremation) or burial. Funeral services will take place in crematorium chapels, at the graveside or at the deceased's home. In some traditions, any religious items of significance to the deceased must be buried or burned with the body. Ritual jewellery, personal ritual items such as the Witch's athame, and the person's religious writings (such as the Book of Shadows) are commonly buried with or burned with the body. A wake (mourning ceremony) carried out around the body by friends and relatives is common in some traditions.

Rastafarians

Death Customs

No particular rituals are observed. The dying person will wish to pray. When a Rastafarian person passes (dies) a gathering takes place where there is drumming, singing, scriptures read and praises given. Usual on 9th and or 40th night of person passing.

Seventh-day Adventists

Dying

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 were not available. Adventists do not hold the sacraments as required rituals; hence Sacrament of the Sick would not be necessary.

Death Customs

Cremation or burial is a matter of personal or family preference.

APPENDIX 3

Emergency Mortuary / Temporary Storage

Once there is insufficient space to store the deceased it is the local authority's responsibility to identify and manage an emergency mortuary or storage facility. This includes the provision of the Structure, Equipment & Personnel. The following storage solutions will be considered:-

- **Funeral homes and hospital mortuaries.**

Capacities are detailed at these locations and there is limited extra capacity in an extreme emergency. The excess deaths plan will seek to accelerate the process to move bodies through the system quickly and efficiently. Trigger points are in place for the hospitals to alert the Emergency Planning /Civil Resilience Units when they are close to capacity.

- **Previously identified locations for temporary mortuaries.**

These include identified military premises and are presently being reviewed within the Mass Fatalities Plan. They were identified in the main for the one off mass / multi fatality incident (or {subject to forensic requirements} potential linked incident sites). They are based around constructing a demountable structure eg NEMA / LEMA and are not considered entirely suitable for an across County pandemic event. Work is under way to look at providing additional resilience capability to designated mortuaries or sites.

- **Temporary demountable structures.**

There are two purpose built demountable structures (NEMA) currently available for use nationally. Based in Bicester it is unlikely that these would be available during a pandemic.

- **Modular mortuaries hire companies.**

There are a number of commercial organisations around the Country offering modular mortuaries for sale or rent. These are currently being assessed as part of the Mass Fatalities working group on the basis of a LEMA contract / capability. As with the demountable structures mentioned above it is unlikely that these would be available during a pandemic due to the natural demands on these services or facilities, dormant contracts could be set up but is likely that these would be prohibitively expensive.

- **Refrigerated trailer / container hire.**

Large haulage companies do have refrigerated trailers (hold 25-30 bodies without additional storage). Issues arise from public perception of this storage option, companies may not wish to hire vehicles for storage of the deceased and it may also reduce their availability for food transit.

To reduce any liabilities for business losses, avoid using trucks with markings e.g. supermarkets etc, as use of such trucks for the storage of dead may result in negative implications for business.

Security and staffing will be difficult and needs consideration.

• **Vacant warehousing.**

Due to commercial sensitiveness surrounding the subject sites will be identified when appropriate. Arrangements have been made to identify property services organisation, industrial estate agents, suppliers of refrigeration equipment, refrigeration engineers, equipment hire companies and other associated suppliers.

The LRF is presently in consultation with the organisation 'Community Resilience', any contractual arrangements will be added to this document.

Temperature specification for Emergency Body Storage Facility

Detail optimum storage temperature and approx time body could be stored for Include freezing bodies and additional equipment required.

A temporary mortuary (storage facility) must be maintained at +4 (ideally) to 8C.

Bodies will begin to decompose in a few days if not stored at this temperature.

in the case of a pandemic, bodies may have to be stored for extended periods of time, consideration should be given to plans to preserve the body (i.e. embalming). If the body is not / cannot be buried or cremated within a short period of time.

EQUIPMENT

May Include:

Refrigeration equipment suppliers and engineers.

Racking

Suitable flooring

Directions Signs

Stationary

IT equipment

Information Boards – White boards, Pin boards etc

Body Labelling and storage record system.

Body Bags

Medical Equipment

Partitions/screens/room dividers

Plastic Sheeting

Portable generators

Refuse Bags – Clinical and domestic

Trolleys

PPE - Gloves, Masks, Aprons, etc

Manual handling / Forklift trucks

Cleaning Equipment

NB – A Temporary Mortuary will require a large amount of additional equipment this inventory is detailed in the Devon, Cornwall and Isles of Scilly Mass Fatalities Plan.

PERSONNEL

- Personnel is a key and possibly problematic area –
- 24hr operation?
- 24hr Security
- Reception Officer – Check bodies in and out (including specialist documentation of death and registration certificates)
- Storage Manager
- Facilities Manager
- Documentation staff.
- General staff.
- Health & Safety Manager
- Environmental Health Officer – Advise on disposal of bodily fluids
- Special Advisors
- Equipment and supplies officer
- Transportation supervisor
- Cleaners! – Hospital!

See Mass Fatalities plan for any additional roles and responsibilities, layout arrangements etc. *(copy of which may be added to this plan within appendix).*

STRUCTURES

The Emergency Planning / Civil Contingency Units are in the process of identifying premises as possibilities for use in an emergency. Work is ongoing to obtain lists of vacant buildings across the LRF within house and through 'Community Resilience who will liaise with Industrial Estate Agents and other property owners to acquire appropriate buildings if necessary.

Considerations on building type include:-

- Location Ideally located away from residential dwelling
 Easily accessible for all types of vehicles
 Shielded from the public / media 'eye'.
- Space available
- Cold Storage, Insulation and ventilation
- Flooring solid and impervious to liquids
- Storage options – shelving, floor, racks
- Drainage and waste disposal
- Power and Lighting
- Water Supply
- Security
- Privacy
- Parking
- Office Facilities
- Heating for office areas
- Washrooms and changing facilities
- Secure area for valuables

APPENDIX 4

Collective Burial

The term collective burial is used where burials occur in a trench in rapid succession, each burial separate and identified. It can be provided by relatively unskilled staff and does not rely on technology or external help. It is not “mass” burial or “mass grave” where the bodies are placed together. Each internment is discrete and segregated.

This could have a serious psychological impact on the bereaved in that the body will not be finally placed for some months and the grieving process will be interrupted.

Collective burial would be necessary where:

- The number of dead exceeds the capacity to store, inter or cremate them
- Where the dead have to be temporarily interred because autopsy, registration or the Coroner’s service is under extreme pressure.

Collective burial would involve excavating a trench 4’ 6” (1350mm) deep, 300’ (90000mm) long and 8’ (2400mm) wide which would accept 100 coffins laid side by side 3’ (900mm) apart. One hectare would accept about 2,000 bodies.

A collective burial site could be used purely to put bodies into a sterile environment, as soil has an antiseptic quality, in order to hold back decomposition. After the emergency the bodies could be exhumed for post mortem or reburial/cremation in the conventional way.

The duration of temporary internment should be considered:

- What is an acceptable period for temporary internment?
- Would there be post incident site use issues?

In view of the negative impact collective burial would only be instigated on the authority of the UK Civil Contingencies Committee where all other methods are unavailable.

See Exercise Gable report attached at Appendix 10

This is the findings of a collective Burial Exercise.

The LRF are reviewing the findings with our Cemeteries and Crematoria Representative. Work streams in respect of all aspects Disposal continue with the intention that Exeter District will pilot any training issues identified..

APPENDIX 5 (Detail required that will be built into the Local Authority Tactical and Operational planning)

Mortuary, Registration, Cemeteries & Crematorium

(Work streams in progress across the LRF to confirm and populate)

Existing capacity for dealing with deceased people across Devon and Cornwall								
Venue Contact details (Broken down by County / District / Parish)	Existing Mortuary Capacity	Total number of Registration Officers available	No. of Registers of Death held in the Authority	Maximum no. of Deaths that could be registered per day	No. of trained grave diggers employed	No. of graves dug per day	No. of certified crematoria operators employed by the Premise	No. of cremations per day
<u>DEVON</u>								
<u>TORBAY</u>								
<u>PLYMOUTH</u>								
<u>CORNWALL</u>								
<u>ISLES of SCILLY</u>								

APPENDIX 6

Devon Cornwall and Isles of Scilly Mass Fatality Arrangements

Summary

The Mass Fatality Plan outlines the arrangements in place within Devon Cornwall and Isles of Scilly to respond to mass fatality incident(s). The plan is split into three parts; Strategic overview, operational plan, and roles and responsibilities.

The plan describes the arrangements in place for responding to any incident involving fatalities where:

- Normal arrangements are overwhelmed
- There are multiple site linked incidents

Activation of Arrangements

Single Site

The decision to move to mass fatality arrangements will be made by the Coroner whose jurisdiction the fatalities fall within, in consultation and agreement with other stakeholders

In the event of the mass fatality arrangements being activated, Devon and Cornwall Police (D&CP) will at the Coroner's request, arrange a meeting of the Mass Fatalities Co-ordination Team (preferably within 9 hours of the incident). This meeting is likely to take place at the Strategic Co-ordinating Centre (D&CP HQ Middlemoor) or via telephone/video conferencing.

Multiple site *linked* incidents crossing police force areas

Regional arrangements could be activated for multi site *linked* incidents crossing county boundaries. The Coroner/s will activate these arrangements via the South West Regional Resilience Team.

Emergency Mortuary's

The plan contains information regarding Emergency Mortuary, sites, structures and equipment details; this should be used for reference in establishing a temporary body storage facility / ies.

APPENDIX 7

RRF Mass Fatality Arrangements

Summary

If the arrangements detailed in the Devon Cornwall and Isles of Scilly Mass Fatalities Plan are considered insufficient or in circumstances where there are multiple site incidents (linked or otherwise) crossing police force areas, regional arrangements will be activated.

The regional arrangement is essentially mutual aid, support and co-operation on a South West basis.

Activation

The Coroner/s will activate these arrangements via the South West Regional Resilience Team.

When regional arrangements are activated a Mass Fatalities Co-ordination Team will be convened. The primary role of this team is to ensure that the key elements of response are delivered on behalf of the Coroner and Overall Incident Commander.

The Home Office programme of assistance comprises of four elements

- National Emergency Mortuary'
- The UK Disaster Victim Identification Team (UK-DVI)
- Stockpiles of essential non-specialist mortuary equipment
- Specialist Mortuary Equipment

APPENDIX 8

Key Organisation Contacts (Detail required that will be built into the Local Authority Tactical and Operational planning)

(Work streams in progress across the LRF to confirm and populate)

Key Organisation Contacts:					
Organisation (Broken down by County / District / Parish)	Name	Contact address	Landline number	Mobile number	E-Mail
<u>DEVON</u>					
<u>TORBAY</u>					
<u>PLYMOUTH</u>					
<u>CORNWALL</u>					
<u>ISLES of SCILLY</u>					

APPENDIX 9

Funeral Directors Information & Contacts

(Detail required that will be built into the Local Authority Tactical and Operational planning)

(Work streams in progress across the LRF to confirm and populate)

(May need column inserted as to any agreement to work with Local Authority under an MOU ? as this work progresses)

Funeral Directors Information and Contacts.								
Company (Broken down by County / District / Parish)	Address	Landline & 1st contact	Police rota / out of hours	Capacity <i>a.</i> Usual <i>b.</i> Maximum	Capacity - Room for additional storage	Vehicles	Staff	Other info.
<u>DEVON</u>								
<u>TORBAY</u>								
<u>PLYMOUTH</u>								
<u>CORNWALL</u>								
<u>ISLES of SCILLY</u>								

APPENDIX 10

Extract from : POST EXERCISE REPORT SEPTEMBER 2008

Venue: Worcester Crematorium

EXERCISE GABLE

Thursday 4th September 2008

Exercise Aim and Objectives

Exercise Aim	Achieved
To exercise, or practice, whereby a collective grave is dug in a cemetery environment, in order to explore the practical issues, which may be identified.	✓

Exercise Objectives	Achieved
1. To identify what machinery and/or human resource is necessary to dig a collective grave	✓
2. To explore what size of collective grave is appropriate.	✓
3. To determine options on grave configuration i.e. how to best use available space	✓
4. To highlight practical issues for which solutions may be needed	✓
5. To give delegates an opportunity to view the process	✓

Issues raised and explored

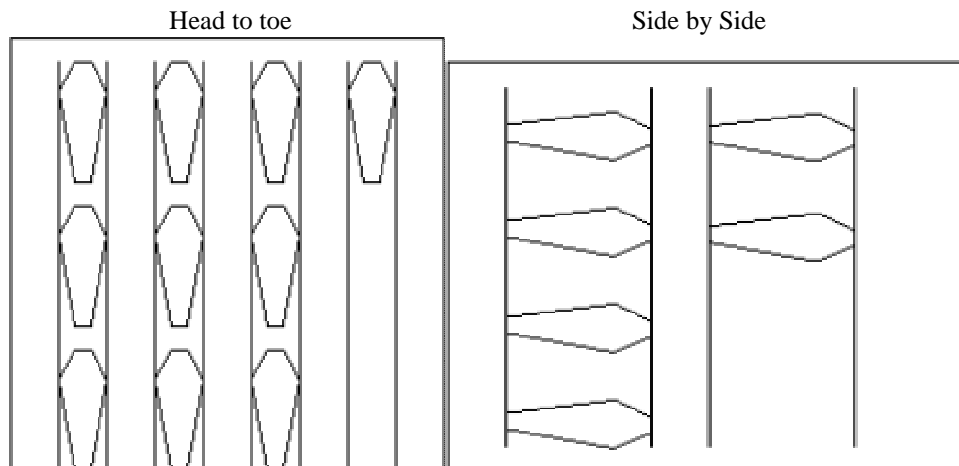
At the introductory briefing the following issues were raised.

1. Temporary interment followed by exhumation and permanent burial should be discouraged as an option.
2. The cost of exhumation is very high. Logistically because of shortage of staff and machinery, high human resource usage, religious, moral, health and safety and environmental issues it should be discouraged.
3. During PI, availability of coffins is likely to be an issue there won't be enough. Coffins suppliers will be out sourced therefore the use of body bags will be the alternative method however, body bags may also be out sourced. Identification of Body Bags and Coffins during the PI may need to be investigated.

Further issues were raised during discussion in the cemetery which were further discussed during the later de-briefing conversation.

4. The configuration of graves for collective burial was discussed; the two broad options were side-by-side interment or head to toe interment. Side by side presented difficulties in that it would be impossible to lower a coffin in traditional style. Head to toe allowed the creation of one grave (trench) and by introducing correctly sized sturdy bridges (allowing people to pass from one side to the other) would allow traditional lowering. Later in discussions it was acknowledged that this was the only realistic model allowing dignified traditional style lowering. Lowering practice also can only be carried out by trained personnel who have carried out manual handling and risk assessments.

Basic Principal of: -



5. Trench collapse is a risk, appropriate shoring struts must be available in the required quantity.
6. The width of the trench must be suitable to accommodate larger coffins. It would be possible to operate different width trenches in parallel.
7. The distance between trenches was proposed as 18". Post exercise observation: Worcester City Council have observed post exercise, that a wider gap maybe necessary potentially between 36" and 48" to support the weight of machinery in all weathers. The extra spacing could then be utilised at a later date. This would allow the possibility of purchase in reserve for future family interments.
8. Capacity was discussed, i.e. how many burials could take place in sequence. The requirement or not to have a funeral service was relevant to this issue. Capacity is also directly related to the capacities of undertakers.
9. The presence of mourners at a trench graveside was noted as having health and safety implications.
10. There were discussions about digging trenches that were single depth or double depth graves. Linked to this was the issue of family burial as against burial with strangers, legal and cemetery documentation will still be required as normal therefore the facility for purchase of right of burial or non-purchased graves will still be a factor and subsequently records of all interments will be kept in the normal manor.
11. It was observed that there might be security issues at such a gravesite.
12. It was acknowledged that public gatherings could be limited by special powers though this was felt to be unlikely.

13. There was discussion about the requirement for a funeral service which may be shortened to maximise time.
14. It was queried whether side by side as against head to toe burial used up more land or less. Attendees believed that there is no difference.
15. Soil type, ease of digging and water table height were noted as relevant. Cemetery operators should have a detailed site survey completed in advance.
16. It was discussed as to whether there was any limit on the length of a trench and consensus suggested only the size and limitations of a cemetery.
17. It was observed that the model of collective burial by trench being explored did not equate to a 'mass war type grave'. In that model attendees anticipated many bodies being buried in one large grave, very quickly, probably without coffins and with little ceremony. The trench burial model being explored in the exercise was something of a 'half way house' in as much as it is designed for volume but still includes appropriate dignity and ceremony. It would also allow for individual monumental memorials to be placed on each gravesite at a later date if required.
18. It was noted that cultural issues would need detailed exploration. Burial of different faiths may raise issues that should be worked through in advance with diversity representatives.
19. A mechanical digger is required to dig a burial trench. The availability of such equipment should be explored per cemetery site. A two-person team is required to dig using the mechanical digger; operators must be trained and certificated for the activity as well as appropriately insured. More than one width of digger bucket may be required. Hand finishing of a trench may be necessary. Experience in digger operation and training has to be taken beforehand with a four hour digger driver test conducted by external examiners. (This is a specialist test designed for mechanically grave digging on Local Authority land as opposed to generic Construction Industry Training Board (CITB) Mechanical digging).
20. Planners should calculate exactly what their likely land/space requirements are against the predicted rate of death models in national guidance.
21. Digging a trench to the wider requirement will allow the full range of narrow to wide coffins to be accommodated.
22. The question was raised as to whether all burials would be conducted this way during PI or just those deaths attributed to the virus. It was noted that it may be practically difficult to manage more than one 'standard' arrangement for burial therefore the collective trench is likely to become the only option.
23. Planners should be modelling the likely throughputs at their sites and anticipating the likely logistical issues. For example, if throughput is raised this may lead to a substantial increase in graveside mourners present at one time with other attendant problems around car parking.
24. It was noted that the requirement for grass matting, webbing and struts at graveside would continue as normal standard practice. There will be a need for wooden bridge structure also.

During facilitated closing de-brief discussion the following issues were highlighted being significant.

- Cemeteries should be surveyed in advance (see point 15).
- The number of burials per day should be modelled in advance and attendant logistical consideration be identified (see point 24).
- During PI it may be necessary for authorities, LRFs, counties etc to assemble an excess deaths implementation and logistics sub-group, which would report as appropriate through co-ordination channels.
- Increasing body storage capacity was identified as being crucial in the anticipated circumstances. Planners should prioritise the identification of increased capacities in their local areas.
- The use of 'plain' chilled storage vehicles was identified as a potential part solution but the associated economic damage may prevent this option. Also with the predicted levels of XS deaths Countrywide there will not be enough for this to be a feasible option.

APPENDIX 11

Details from Annex G Framework for Planners Preparing to Manage Excess Deaths

ANNEX G: ProForma for SCG Request to RCCC for Implementation of Phase Three

To: [insert name] Regional Resilience Director GO [insert Region]

From: [insert name] Chair, SCG [insert area]

MANAGEMENT OF EXCESS DEATHS – REQUEST TO MOVE TO PHASE THREE

I am writing further to my regular situation report to request that you endorse this request to CCC to implement Phase Three according to the sequence of events set out in the *Framework for Planners Preparing to Manage Excess Deaths* and the LRF Plan for [insert area].

In line with the LRF Plan, the SCG has implemented the following Phase Two measures:

Phase Two Different Ways of Working	Date of Implementation

However, due to [insert local circumstances e.g. staff absenteeism in the registration service] and the number of excess deaths we are suffering locally these measures have not proven sufficient to manage the level of fatalities we are currently experiencing and [insert anticipated consequences and timescale for service failure].

I have the agreement of all the members of the SCG in making this request.

We further request the implementation of the following Phase Three Section Two Different Ways of Working:

Phase Three Section Two Different Ways of Working Requested

Signed: Chair of the [insert area] SCG
Name:
Date:

Endorsed: Regional Resilience Director GO [insert region]
Name:
Date:

APPENDIX 12

Links and Further Information

General Guidance and Information

UK Resilience <http://www.ukresilience.info>

Registrars

Office of National Statistics <http://www.statistics.gov.uk/>

Office of Public Sector Information www.opsi.gov.uk

General Register Office <http://www.gro.gov.uk>

Mortuary

Association of Anatomical Pathology Technologists - <http://www.aaptuk.org>

Funeral Directors

National Association Funeral Directors <http://www.nafd.org.uk>

Society of Allied and Independent Funeral Directors <http://www.saif.org.uk>

HM Coroner

Department of Constitutional Affairs <http://www.dca.gov.uk/>

Coroner's Officers Association <http://www.coronersofficer.org.uk>

Burial Cremation & Crematorium

Department of Constitutional Affairs <http://www.dca.gov.uk/>

Institute of Cemetery & Crematoria Management

<http://www.iccm-uk.com/>

Federation of Burial and Cremation Authorities <http://www.fbca.org.uk>

Faith Issues

Department for Communities and Local Government

<http://www.communities.gov.uk>

Mortuary Guidance

Human Tissue Authority <http://www.hta.gov.uk>

Relevant Documents and Plans

UK Influenza Pandemic Contingency Plan

www.dh.gov.uk/en/pandemicflu/index.htm

Pandemic Flu – Workplace Guidance

HSE guidance promoting personal hygiene measures

www.hse.gov.uk/biosafety/diseases/influenza.htm

The needs of faith communities in major emergencies – Home Office

www.ukresilience.info

Glossary of Terms

Bereavement – the loss, through death, of someone to whom there has been a strong attachment.

Burial – the placing of a body in a grave.

CAERP – LRF Combined Agency Emergency Response Protocol.

Coroner – The Official who has responsibility for the investigation of violent, sudden or suspicious deaths. May instruct or issue **Coroners Forms** :

Form A – Form issued to the registrar of births deaths and marriages by the coroner when he is satisfied that the death was from natural causes. Known as 'Part A'.

Form B – Form issued to the registrar of births, deaths or marriages by the coroner after post-mortem.

Authority for burial or cremation – registrar's authority for burial or cremation usually issued after death registration. Known as 'the green'

Burial Order – coroner's authority for a burial to take place issued after inquest adjourned.

Form E – coroner's authority for a cremation after post-mortem

Cremation – to reduce the body to ashes by burning.

Cremation Certificates – forms which need to be completed for a cremation to take place. A funeral director will arrange for these to be signed and delivered to the crematorium.

Application for Cremation (Form A - Now Form 1) - This is required for all cremations and is completed and signed by someone representing the family and the funeral director.

Certificate of Medical Attendant (Form B - Now Form 4) - This is completed and signed by a doctor who attended the deceased before death and who has also seen and identified them after death.

Confirmatory Medical Certificate (Form C - Now Form 5) - This is completed and signed by a different doctor who has seen the deceased after death.

Consultant Histopathologist - Specialist Doctor in examining tissue and diseases

Authority to Cremate (Form F - Now Form 10) – This is completed and signed by the Medical Referee at the crematorium once they are satisfied that all the legal requirements have been met, that the cause of death has been definitely ascertained and that there is no need for any further enquiry or examination . The medical referee has power to refuse cremation, order a post-mortem examination or refer the death to the Procurator Fiscal.

Death Certificate – A copy of an entry in the Register of Death. An official document issued by the Registrar of Births, Marriages and Deaths when the death is registered at the Register Office. There is a small fee for this and you may need extra copies for insurance, banking, pension or other purposes. It is officially known as an '**extract of an entry in the register of deaths**'.

Extract of an Entry in the Register of Deaths - commonly known as a 'copy of the death certificate' (see above).

Funeral Director (also called an Undertaker) – someone whose business is preparing bodies for burial or cremation and arranging and managing funerals.

GP – abbreviation for General Practitioner, the family doctor.

Medical Certificate of the Cause of Death (MCCD) – an official document issued by a doctor, stating the date, place and cause of a person's death. You will need this to register the death.

Post Mortem Examination – a medical examination of the body after death to determine the cause of death (conducted by a **Pathologist**).

Procurator Fiscal – (Scotland only – similar functions to that of Coroner) a public official who has a duty to enquire into the cause of death where it has been sudden, unexplained or where there is reason to suppose that it might not be due to natural causes.

Registrar of Births, Marriages and Deaths – a public official responsible for keeping a record of births, marriages and deaths in their district.

Specialist Registrar – A doctor who is receiving advanced training in a specialist field of medicine in order to eventually become a consultant.

Will – a legal declaration of how somebody wishes to have their property and possessions distributed after their death.

Abbreviations

ABBREVIATIONS

ACS	Adult and Children's Services
BCP	Business Continuity Plan
CAERP	Combined Agency Emergency Response Protocol
CCC	Civil Contingencies Committee
CCC(O)	Civil Contingencies Committee (Officials)
CCDC	Consultant in Communicable Disease Control
CCS	Civil Contingencies Secretariat
CLG	Department of Communities and Local Government
CLO / CO	Coroners Liaison Officer / Coroners Officer
COBR	Cabinet Office Briefing Rooms
CRIP	Common Recognised Information Picture
DAs	Devolved Administrations
DCSF	Department for Children, Schools and Families
DEFRA	Department for the Environment, Food and Rural Affairs
DH	Department of Health
EPS	Emergency Planning Service
GO	Government Office
GOSW	Government Office for the South West
GP	General Practitioner
HICC	Health Incident Coordination Centre
HPA	Health Protection Agency
JMG	Joint Media Guide
JRLO	Joint Regional Liaison Officer
LA	Local Authority
LRF	Local Resilience Forum
MACP	Military Aid to the Civil Power
MCG	Mass Casualties Guide
MIJPG	Major Incident Joint Procedures Guide
MoD	Ministry of Defence
MMU	Media Monitoring Unit
NHS	National Health Service
OFT	Office of Fair Trading
OGD	Other Government Department
PASA	NHS Purchasing and Supply Agency
PCT	Primary Care Trust
PF	Pandemic Flu (Influenza)
PW&I	Public Warning and Information
RCCC	Regional Civil Contingencies Committee
RDPH	Regional Director of Public Health
RRF	Regional Resilience Forum
RRT	Regional Resilience Team
SCC	Strategic Command Centre
SCG	Strategic Coordinating Group
SITREP	Situation Report
STAC	Scientific & Technical Advice Cell
WHO	World Health Organisation