



Department
of Health &
Social Care

Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Government response to consultation

DH ID box
<p>Title: Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Government response to consultation</p>
<p>Author: Directorate/ Division/ Branch acronym / cost centre GPH/PH/HE/24641</p>
<p>Document Purpose: Policy</p>
<p>Publication date: June 2018</p>
<p>Target audience: NHS and Social Care Organisations Local Government Central Government General public Bereavement Services Funeral Industry Professional and Regulatory Bodies Religious or Faith Groups Coroner Services Healthcare Professionals Registration Services</p>
<p>Contact details: Death Certification Reform Programme Team Department of Health and Social Care, 2N16, Quarry House, Quarry Hill, Leeds LS2 7UE</p>

You may re-use the text of this document (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit:

www.nationalarchives.gov.uk/doc/open-government-licence/

© Crown copyright 2018

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Contents

Contents

1. Introduction	5
2. Consultation and Engagement	7
3. Summary of responses	9
4. Funding local medical examiner system in England	10
5. Death Certification Regulations	13
6. Notification of Death to Coroners Regulations	17
7. Cremation Regulations	25
8. Conclusions and Next Steps	26
Annex A	28
Annex B	36

1. Introduction

- 1.1. The death certification system in England and Wales is overdue for reform - it has remained largely unchanged for over fifty years. Introducing a robust system in England and Wales whereby all deaths would be subject to either a medical examiner's scrutiny or a coroner's investigation has been an ambition of successive Governments and ministers since 2007. We are therefore very pleased to publish this document which sets out the changes we intend to make following our consultation.
- 1.2. A high level consultation was undertaken in July 2007 in response to observations made in the Third Report of the Shipman Inquiry Chaired by Dame Janet Smith. This Inquiry proposed a radical overhaul of the system of death certification and the process that follows and a common approach to certification and scrutiny, regardless of whether a body was to be buried or cremated by a medical examiner system. The report of the Mid Staffordshire NHS Foundation Trust public inquiry report, published in February 2013, made a number of observations about certification and inquests relating to hospital deaths.
- 1.3. The medical examiner system will promote a robust, transparent system of independent scrutiny to the process of death certification. The key aims are to:
 - Introduce medical examiners to provide a system of effective medical scrutiny applicable to all non-coronial deaths;
 - Enable medical examiners to report matters of a clinical governance nature to support local learning and changes to practice and procedures;
 - Provide information on public health surveillance (as requested by Directors of Public Health);
 - Increase transparency for the bereaved and offer an opportunity to raise concerns;
 - Improve the quality and accuracy of medical certificates of cause of death;
 - Link the introduction of medical examiners with enhancements to related systems, especially data on avoidable mortality, generated from the Learning from Deaths programme.
- 1.4. A new local medical examiner system with medical examiners appointed within the NHS has been delivered in a number of different locations in England and Wales which has demonstrated that a medical examiner system can work in a range of settings: in hospital, in the community, in urban and in rural areas. The two flagship pilots in Gloucester and Sheffield have been extended to enable the pilots to operate on an urban and rural basis to test how a medical examiner system may work on a scale that will be required for wider implementation. These two sites are now valuable resources to show how a medical examiner system would operate in practice.
- 1.5. The response to the consultation demonstrates that there is widespread support for the aims of the reforms and for the introduction of medical examiners but there were concerns about some aspects of the proposals. In particular, concerns were raised about how the proposed model, to be based in local authorities, would work in practice and about the proposed timeframes for implementing the system. Feedback on a proposed funding model was also received. Since the Government consulted on the package of Death Certification reforms events have moved on. New information on how medical examiners could be introduced across England within the NHS has been generated by

our pilot sites and NHS Trusts that have adopted a medical examiner model to support their work on the Learning from Deaths process, which has been in place since March 2017. Going forward section 21 and 18 of the Coroners and Justice Act 2009 will be commenced, this will provide for the appointment of a National Medical Examiner and a power to introduce regulations that would require medical practitioners to report deaths to the coroner for which the coroner has a duty to investigate. We will progress with the introduction of the medical examiners by April 2019 and, in parallel, explore the option to amend the 2009 Act to make the requirement for medical examiners statutory. The revised plans are designed to respond to the issues raised in consultation, to reflect developments within the NHS and to build on elements of the process that have been shown to deliver real improvements, in particular, for the bereaved.

2. Consultation and Engagement

- 2.1. The Government's consultation on medical examiners and reforms to death certification ran from 10 March to 15 June 2016. It invited comments on proposals for a number of changes to the death certification process, safeguards before a deceased person's body can be cremated or buried and registration of deaths in England and Wales as well as formalising the reporting of deaths to the coroner.
- 2.2. Successive governments have attempted to introduce reforms to death certification. This involves a complex set of reforms across a number of Government departments. We will ensure that the changes that we make take account of the cross Government requirements whilst focusing on what is achievable.
- 2.2. The Coroners and Justice Act 2009 provides a legal framework for reforms in both England and Wales. It also allows Ministers in Wales to develop their own regulations in respect of key aspects of the new system, including the terms for the appointment of medical examiners and their functions.
- 2.3. In terms of legislative changes the consultation invited comments on the Department of Health and Social Care's proposed regulations requiring a doctor's certification of cause of death to be scrutinised and confirmed by an independent medical examiner taking into account any concerns that the bereaved or informant (a representative of the deceased person) have, including about the care the deceased received before their death. Under this reformed system, a cause of death will only be registered after either scrutiny by a medical examiner or a coroner. We also consulted on the Ministry of Justice's proposed regulations requiring doctors to report certain deaths to the coroner.
- 2.4. The associated regulations the Government consulted on were:
 - The Death Certification Regulations
 - The Death Certification (Medical Examiners) (England) Regulations
 - The Death Certification (Medical Examiners) (Fees) (England) Regulations
 - The National Medical Examiner (Additional Functions) Regulations
 - The Notification of Deaths Regulations
- 2.5. We sought views on the impact that the introduction of the medical examiner system, set out in the Coroners and Justice Act 2009, will have on the necessary documentation and procedures in advance of cremations.
- 2.6. The Welsh Government will consider what regulations would be appropriate in respect of Wales only and have consulted on these separately.

Further stakeholder engagement

- 2.7. In addition to the public consultation the Death Certification Reforms programme team, with support from the Gloucester and Sheffield Medical Examiner pilot sites, undertook a series of engagement activities either by attending local network events in person or disseminating information via digital means. The Department of Health and Social Care tweeted the consultation to its 199,000 followers. Details of these activities can be found at Annex B.

- 2.8. We are especially grateful to Dr Suzy Lishman and the Royal College of Pathologists for providing an opportunity to discuss strategic issues affecting the scope and implementation of the reforms at the roundtable discussions held on 1 June 2016 with key delivery partners and national organisations. A summary of the key discussion points was published on the Royal College of Pathologists website.
- 2.9. This document summarises the responses to the consultation and stakeholder engagement activities and explains how these have influenced the decisions the Government has made regarding improvements to death certification in England and Wales.
- 2.10. The following chapters set out the key issues raised by respondents and our response and proposed actions. We have grouped the questions thematically within each chapter. We have sought to reflect balanced input from respondents.

3. Summary of responses

- 3.1. In total, there were 265 responses to the consultation. Of these, 13 were from individuals (members of the public) with the remaining 252 from a range of organisations including NHS / social care organisations, professional and regulatory bodies, healthcare professionals, faith communities, local / Central Government (including Registration Services), the funeral industry, Cremation and Burial Authorities and coroners and coroner service managers.
- 3.2. The following table breaks down the respondents to the consultation into categories.

Category	Number of Respondents
NHS / Social Care organisations	30
Professional or Regulatory Bodies	22
Individual Healthcare Professionals	44
Religious Faith Groups	5
Local / Central Government*	76
Funeral Industry	17
Cremation and Burial Authorities	5
Members of the public	13
Other**	49
Not Answered	4

* Includes Registration Services

** Includes Coroner Services

- 3.3. Respondents had the option to submit their responses either on-line or in a questionnaire form by email. Some organisations and networks chose to respond on behalf of their members but for the purposes of the above table, we have counted such responses as a single response. Some respondents opted to submit their responses in the form of a more general letter addressing the broad topics of the consultation.
- 3.4. Respondents were broadly supportive of the proposals set out in the consultation document leading to an improved death certification process with the bereaved at the heart of a more transparent system.

4. Funding local medical examiners system in England

Liability to pay the medical examiner fee

The Coroners and Justice Act 2009 provides for the medical examiner system to be funded by a fee payable to local authorities in England or local health boards in Wales. In the consultation we proposed that the medical examiner service would be funded by a single fee paid by the person who gives the medical certificate of cause of death to the Registrar, who in most cases will be a member of the deceased's family.

We sought views on whether a person should be prescribed in legislation as responsible for paying the medical examiner fee and who that person should be. We also sought views on whether any fee exemptions should apply.

Q1. Do you agree that an individual should be prescribed in legislation as being responsible to pay, or to arrange to have paid, the medical examiner fee?

Over two thirds of the total number of respondents answered this question with the majority of those who answered agreeing that an individual should be prescribed in the legislation as being responsible to pay the fee. The executor of the deceased's estate was proposed but it was highlighted that this is not a complete solution as there is not always an executor identified.

Q2. Should the person prescribed be:

A) the individual that collects the medical certificate of cause of death from the medical examiner, or B) the death registration informant?

The draft Death Certification Regulations provide that the attending doctor or medical examiner must ensure that reasonable steps are taken to make the certificate available for collection by or delivery to the prospective informant, or another person nominated by the prospective informant, within two days of completion. In the regulations, the prospective informant means the person who intends to be the informant in relation to the death. The term 'informant' is defined in section 20(7) of the Coroners and Justice Act 2009 as the person who gave particulars concerning the death to the Registrar under section 16 or 17 of the Births and Deaths Registration Act 1953. In other words, the death registration informant is the person who registers the death at a register office.

Less than half of all respondents answered this question. Of those who did answer the question, the majority agreed that person prescribed in legislation should be the individual who collects the medical certificate of cause of death or the death registration informant.

There was no clear consensus of views on which specific person should be prescribed given the format of the online consultation question.

Other suggestions from respondents were the executor of the will, beneficiary or next of kin or to identify a list of relevant people.

Response and proposed action

- We have considered carefully the responses received. At this time we do not propose to proceed with all the elements of the reforms consulted upon. The revised plan is for a medical examiner system operating in the NHS in England, based on the model developed in the pilots supported by Department of Health and Social Care and demonstrated by the early adopter sites. There will be two stages to funding the ME system to enable its introduction while legislation is in progress. Initially, medical examiners will be funded through the existing fee for completing medical cremation forms, in combination with central government funding for medical examiner work not covered by those fees. Following this interim period and when Parliamentary time allows for the system to move to a statutory footing, the existing medical cremation forms and fees payable associated with those forms will be replaced by the new medical examiner forms and an equivalent fee in respect of scrutiny of deaths for both cremation and burial.
- Legislation to create a National Medical Examiner will be taken forward. The Coroners and Justice Act will be amended when an opportunity arises to put the medical examiner system on a statutory footing. Further legislative requirements will be reviewed post implementation in April 2019.
- To date the pilots demonstrate engagement with the bereaved, where positive feedback has been received, improved quality of death certification and enhanced scrutiny. The pilots also suggest the service has worked efficiently with the coroner service, improving the quality and appropriateness of referrals.

Q3. Should the regulations exempt an official or employee who acts as an informant, as being responsible to pay, or to arrange to have paid the medical examiner fee?

The draft Fees Regulations do not exempt an official or employee who collects the medical certificate of cause of death or acts as informant from paying the medical examiner fee. We sought views on whether there should be such an exemption.

There were a range of views on whether the Fees Regulations should contain an exemption and which people should be exempt from paying the medical examiner fee.

For example, some respondents pointed out that in the current system some individual doctors make a personal choice to waive cremation form fees for deaths of children and called for a fee exemption to apply to families of deceased children.

Response and proposed action

Going forward, the Government has proposed that it is appropriate that all child deaths (up to age 18) be exempt from the cost associated with the medical examiner system including the existing medical cremation form fees.

The Department of Work and Pensions remains committed to supporting vulnerable people going through bereavement. This includes providing Funeral Expenses Payments to help people on qualifying benefits with the costs of arranging a funeral.

Collection of the medical examiner fee

In the consultation, we set out how it is not always convenient or sensitive to deal with payment of a medical examiner fee immediately and proposed a time limit in the draft Fees Regulations.

We also outlined that local authorities would have discretion to determine the local process for payment and could, if they wished, work with third parties such as funeral directors. We sought specific views from local funeral services on whether they would be willing to collect the medical examiner fee.

Q4. Should there be a 28 day or three month period for payment of the medical examiner fee?

Q5. As a local funeral service would you be willing to collect the medical examiner fee on behalf of the local authority, for a small administrative charge? The bereaved would see the fee itemised in the funeral director's bill. YES/NO

Response and proposed action

As a new public fee is not being introduced at this time, the consideration of the time period for payment is not currently relevant. The Government will further consider this when reviewing relevant legislation post April 2019 and in the interim the existing medical cremation forms will be retained. In practice, the existing method for collection of the medical cremation form charge is likely to remain in place. We will consider whether it is necessary and appropriate to take any steps to amend the existing collection arrangements going forward.

5. The Death Certification Regulations

The draft Death Certification Regulations covers much of the detailed process for death certification under the new system.

Administrative and Clinical Information

Q6. Do you believe the provision of “administrative and clinical information” set out in Schedule 1 is necessary and sufficient for all deaths, either for a medical examiner’s scrutiny or for a coroner’s investigation? If not, what would you add or delete and why?

The consultation sought views on the meaning of "administrative and clinical information" in Schedule 1 of the Death Certification Regulations. We received substantial comments about the administrative and clinical information from a small number of respondents such as avoiding duplication of information where possible, but generally respondents agreed with the list.

Response and proposed action

As the full set of legislative changes is not being made at this time, responses in relation to Schedule 1 are not relevant. We will revisit the legislative requirements for revising the statutory certification process post implementation in April 2019 and will have regard to the comments we have received in finalising the list in Schedule 1 at that time. In the interim, the National Medical Examiner will consider exactly what the medical examiner should document and provide guidance where it is required.

Stakeholders have raised the need for the medical examiner system to be a computerised. A digital strategy is under development to explore ways to make the process of information flow digital. Working with key stakeholders throughout the system the aim is to provide a digital by default solution where possible.

External Examination of the Body

Q7. Do you agree that the medical examiner should have discretion about whether an independent non-forensic external examination of the body is necessary?

The draft Death Certification Regulations say that a medical examiner may undertake an external examination of the body or instruct another individual (whom the medical examiner considers to have suitable expertise and be sufficiently independent) to do so on their behalf. We sought views on whether the medical examiner should have this discretion.

The majority of respondents agreed that the medical examiner should have discretion about whether an independent non-forensic external examination of the body is necessary. Attending doctors will continue to have the option of carrying out an examination of the body when establishing a cause of death. Any observations noted, or the fact that an examination had been carried out, must be shared with the medical examiner.

Some respondents proposed that there should be some principles surrounding a non-forensic external examination of the body. Specifically in relation to provisions being made for certain groups, for example faith groups or child deaths, where a specific request is made for a medical practitioner to view the body.

Q8. In your view, are there sufficient safeguards if a person without a medical qualification but with suitable expertise and sufficient independence carries out a non- forensic external examination of the body on behalf of the medical examiner?

The draft Death Certification Regulations set out circumstances in which the medical examiner can appoint an individual with suitable expertise to undertake an external examination of the body. We sought views on whether there are sufficient safeguards in relation to this.

Some respondents suggested that, with the exception of certain cases, this activity can be carried out by for example funeral directors and mortuary technicians, a medically trained professional or a non-medical professional.

Response and proposed action

Based on the responses to the consultation and the Shipman Inquiry's observations, medical examiners should be able to make arrangements to appropriately delegate non-forensic external examination of the body. We would expect a medical examiner to have regard to whether the individual conducting the non-forensic examination has completed the external non- forensic examination session of the e-learning medical examiner module. This might include, for example, a coroner's officer or mortuary staff.

We would expect that National Medical Examiner guidance will reflect the above concerns for example, in relation to faith and age and in specific circumstances for a non-forensic external examination of the body by a medical practitioner.

Medical Examiner Process in Periods of Emergency

Q9. Under regulation 26, do you agree that the medical examiner process should be suspended during a period of emergency?

Regulation 26 of the draft Death Certification Regulations sets out how the Regulations apply during a period of emergency. We sought views on the operation of regulation 26.

A significant number of responses supported that the medical examiner process should be suspended during a period of emergency. This would free up medical practitioners to provide care as well as certify deaths when the healthcare system might be under added pressure. Some respondents suggested that the term 'emergency' should be clearly defined in regulations.

There were suggestions that there should be retrospective scrutiny of deaths after the emergency ends because at times of pressure, there is a greater risk of clinical governance matters/suspicious deaths going undetected.

Q10. Do you agree that during a period of emergency any registered medical practitioner could certify the cause of death in the absence of a qualified attending practitioner?

Respondents were generally in agreement that during a period of emergency any registered medical practitioner may certify the cause of death in the absence of a qualified attending practitioner.

Response and proposed action

We will explore how the medical examiner process will operate during a period of emergency including how to suspend the process so that, in the absence of a qualified attending practitioner, any registered medical practitioner could certify cause of death.

The Coroners and Justice Act 2009 defines the term 'period of emergency' as "a period certified as such by the Secretary of State on the basis that there is or has been, or is about to be, an event or situation involving or causing, or having the potential to cause, a substantial loss of human life throughout, or in any part of, England and Wales."

Q11. Are the proposed certificates and medical examiner forms set out in schedules 2-7 fit for purpose? If not, please say why.

Of those who responded to the question, they were generally content with the proposed certificates and medical examiner forms. A very small number disagreed.

Response and proposed action

The existing medical cremation forms will be retained at this time. Medical cremation form 5 may be completed by a medical examiner. We will revisit the statutory certification process and any associated forms post implementation in April 2019. In the interim it is our intention to develop standardised forms recommended for use by all medical examiners.

Standard for medical examiners

Q12. In relation to regulation 5 of the National Medical Examiner Regulations, what other aspects should standards cover for monitoring medical examiners' levels of performance?

The draft National Medical Examiner (Additional Functions) Regulations set out additional functions for the National Medical Examiner which would include setting standards for medical examiners and issuing guidance to local authorities in England and local health boards in Wales.

Response and proposed action

We are grateful that the Royal College of Pathologists, as the lead College for medical examiners, has expressed their intention to finalise draft standards to support monitoring. These will be published for use in the NHS, not local authorities.

As far as professional performance standards are concerned, medical examiners are first and foremost registered medical practitioners and therefore subject to the oversight of the General Medical Council, as the professional regulatory body for medical practitioners.

Revalidation is the process by which all registered medical practitioners are required to demonstrate on a regular basis that they are up to date and fit to practice in their chosen field. For the purposes of revalidation of medical examiners, the National Medical Examiner will work with the Royal College of Pathologists to issue additional guidelines to support this process.

Q13. Do you agree with the estimates of costs and benefits of the death certification reforms set out in the consultation impact assessment?

At this stage a new public fee to pay for the service will not be introduced. The existing medical cremation forms and associated fees will continue to apply. An impact assessment accompanies this Government response to consultation and takes account of comments received.

6. The Notification of Deaths to coroners' Regulations – Regulations made under section 18 of the Coroners and Justice Act 2009 and associated guidance

Under section 1 of the Coroners and Justice Act 2009, coroners have a duty to investigate a death where there is reason to suspect the deceased 'has died a violent or unnatural death', or the cause of death is unknown, or, in all cases where the death occurred while the person was in custody or otherwise in state detention.

In order to make sure doctors are clear about which deaths they should report to the coroner, the consultation document asked for views on draft Notification of Death Regulations that set out which deaths medical practitioners must notify to the coroner and the process for doing so. We proposed in the consultation that the requirement to report to the coroner a death of unknown cause will be provided for through the referral regulations included in the draft Death Certification Regulations.

With a revised approach where the implementation of Death Certification Regulations has been deferred we will still implement the Notification of Death Regulations which we will revise to require medical practitioners to report to the senior coroner a death of unknown cause. The draft guidance will also be amended to reflect this change.

Q14: Do you agree that a death should be notifiable if it is “otherwise unnatural”?

Draft Notification of Death Regulations 3(2) (a) to (g) specified particular circumstances of deaths which medical practitioners must refer to coroners. We asked for respondent views on draft regulation 3(2) (h) which then referred to 'otherwise unnatural' deaths, to encompass deaths which did not fall into the (a) to (g) circumstances, to make sure that doctors also refer any such deaths to coroners.

Over two thirds of the total number of respondents answered this question, and nearly all of those, including almost all healthcare professionals and a large number of local government authority respondents, agreed that the regulations should require doctors to notify coroners of 'otherwise unnatural' deaths. A very small number of respondents explicitly disagreed with the proposed regulation and a small number of respondents provided additional comments without answering Yes or No.

Q15: Do you believe there is sufficient understanding between members of the medical and coronial professions as to the meaning of “unnatural” and that further definition is not required? If not, we would be grateful for suggestions as to what the guidance may include.

Nearly two thirds of respondents answered this question. Over one-third of those agreed that there is sufficient understanding in the coroner and medical professions as to the meaning of 'unnatural', while a third of respondents disagreed. The remainder who responded did not indicate whether they agreed, but provided related comments. All but two coroners who answered the question indicated that they did not believe there was sufficient understanding of 'unnatural'.

Response and proposed action

- Consultation responses suggest that there is considerable variation in understanding of the term ‘unnatural’ with concern about how medical professionals might interpret the term when deciding whether they would have a duty to notify a coroner of a death under the new regulations.
- We also recognise the concerns made that the use of the term ‘otherwise unnatural’ as a catch-all potentially excludes a natural but unexpected death. However, regarding such “unexpected” deaths the draft guidance provides that in circumstances where the death ‘is related to any treatment or procedure of a medical or similar nature’ and the death ‘occurs unexpectedly given the clinical condition of the deceased prior to receiving medical care’ then it should be reported to the coroner. Further, the draft guidance where the death was ‘otherwise unnatural’ states a death is unnatural unless it resulted from ‘...a naturally occurring disease process running its full course’.
- We consider that “otherwise unnatural” is the best term to use in section 3(2) (h) of the regulations for these categories of death. This reflects the wording of section 1(2) (a) of the Coroners and Justice Act 2009.
- Given the concerns regarding whether the regulation includes unexpected deaths we will review our guidance on the new regulations to ensure that there is clarity that ‘otherwise unnatural’ includes where a naturally occurring disease has not run its course in an expected manner.

Q16: Do you agree that provision needs to be made with regard to poisoning, given that cases of poisoning are rare?

This question asked whether specific provision for poisoning was needed in the regulations given the rarity of poisoning cases. Over half of the respondents answered this question and, of these, well over three quarters agreed that provision needed to be made with regard to poisoning. Some respondents who did not express a view indicated that this question was for coroners to respond to. All but one coroner were content with the draft regulation.

Most respondents agreed that even though poisoning fell under the “otherwise unnatural deaths” at regulation 3(2) (h), it was better to explicitly refer to it.

A small proportion of respondents (less than a tenth) argued that specific provision for poisoning was not appropriate in the regulations, suggesting that poisoning was adequately covered by “otherwise unnatural” deaths.

Q17: Do you believe that “poisoning, the use of a controlled drug, medicinal product or toxic chemical” sufficiently covers all such circumstances of death? If not, should the guidance be broadened?

Paragraph 3(2) (a) of the draft regulations says that a medical practitioner should refer a death to a coroner if he/she has reason to suspect that the death occurred as a result of “poisoning, the use of a controlled drug, medicinal product or toxic chemical”. Question 17 asked whether this sufficiently covered all the circumstances of a poisoning-related death. Over half of respondents answered this question, with around two thirds of those indicating that they agreed. Respondents across all categories answered the question, with local and central government respondents providing the majority of answers given.

A quarter of those who answered this question did not agree with the wording of the regulation, although many of those suggested ways that the guidance could be used to

supplement the regulation, there was also concern that the currently drafted regulation potentially excluded some types of poisoning. There was also concern that properly administered medicines could, but may not always be, interpreted as a poisoning death.

Response and proposed action

- We note the reasons given by those who consider ‘poisoning’ to be significant enough to be identified separately in regulations. We therefore propose to retain it as a discrete category in the notification of deaths regulations.
- We will consider again the wording at paragraph 3(2) (a) of the draft Notification of Deaths Regulations in the light of concerns that it does not sufficiently account for all the relevant circumstances in which a person might be exposed to a poison or the full range of agents that can result in poisoning.
- We recognise the potential overlap between poisoning in a medical setting and deaths that are related to a medical treatment or procedure. We will review our guidance to provide clarity on the appropriate category to use and importantly to ensure no relevant circumstance falls between the two.

Q18: Do you believe there is a sufficient understanding of “neglect”? If not, should this be made clearer in the draft regulations rather than guidance?

Draft regulation 3(2) (g) would require a medical practitioner to notify a coroner of a death if there was reason to suspect that the death “occurred as a result of neglect or failure of care by another person”. A total of 159 respondents addressed this question, with over half confirming their view that there is not currently a sufficient understanding of the term ‘neglect’.

On the other hand over a third who answered this question considered that there was sufficient understanding of ‘neglect’. Many of these respondents came from the healthcare professional and local/central government categories. Nonetheless they still provided suggestions for further clarification of its meaning in guidance.

Some of those who did not provide a specific view suggested that this was a matter for coroners. Most coroner respondents did not believe that there was sufficient understanding of ‘neglect’.

While several coroners and other respondents felt that the ‘Jamieson’ definition should be given in guidance, other respondents, such as the Royal College of Pathologists, noted that guidance would need to evolve with the definition.

Many respondents, who agreed that there was a sufficient understanding of neglect, did not expand beyond this. Of those that did, some referred specifically to the medical profession’s good understanding.

Response and proposed action

- We propose to keep the wording of the notification of deaths regulation as set out in the draft – i.e. “occurred as a result of neglect or failure of care by another person;”
- We recognise that medical practitioners should have a clear understanding of “neglect” as it relates to the coroner’s duty to investigate a death so that medical practitioners notify all relevant deaths to coroners. We will therefore review the guidance in light of the concerns raised.

Q19: Do you agree that regulation 3(2) (e) – “occurred as a result of an injury or disease received during, or attributable to, the course of the deceased person’s work” – is clear that it includes any death that has occurred as a result of current or former work undertaken by the deceased, including cases such as mesothelioma or other asbestos related cases? If not, we would be grateful for alternative suggestions.

Two thirds of respondents answered this question. Many of those who did not provide a substantive answer said that the question was for coroners and medical professionals to answer. Nearly half of all answers to the question were received from coroners, medical professionals and NHS/social care organisations.

Nearly three quarters of those who provided an answer agreed that the regulation was clear, whilst around one sixth did not agree.

Many respondents, across those who agreed and those who disagreed with the proposed regulation submitted suggestions for its improvement.

A number of respondents wanted “current or former work” to be spelt out explicitly, and some emphasised that all occupations in the whole life of the deceased needed to be considered.

Many respondents suggested that the scope of the regulation should include cases where a deceased person was not necessarily engaged in the pertinent industry but nonetheless developed an industrial disease.

In contrast our draft guidance on the proposed regulations suggests such a death is an example of a death that ‘occurred as a result of trauma, violence or physical injury, whether inflicted intentionally or otherwise’.

A few respondents suggested that the regulation should have within its scope work-related psychological and other issues.

Some respondents suggested there were practical difficulties for doctors in fulfilling the regulations requirement.

Response and proposed action

- We recognise that it may be difficult for a medical practitioner to ascertain the deceased’s full work history over what can be many decades and in a variety of places. We do not consider that a full and comprehensive work history is required in order for medical practitioners to comply with this regulation. We consider that this information will, in most cases, already form part of the medical record insofar as the medical practitioner believes the work history to be relevant to the person’s health when they were living.
- We will give further thought to ensuring that recognised industrial diseases that are developed by people who were not actively employed in those industries but nonetheless have been equally exposed to the factors that cause such disease are reported to the coroner. We note the view that such cases should not constitute a death that occurred as a result of trauma, violence or physical injury” as described at 3(2) (b).

Q20: Do you agree that it should be possible to make notifications orally; but that where an oral notification is made the information must be recorded in writing and confirmed?

Draft regulation 4(3) provides for a medical practitioner to notify a coroner orally of a relevant death, requiring the coroner to then record the information in writing and the medical practitioner to confirm the record is correct. Almost three quarters of respondents answered question 20 and more than half of those were content with the draft regulation, although often with caveats. Over a quarter of respondents expressed concern about the draft regulation. Just over half of coroners supported the proposal.

Those who were supportive of allowing oral notifications often emphasised that they should be exceptional, for flexibility, and followed up with written notification within a strict time limit, such as 24 hours. Some coroners who agreed with the draft regulation qualified their support with the view that there should be a timescale for the written confirmation:

Response and proposed action

We recognise the potential that modern technologies have and will further have in allowing medical practitioners to retrieve and or/compose documents wherever they may be and at any hour of the day and to then immediately transmit those documents to the coroner service. We equally recognise that the same technologies can provide coroners access to that communication wherever and whenever.

However, despite these technologies we wish to exceptionally provide for medical practitioners to notify coroners of deaths in circumstances where it is not practical to provide the normal documented notification. We will use guidance to clarify those exceptional circumstances in which oral notifications will be permitted.

Where such oral notifications are accepted by the coroner we will provide that the coroner provides a written record to the notifying medical practitioner.

Q21: Do you agree that regulation 3(6) should prevent duplication of notification? We would be particularly grateful for views on how this would work in a surgical environment.

Draft regulation 3(6) removes the duty to notify from the medical practitioner where he or she reasonably believes that another medical practitioner has already notified the coroner of the death. Nearly half of all respondents answered this question, with over two thirds of those agreeing that regulation 3(6) should prevent duplication of notification. There was general support for the draft regulation across most of the respondent categories although, notably, few coroners who responded were in favour of it.

Some respondents were concerned to make sure that appropriate deaths were notified to coroners.

A small number of respondents did not agree with the proposed regulation because of the risk of a relevant death not being reported. These responses were received mainly from within the coroner, local government and healthcare categories who were concerned that deaths could go un-notified due to assumptions being made about previous notification.

Others who agreed with the proposal suggested that there might be merit in defining 'reasonably believes', as each member of the surgical team may well reasonably believe that someone else had completed the notification.

Response and Proposed Action

Responses to this question indicated broad agreement for the proposed regulation.

- We recognise the concerns expressed that in minimising the duplication of notifications we do not achieve the opposite effect where deaths are not properly notified to the senior coroner. While we do not propose to amend the regulation, we will review the draft accompanying guidance to stress the need for medical practitioners to be satisfied that coroners are notified of all relevant deaths, and that a duplication of a notification would be preferable to no notification at all.

Q22. Do you have any other comments about the draft Regulations?

Nearly two thirds of respondents answered this question, however, the comments received were wide ranging and included issues and concerns not related to the draft Notification of Deaths Regulations.

All respondent categories were represented, with the largest number of responses received from local government and health care professionals, with comments that related to the general proposals for death certification reforms and are addressed elsewhere in this document. A number of respondents addressed how the new regulations would be implemented.

Q 23 – In relation to the guidance, do you agree with the examples used under each category of death? If not, we should be grateful for further examples or suggestions for definitions.

Over half of respondents answered this question. Of these, over three quarters agreed with the examples used under each category of death and had no additional comments to make. Such responses were received from across all respondent categories.

Several representatives of local authority registration services said that paragraph 17 of the guidance should make clear that the category 'in prison, police custody or other state detention' includes Deprivation of Liberty Safeguarding Authorisations.

About a fifth of those who answered the question, mainly from the NHS and Professional and Regulatory Body categories, submitted comments suggesting further consideration should be given to expanding the guidance to incorporate additional examples. Suggestions included: legal highs; choking; dementia / old age / frailty; neurological conditions; chronic obstructive pulmonary disease; organ failure; deaths less than 24 hours after being admitted to hospital; deaths within three months of chemotherapy or radiotherapy; recreational drugs; sudden infant deaths and intrapartum stillbirth of normally formed babies.

A number of respondents argued for greater clarification of the wording of some examples, particularly in relation to paragraphs four (poisoning) and six (medical treatment or procedure) of the guidance.

A small number of respondents indicated that they did not agree with the examples and felt that further clarification was required. Of these, several reiterated the suggestion to include 'recreational drug' in paragraph four.

Q 24 Also in relation to the guidance, do you agree that no specific reference is needed as to whether certain deaths will be subject to jury inquests or not (such as those that have occurred under state detention)?

Over half of all respondents answered this question, with nearly two thirds of those agreeing that no specific reference was needed in the guidance as to whether certain deaths will be subject to jury inquests or not. Over half of all such responses were received from the 'healthcare professional' and 'local and central government' categories. Significantly, those who agreed included well over half of all coroner respondents.

Several respondents who agreed, suggested that the information would be; "irrelevant when reporting or notifying a death." A small number of respondents felt that there should be specific reference to whether certain deaths would be subject to jury inquests. A few of these focused on the issue of Deprivation of Liberty Safeguards cases.

Q25. Do you have any other comments about the guidance?

Over half of all respondents provided comments in response to this question. Comments received were wide ranging and often included issues and concerns not always referenced in the 'Draft guidance for registered medical practitioners'. Well over a third of responses were received from the local /central government category. A significant number were also received from health professionals and professional and regulatory bodies.

Roughly a quarter of responses to this question, mainly received from the local government (registration services) category, had the same concerns which they did not feel had been sufficiently tested through the medical examiner pilot schemes.

Another recurring concern of this group of respondents was that implementation of the new medical examiner system might increase the number of deaths referred to the coroner, as unlike the medical examiner system, coroner referrals did not attract a fee.

Other respondents also thought the new system might increase coroner workload.

Some respondents, including the Office for National Statistics, raised concern that the requirement for medical practitioners to notify coroners of all deaths of patients subject to Deprivation of Liberty Safeguards caused unnecessary delays and problems.

Response and Proposed Action

- We appreciate the many considered and detailed responses to this consultation on the draft Notification of Deaths Regulations and associated draft guidance. We will, as set out in the draft regulations, provide for the regulations to define six broad categories of deaths that medical practitioners must report to the senior coroner. In order to remove any doubt as to whether a death should be notified we will, again as set out in the draft regulations, include a further category of 'otherwise unnatural' to ensure that medical practitioners are responsible for notifying coroners of all violent and unnatural deaths for which they have a duty to investigate.
- The Notification of Deaths Regulations will additionally include the categories of custody and state detention that, where they applied to the deceased, would place a duty on medical practitioners to notify the death to the senior coroner. When we finalise the Notification of Deaths Regulations we will place a duty on medical practitioners to report unknown cause deaths to the senior coroner.
- It is important that training is provided in advance of the implementation of these regulations and this will be provided as part of a comprehensive package of learning that will be delivered to medical practitioners and coroners.

- A majority of respondents supported the view that whether or not a coroner's investigation will, or is likely to, result in a jury inquest makes no material difference to the medical practitioner's notification of the death. We will not be providing any reference in the guidance to the types of investigations for which a coroner may summon a jury.
- We appreciate the additional and alternate examples contributed by many respondents to the consultation and will draw on these as we finalise the guidance that will support the Notification of Deaths Regulations.

7. Cremation Regulations made under Cremation Act 1902

We confirmed in our consultation that in implementing the death certification reforms as provided in the Coroners and Justice Act 2009, the role of medical referees (the doctors in the crematoria who authorise cremations) would be abolished. There is no provision in statute for medical examiners to be involved in making determinations with regard to body parts and stillborn babies due to the medical examiners' limited remit to scrutinise deaths.

The consultation therefore asked questions about the scrutiny of applications for the cremation of stillborn babies and body parts in the absence of medical referees and where there is no involvement of medical examiners. We also indicated we would consult on revised cremation regulations in advance of introducing the death certification reforms, including the statutory medical examiner scheme.

With our revised proposals not to establish the statutory medical examiner provisions at this time we will defer the abolition of the medical referee and will revisit the issue of revised cremation regulations in due course when we consider again implementation of the statutory scheme. In July 2016 in our response to the *Consultation on cremation: Following recent inquiries into infant cremations* we confirmed our commitment to separately reform cremation regulations and this will not be effected by the decision to retain the role of medical referees at this time.

8. Conclusions and Next Steps

This government response to consultation sets out an approach to introduce a non-statutory medical examiner system where medical examiners are appointed within the NHS without the introduction of a new fee at this time. We intend to commence sections 18 and 21 of the Coroners and Justice Act 2009 to provide for regulations to require medical practitioners to report deaths to the coroner for which the coroner has a duty to investigate and for the appointment of a National Medical Examiner. As we progress with the introduction of a medical examiner system we will continue to engage with interested parties. The Government will amend the Coroners and Justice Act 2009, when an opportunity arises, to put the medical examiner system on a statutory footing and further consider legislative requirements post April 2019.

The key aims of the introduction of medical examiners are to:

- Introduce a system of effective medical scrutiny applicable to all non-coronial deaths;
- Enable medical examiners to report matters of a clinical governance nature to support local learning and changes to practice and procedures;
- Provide information on public health surveillance (as requested by Directors of Public Health);
- Increase transparency for the bereaved and offer them an opportunity to raise any concerns;
- Improve the quality and accuracy of medical certificates of cause of death;
- Link the introduction of medical examiners with enhancements to related systems, especially data on avoidable mortality, generated from the Learning from Deaths programme.

Annex A

List of respondents

Acorns Children's Hospices
Action Against Medical Accidents
Rafik Adam
Adath Yisroel Burial Society
Alzheimer's Society
Anonymous
Anonymous
Anonymous
Ian Arrow (Senior Coroner Plymouth, Torbay & South Devon)
Association of Anatomical Pathology Technology
Association of Directors of Public Health
Association of Directors of Public Health for London
Barnsley Hospital NHS Foundation Trust
Barnsley MBC
Bedford Hospital NHS Trust
Bereavement Services Association
Birmingham City Council
Birmingham & Solihull Coroners Service
Blackburn with Darwen Council
Blackpool Crematorium
Blackpool Teaching Hospitals NHS Foundation Trust
Blaenau Gwent County Borough Council
Jim Blair
Philip Blatchly
BLM Law
Bradford Teaching Hospitals NHS Foundation Trust
Bridgend Register Office
Brighton and Sussex University Hospitals NHS Trust
British Infection Association
British Nuclear Medicine Society
Cathryn Brown

Buckingham County Council
Mark Burleigh
Caerphilly Registration Service
Calderdale and Huddersfield NHS Foundation Trust
Campaign for Safer Births
Capsticks
Cardiff Registration Services
Care Quality Commission
Carmarthenshire Registration
Ceredigion Registration Services
Dr Nick Chiappe
City of London Corporation and City of London Coroner
City of Stoke on Trent Crematorium & Burial Authority
CO-Gas Safety
Jonathan Cole
Simon Collins
Co-op Funeralcare
Cornwall Council
Coroner's Service West Yorkshire (Eastern)
Coroners' Society of England and Wales
Dr Chris and Jane Corrigan (personally sent)
Cruse Bereavement Care
Dr Allan Dawson
Department of Health - EPRR Infectious Diseases and Influenza Pandemic
Department for Work and Pensions - Digital Bereavement Support Team
Devon and Cornwall, Isles of Scilly, Plymouth and Torbay- Police, Local Authority and Coroners
Regional Forum
Devon County Council
Dignity Funerals Limited
Dudley Metropolitan Borough Council
Durham County Council (includes Public Health Team and HM Coroner for County Durham)
East Anglian Registration Board
East Lancashire Hospitals NHS Trust
East Riding of Yorkshire Council
East Sussex County Council
Elaine

David Evans
Essex County Council Authority
Charlotte Ferriday
Alison Finall
Funeral Directors & Monumental Masons
Malcolm Galloway
Dr Craig Gannon
Gardens of Peace Muslim Cemetery
Gateshead Council
General Medical Council
Gillotts Funeral Directors, Nottingham
M. K. Ginder & Sons Gloucestershire
Coroners Court Gloucestershire County
Council Gloucestershire Early
Implementation Site
Great Ormond Street Hospital for Children NHS Foundation Trust
Greater Manchester Directors of Public Health
Malcolm Griffiths
Dr Alison Guadagno
Andrew A Haigh - HM Senior Coroner for Staffordshire (South)
Dr Rebecca Halas
Veronica Hamilton Deeley (HM Senior Coroner for Brighton & Hove)
Hampshire County Council
Peter Hare
Marise Hargreaves
Tim Harlow
Andrew Harris (Senior Coroner for London Inner South)
Dr Bill Harris
Katherine Harrison
Justin Harrison Dr
Emily Harrop Havering
Public Health Elizabeth
Hawden
Healthcare Inspectorate Wales
Tim Helliwell
Mr. David Heming (Senior Coroner Cambridgeshire and Peterborough)

Hertfordshire County Council
Hill Dickinson
M Horner
Dr Daniel Hughes
Hull City Council
Hywel Dda University Health Board
Institute of Biomedical Science
Institute of Cemetery & Crematorium Management
Elaine Isaacs (personally sent)
Dr Tillmann Jacobi
Debbie Jenkins
Peter Johnson Funerals Ltd
Martina Kane
K Kelleher
Kent County Council
Dr Pnt Laloë
Lancashire County Council
Dr Julian Law
Leeds Palliative and End of Life Care Managed Clinical Network
Leeds Teaching Hospitals NHS Trust
Lincolnshire County Council
Liverpool Local Medical Committee
Local Government Association
London Ambulance Service NHS Trust
London Borough of Barking and Dagenham
London Borough of Waltham Forest
Dr Jan Longworth
Dr Sandy Lukats
Macmillan Cancer Support
Dr L Mahon-Daly
Manchester City Council
Manchester Local Medical Committee
Marie Curie
Stephen McGrath
Nigel Meadows (HM Senior Coroner for Manchester)
Medical Defence Union

Medical and Dental Defence Union of Scotland
Medical Examiners (Queen Elizabeth Hospital Birmingham)
Dr Chris Meehan
Merthyr Tydfil Local Authority
Mid Cheshire Hospital NHS Foundation Trust
Milton Keynes Council
M Mirza
Lorraine Molloy
Stephen Morley
Shahid Munshi
Muslim Burial Council of Leicestershire
Muslim Council of Britain
National Association of Funeral Directors
National Panel for Registration
Newcastle City Council
Newport Registration Service
NHS England
NHS Wales Informatics Services
Nigel Lymn Rose
H Noble Funeral Directors Ltd
North Lincolnshire Registration Service
North Tees & Hartlepool NHS Foundation Trust
North Yorkshire County Council
Nottingham City Council
Nottinghamshire Registration
Office for National Statistics
Oxfordshire Registration and Coroners' Services
Oxley's Funeral Services
Roy Palmer (other – coroner services)
Parkinson's UK
Jeremy Pemberton
Plymouth City Council
Powys Registration Service
Princess Alice Hospice
Dewi Pritchard Jones (HM Senior Coroner North West Wales)
Public Health England

Dhul Qurnayn
Reading Borough Council
André Rebello OBE (Senior Coroner for Liverpool and the Wirral)
Emma Redfern
Colin Rescorla (personally sent)
Lynda Reynolds
Ruth Richardson
David Ridley (HM Coroner Wiltshire & Swindon)
James Robertson
F W Robinson
R Rowan
Salford and Trafford Local Medical Committee
Sanctuary Care
Sands
Sandwell Metropolitan Borough Council
Jason Shannon
Professor Michael Sheaff
Sheffield Teaching Hospitals NHS Foundation Trust
Grahame Short (Senior Coroner Hampshire Central)
Sid (Member of the public)
Guy Singleton
Katherine Sleeman
Ian Smith (HM senior coroner for Stoke-on-Trent & North Staffordshire)
Solihull Registration Service and Solihull Bereavement Service
South Wales Registration Group
South West Registration Service Managers Group
Stockport Council
Suffolk County Council – Registrars and Coroners Service
Sunderland City Council
Surrey County Council
Swansea Coroners, Crematorium Medical Referees Bereavement and Registration Service
Swansea Register Office
Judith Talbot
Susan Taylor
Telford & Wrekin Council
The Academy of Medical Royal Colleges Wales

The Association of Private Crematorium and Cemeteries
The Board of Deputies of British Jews
The British Medical Association
The Care Quality Commission
The Chief Coroner
The Cremation Society of Great Britain
The Federation of Burial and Cremation Authorities
The London Ambulance Service NHS Trust
The Lullaby Trust
The National Bereavement Alliance
The National Council for Palliative Care
The National Society of Allied & Independent Funeral Directors
The Office for National Statistics
The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
The Royal College of General Practitioners
The Royal College of Midwives
The Royal College of Nursing
The Royal College of Paediatrics and Child Health
The Royal College of Pathologists
The Royal College of Pathologists (Round Table)
The Royal College of Physicians
The Royal College of Physicians of Edinburgh
The Royal College of Psychiatrists
The Royal College of Radiologists
The Royal College of Surgeons of Edinburgh
The Royal Statistical Society
Ann Thomas
Together for Short Lives
Torfaen Registration Service
Trafford Council
Trinity Hospice, Blackpool
Tunbridge Wells Borough Council
Andrew Tweddle (HM Senior Coroner for County Durham and Darlington)
Vale of Glamorgan Registration Service
Velindre NHS Trust
Veterans Funerals UK

John

Virago

Wakefield

Council

Julie

Walker

Dr MP Ward Platt

A Welch & Sons LTD

West Midlands Local Authority Regional Registration Group and the West Midlands
Local

Authority Regional Coroner

Group West Sussex

County Council

Westerleigh Group

Sandra Whitlock

Wiltshire & Swindon Coroner's Court

Derek Winter DL (HM Senior Coroner for the City of
Sunderland) James Winwood

Worcester Council

Worcestershire Health and Care NHS Trust

Dr Esther Youd

ANNEX B

Face to Face Stakeholder Engagement

Table 1: Dissemination of the Consultation by Programme Board and Reference Group Partners

Name of Organisation	To whom the consultation was disseminated
General Register Office	Circular sent to local registration service – all 174 local authorities across England and Wales and all registration officers
Ministry of Justice	Members of the Burial and Cremation Advisory Group Medical referees
Office for National Statistics	Tweeted the consultation to followers
Gloucestershire Early Implementation Site	Bereavement Services Association - members are connected nationally through their own organisations (including Acute Trusts and charity organisations delivering bereavement support etc.) Local Health and care organisations
Cruse Bereavement Care	Members of the Funeral Poverty Alliance
Coroners' Officers Association	All registration services in England and Wales All regional coroner groups
Federation of Burial & Cremation Authorities	More than 1350 members
National Society of Allied & Independent Funeral Directors	All members Advertised on website Highlighted in the next copy of monthly magazine
National Association of Funeral Directors	Feature article in the Funeral Director Monthly magazine Article and link in monthly e-newsletter News piece on website Social media activity promoting the post on the news page of the website Speakers at area & local meetings promoting the consultation Debate at their 2016 Conference.
Cremation Society GB	Proposed to include in Pharos International, the Society's quarterly journal

Local Government Association	Advertised the consultation in a number of monthly bulletins and networks, reaching several thousand individuals
National Medical Examiner	Requested the Royal College of Pathologists to promote the consultation to its membership
Welsh Government	<p>Across the Welsh NHS system</p> <p>Coroners in Wales</p> <p>Royal Colleges and Societies in Wales</p> <p>Local Authority Directors</p> <p>Welsh Local Government Association</p> <p>Health Boards</p> <p>Commissioners and Regulators in Wales</p> <p>Community Health Councils</p> <p>Police</p> <p>Unions</p> <p>Voluntary Sector</p>

Table 2: Presentations and Events

Name of Event	Event details
Department of Health Voluntary Sector Strategic Partners	A bespoke summary document was produced for the Secretariat of the Committee to raise in Any Other Business, highlight the consultation, and offer to discuss the consultation.
Faith Action blog and summary	Proactively contacted and telephone conversations held. Guest blog written and published
Harrogate Hebrew Congregation and Board of Deputies of Jewish Faith	Harrogate Hebrew Congregation contacted in relation to requesting permission for taking photographs for the blogs This led to increased focus on the consultation from the Board of Deputies
National Association of Funeral Directors AGM	A representative from the Team was unable to attend the NAFD AGM in Belfast 200 copies of a Summary Overview Booklet were sent to the AGM for dissemination
National Council for Palliative Care	Telephone conversations held Documents exchanged for publishing
Interfaith	Documents and emails were exchanged to offer the opportunity to attend and present at any of their events
Race Foundation	Documents and emails were exchanged to offer the opportunity to attend and present at any of their events
National Care Forum	Guest blog provided for publication
Gardens of Peace and Muslim Council of Great Britain	Documents and emails were exchanged to offer the opportunity to attend and present at any of their events
Local Authority Leadership	Offer to present at upcoming Health Transformation Task Group meetings – Paper and Checklist submitted Offer to present at upcoming SOLACE meetings
Local Authority Groups	Presented at the Southern, West Midlands, and South West Coroners Regional Managers Groups Presentation delivered by National Medical Examiner at the Local Registration Services Association Presentation delivered at the National Panel for Registration

Royal College of Pathologists	Roundtable meeting convened by RCPATH to discuss the Medical Examiner system
National Bereavement Alliance	Meeting convened to discuss the reforms, presentation delivered
Cremation and Burial Communication and Education 2016	Presentation delivered by Sheffield Implementation Site Medical Examiner
Dying Matters Awareness Week	Presentation provided for use by North West England Bereavement colleagues to promote the consultation and reforms