Summary of Responses to the Consultation on Improving the Process of Death Certification

May 2008

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Section 1: Introduction

1.1 The consultation paper *Improving the Process of Death Certification* was published by the Department of Health in July 2007. The paper sought views on proposals to address weaknesses identified by the Shipman Inquiry in the process of death certification in England and Wales. Consultation on the proposals closed on 24 October 2007.

1.2 The key proposals set out in the consultation paper are that:

- all Medical Certificates of Cause of Death (MCCDs), with the exception of cases referred directly to the coroner by the certifying doctor, would be subject to scrutiny by an independent medical examiner appointed by a Primary Care Trust (or an equivalent organisation in Wales) and with strong links to NHS clinical governance[1] teams;
- if the medical examiner was satisfied that all was in order, he/she would issue an authorisation enabling the family of the deceased to register the death and proceed to burial or cremation;
- where the medical examiner was not satisfied that the MCCD told the full story, or felt that there were other unusual circumstances, he/she would refer the case to the coroner for further investigation, along with his/her reasons for doing so;
- the medical examiner would have full access to medical records and would be empowered to discuss the circumstances of the death with the doctor signing the MCCD and with the family of the deceased; and
- NHS clinical governance teams would collate information from MCCDs and would use this to analyse trends and patterns, looking out for unusual features, such as those revealed by Shipman's pattern of deaths.

1.3 The Department of Health believes that these proposals represent a transparent, proportionate, consistent and affordable response to the weaknesses identified by the Shipman Inquiry that will provide greater protection for the public and improve the quality and accuracy of death certification. The proposals will also improve local public health

1 Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care

surveillance and remove current inequalities in the way burials and cremations are dealt with.

1.4 This paper summarises respondents' comments to the proposals set out in the consultation paper and other matters of interest they raised. The paper also refers to, and takes account of, a related public consultation undertaken in 2007 by the Ministry of Justice concerning the statutory duty for doctors and other public service personnel to report deaths to the coroner.[2] The response to that consultation was published alongside this paper.

1.5 In 2007, the Ministry of Justice also carried out a consultation on consolidating and modernising the existing Cremation Regulations.[3] The intention is to make interim improvements in advance of death certification reform. The Cremation regulations, in so far as they apply to an application to cremate a body and certification of cause of death, will no longer exist once the proposed improvements to the process of death certification referred to in this paper are implemented.

1.6 From 1 April 2008, Local Safeguarding Children Boards (LSCBs) have a statutory requirement to collect and analyse information about the deaths of all children in their area and put in place procedures to ensure a co-ordinated response to the unexpected death of a child. In taking forward the proposed improvements to the process of death certification, the Department of Health will ensure that appropriate interfaces are established with these new functions now being delivered by LSCBs.

2 Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner (Ministry of Justice, July 2007)

3 Cremation Regulations Consolidation and Modernisation (Ministry of Justice, 2007)

Section 2: Policy background

2.1 Each year some 500,000 people die in England and Wales. The system for death certification in England and Wales has remained largely unchanged for over 50 years. The current arrangements require that for all deaths the doctor who attended the patient in their final illness should complete a Medical Certificate of Cause of Death (MCCD). Additional certification is required before bodies can be released for cremation. Currently around 70 per cent of deaths are followed by cremation.

2.2 In its *Third Report*,[4] the Shipman Inquiry examined the process of death certification and the coroner system. The Inquiry concluded that existing arrangements for scrutinising the MCCD are confusing and provide inadequate safeguards. A Fundamental Review[5] presented to the Home Office in June 2003 came to broadly similar conclusions about the shortcomings of the current arrangements.

2.3 The Government accepted the Shipman Inquiry's conclusions, and its action programme in response to the Inquiry's key recommendations[6] outlined proposals for creating a new rigorous, unified system of death certification for both burials and cremations in England and Wales. The Department of Health consultation paper *Improving the Process of Death Certification* set out these proposals in more detail.

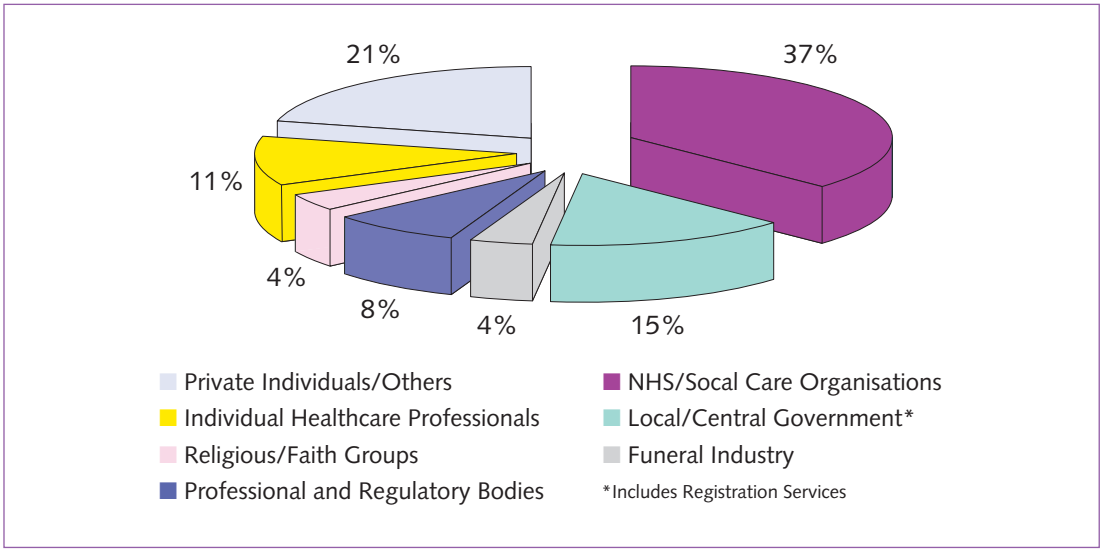
4 Third Report – Death Certification and the Investigation of Deaths by Coroners (TSO, 2003)
5 Death Certification and the Coroner Services in England, Wales and Northern Ireland: The Report of the Fundamental Review (TSO, June 2003)
6 Learning from Tragedy, Keeping Patients Safe (TSO, February 2007)

Section 3: Summary of consultation responses

"We applaud the proposal to reform the current system of death certification with the appointment of a new cadre of medical examiners."
The Royal College of Pathologists

3.1 A total of 157 written responses to the consultation were received. The chart below shows that NHS/social care organisations and private individuals/others were the leading contributors. A full list of the organisations and individuals who submitted a written response is at *Annex A*.

Source of Responses



3.2 As part of the consultation process, the Death Certification Programme Manager also met with a number of national stakeholder organisations and attended some meetings with councillors and representatives from local communities. Many of those who submitted a written response or attended a meeting (and some did both) responded to each of the questions included in the consultation paper. However, some contributors covered only those points of particular concern to them, or points where they had particular expertise or personal experience.

3.3 The Department of Health is very grateful to everyone who contributed to the consultation and would like to thank them all for taking the time and trouble to help develop an improved process of death certification in England and Wales.

Overall reaction to the proposals

3.4 Almost all respondents recognised and acknowledged the concerns expressed about the current process of death certification in England and Wales. The vast majority of respondents supported the proposed introduction of a process of secondary certification of deaths that are not referred to the coroner, and for this scrutiny to be undertaken by appropriately qualified medical examiners. Many respondents also supported the proposal that medical examiners should provide general medical advice to coroners, helping them to fulfil their duty to establish the cause of death in cases referred to them.

3.5 The main concerns raised by respondents were over ensuring that the scrutiny process does not cause significant delays to funerals and ensuring that medical examiners are able to carry out their duties with the necessary degree of independence from NHS and other public authorities. Several respondents also highlighted the importance of ensuring that development and implementation of the proposed improvements to the process of death certification are closely co-ordinated with the Ministry of Justice's coroner reform system. These issues are considered further later in this document.

Section 4: Response to specific questions

Question one

To avoid unnecessary delays, upon receipt of authorisation from the medical examiner, would it be desirable to allow the deceased to be buried or cremated before the death is registered (as is the case now when the coroner issues a cremation certificate or burial order)?

Number of responses: 87 **% answering 'Yes': 71**

4.1 Under the proposed new death certification system, authorisation to dispose of the body will be given by the medical examiner at the time he/she completes the second certification (this will remove the existing responsibility for authorising burial from registrars and abolish the present Cremation Form system). The majority of respondents who answered this question, favoured allowing the deceased to be buried or cremated before the death is registered on the basis that the death had been scrutinised by a medical examiner and the need for referral to the coroner excluded. However, several respondents said that disposal before registration should be the exception, rather than the norm e.g. in situations where cultural or religious practice required a very quick burial.

4.2 A number of respondents also highlighted the importance of retaining the registrar's statutory duty to report deaths to the coroner, particularly where issues are raised by the family member registering the death.

4.3 The Department of Health agrees that, in the case of the majority of deaths, registration should still take place before disposal. If disposal is to take place before a death is registered, it will be important to ensure that the family of the deceased has been asked to confirm that they have no reason to question cause of death as stated on the MCCD and that they have had an opportunity to raise any concerns about the way the deceased died.

Question two

In order to attract medical practitioners with the right level of expertise and experience, and also to maximise the flexibility of the service to minimise any delays to funeral arrangements, would it be desirable to appoint medical examiners on a part-time basis?

Number of responses: 90 **% answering 'Yes': 81**

4.4 A large majority of respondents who answered this question favoured medical examiners being appointed on a part-time basis. There was a general preference for medical examiners to be practising (or recently practising) clinicians, which would be supported by making part-time appointments. Most respondents also agreed with the supposition that part-time medical examiner appointments were important in order to attract medical practitioners with the right level of expertise and experience and to ensure an appropriately responsive and flexible service for communities. The Department of Health agrees with this view.

4.5 A small number of respondents highlighted the advantage of full-time medical examiner appointments in terms of maximising consistency in the approach to scrutiny and certification. This issue will be considered by the Death Certification Stakeholder Working Group (*see Section Six*).

Question three

Would it be beneficial to co-locate medical examiners with coroners where this was agreed locally? If so, what would be the specific benefits?

Number of responses: 89 **% answering 'Yes': 84**

4.6 A large majority of respondents who answered this question identified potential benefits in co-locating medical examiners with coroners. These included the sharing of information and expertise, improved communications and the easier exchange of paperwork. However, a number of the same respondents also highlighted similar benefits that could be gained from locating medical examiners in other locations too, for example, with primary care and secondary care organisations.

4.7 Some respondents felt that the precise location of medical examiners should remain flexible and, ultimately, should be determined in accordance with local

needs, experience and benefits. This issue will be considered further as part of piloting the improvements to the process of death certification.

Question four

Would it be appropriate and practical to have a professional line of accountability between the National Medical Advisor to the Chief Coroner and medical examiners? What do you consider to be the advantages and disadvantages of this proposal?

Number of responses: 69 **% answering 'Yes': 86**

4.8 Fewer respondents to the consultation felt able to give a response to this question. However, a large majority of respondents who did answer the question supported the establishment of a professional line of accountability between the National Medical Advisor to the Chief Coroner (when appointed) and medical examiners. It was felt that such an arrangement would strengthen the independence of the medical examiner (*see also Section Five*) and would be an effective way of supporting the adoption of national standards and guidance.

4.9 Some respondents said that further information on the proposed role of the National Medical Advisor to the Chief Coroner was required in order to be able to judge whether the proposed arrangement was appropriate. A few respondents also questioned whether a second line of accountability was practical given that medical examiners would also be accountable within the organisational structure of PCTs (or an equivalent organisation in Wales). This issue will be discussed further with the Ministry of Justice as part of their coroner reform programme.

Question five

Would it be appropriate for medical examiners to be contracted to provide medical advice to coroners in certain cases?

Number of responses: 74 **% answering 'Yes': 91**

4.10 A very high percentage of respondents felt that medical examiners should be the main source of general medical advice to coroners, and some suggested this should be a core part of the job description of all medical examiners.

A targeted consultation conducted by the Ministry of Justice during late 2007 generated a similar response.

4.11 Generally, respondents felt that medical examiners would be well placed to advise coroners on the most appropriate route for the investigation of the medical cause of death, whether a post-mortem was necessary, what type of post-mortem and who it should be carried out by. Some respondents suggested that where more specialist medical advice was required for a case, this would best be provided or, more likely, procured by the National Medical Advisor to the Chief Coroner.

4.12 The operational processes and infrastructure required for medical examiners to provide general medical advice to coroners will be developed and tested as part of piloting the improvements to the process of death certification.

Question six

Are there circumstances where deaths are discussed with the coroner unnecessarily and should, in the future, be more appropriately be discussed with a medical examiner?

Number of responses: 86 **% in Agreement: 97**

4.13 Almost all respondents who answered this question felt that there were indeed many deaths that are currently discussed with the coroner that should, in the future, more appropriately be discussed with a medical examiner. Respondents suggested that many of these cases are discussed with the coroner because of medical uncertainty or possible public health implications, rather than suspicion of an unnatural cause of death.

4.14 Most, although not all, respondents felt that the establishment of medical examiners would result in a reduction in the number of deaths reported to the coroner (46% of all deaths in England and Wales in 2006)[7] as well as a reduction in the number of coroner post-mortems.

7 Source: Statistics on Coroners, Ministry of Justice

Question seven

Is a qualifying period necessary to achieve the desired aim of ensuring the coroner investigates appropriate cases?

Number of responses: 86 **% answering 'No': 41**

4.15 The 14-day rule for reporting deaths to the coroner is set out in the Birth and Death Registration Regulations. The registrar has a duty to report a death to the coroner if the deceased has not been seen by the certifying doctor either after death or within 14 days before the death. The Ministry of Justice also undertook a public consultation on this issue during 2007 (in the context of which deaths doctors and other public service personnel should have a statutory duty to report to the coroner).

4.16 Responses to both consultations have been similarly mixed. Some respondents clearly felt that the time period was irrelevant and that the quality of information available to the certifying doctor (for example, medical history and information on the circumstances of the death) was far more important. Others felt that a time period was still necessary – although some of these respondents suggested a longer period, e.g. 28 days.

4.17 The Department of Health and the Ministry of Justice intend to use piloting of the improvements to the process of death certification to gather further evidence before coming to a conclusion on whether the 14 day period should be changed. This process will also consider a related issue – how confirmation of death should be recorded (including documenting the death and the circumstances in which it was reported and verified).

Section 5: Themes that came out of the consultation which were not fully covered by the questions

Preventing delays to funerals

5.1 A number of respondents, while acknowledging the need to reform the current process of death certification and introduce a unified system of secondary certification, expressed concern that the proposed scrutiny process would delay funerals. This issue is of particular concern to Jewish and Muslim communities whose religious practice requires burial to take place as soon as possible after the death.

5.2 Allowing the deceased to be buried or cremated before the death is registered (*see Question one*) and maximising the flexibility of the medical examiner service through the use of part-time appointments (*see Question two*) will assist in reducing delays to funerals. The Department of Health is also proposing to use piloting of the improvements to the process of death certification to explore different models of service provision, including an 'emergency medical examiner service'. Understanding the particular needs of different faith communities will also form part of the training curriculum for all medical examiners.

5.3 Finally, several respondents suggested that details of the medical examiner service, including an indication of how long the scrutiny process should generally be expected to take, should be included in an updated charter for the bereaved. The Department of Health and the Ministry of Justice will consider whether the charter is the most appropriate means of communicating these messages.

Arrangements for employing medical examiners

5.4 The consultation paper proposed that medical examiners will be appointed by Primary Care Trusts (or an equivalent organisation in Wales). The Department of Health believes that such arrangements are the best means of ensuring that examiners maintain close links with NHS clinical governance teams. Establishing the medical examiner role within the NHS is also important in terms of attracting medical practitioners with the right level of expertise and experience.

5.5 A small number of respondents expressed concern that the proposed appointment arrangements could lead to a potential conflict of interest and questioned whether the medical examiner would be able to perform his/her role with the appropriate level of independence from the appointing NHS organisation. Some respondents also stressed the importance of ensuring that medical examiners work closely with coroners, and suggested that this might best be achieved by appointing medical examiners as part of the coronial service.

5.6 Clearly, it is vital to ensure that the public can have confidence that the scrutiny undertaken by medical examiners will be proportionate, consistent and effective. The Department of Health is therefore proposing that:

- legislation establishing the role of medical examiner will explicitly require its function to be performed independently of any public authority;
- Primary Care Trusts (or their equivalent in Wales) will involve the coroner in their arrangements for appointing medical examiners; and
- medical examiners should provide general medical advice to coroners (*see Question five*).

5.7 The Department of Health and the Ministry of Justice will also consider establishing a professional line of accountability between the National Medical Advisor to the Chief Coroner and medical examiners (*see Question four*).

Co-ordination of proposed improvements to the process of death certification and coroner reforms

5.8 A number of respondents stressed the importance of ensuring that implementation of the improvements to the process of death certification is properly co-ordinated with the coroner reform programme being taken forward by the Ministry of Justice. This reflects the inevitable overlaps between the processes involved with the certification and investigation of death and the work of the coroner.

5.9 The Department of Health and the Ministry of Justice have established close working between the respective teams responsible for the different reform programmes. These arrangements will now be strengthened by the Death Certification Stakeholder Working Group (*see Section Six*) which will oversee the improvements to the process of death certification and will ensure that the related elements of the coroner reform programme are aligned fully.

Section 6: Taking forward these proposals

6.1 The Department of Health has established a Stakeholder Working Group to direct and support implementation of the proposed improvements to the process of death certification in England and Wales. Details of the Working Group's terms of reference and membership are at *Annex B*.

6.2 Activities being directed and supported by the Working Group include:

- developing guidance for medical examiners on the proportionate and effective scrutiny of death certificates;
- reviewing the content and management of the MCCD and associated forms and recommending proposed changes;
- developing guidance on how/how far the medical examiner role should be integrated into the broader clinical governance teams of Primary Care Trusts (or equivalent organisations in Wales) and advising on what information should be available for wider clinical governance purposes;
- advising on the appointment, accountability arrangements and professional relationships of the medical examiner;
- advising on the local support and infrastructure required by medical examiners;
- designing and developing accredited materials required to train and assess medical examiners and their support officers;
- piloting proposed improvements to the process of death certification, including arrangements for providing medical advice to coroners; and
- advising on interim measures that might be introduced in the NHS to strengthen the process of death certification in advance of legislation.

6.3 The Department of Health intends to pilot the proposed improvements to the process of death certification in a number of different locations in England and Wales during 2008/09. This process will begin with a 'pathfinder' hospital-based pilot in Sheffield in Spring 2008.

6.4 Implementation of the proposed improvements will require significant legislative change, and is therefore subject to the parliamentary timetable for introducing new legislation. It is intended that the timetable for implementation will broadly mirror that for introducing reforms to the coroner service.

Section 7: Consultation criteria

7.1 This consultation followed the Cabinet Office code of practice, which is available from the Cabinet Office website at http://www.cabinetoffice.gov.uk/regulation/consultation/code/index.asp. This requires government departments to:

1. consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of policy;
2. be clear about what proposals are, who may be affected, what questions are being asked and the timescale for responses;
3. ensure that consultations are clear, concise and widely accessible;
4. give feedback regarding the responses received and how the consultation process influenced the policy;
5. monitor their effectiveness at consultation, including through the use of, a designated consultation co-ordinator; and
6. ensure consultations follow better regulation best practice, including carrying out a regulatory Impact Assessment if appropriate.

7.2 The Code also invites respondents to "comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process". For DH consultations, comments or complaints should be sent to:

Consultations Coordinator
Department of Health
Skipton House
80 London Road
London SE1 6LD
Email: (mb-dh-consultations-coordinator@dh.gsi.gov.uk)

Annex A: List of Respondents

NHS/Social Care Organisations

Addenbrooke's Hospital
Beaumont Villa Surgery (Dr Paul Hardy)
Bedfordshire Primary Care Trust
Bellbrooke Surgery (Dr Alison Roberts)
Birmingham East & North Primary Care Trust
Bournemouth and Poole Primary Care Trust
Bristol Primary Care Trust
Butt Lane Surgery (Dr Amanda Robinson)
Cambridgeshire Local Medical Committee
Carmarthenshire NHS Trust
Central Lancashire Primary Care Trust
City and Hackney Teaching Primary Care Trust
City Hospitals Sunderland NHS Foundation Trust
Coventry Teaching Primary Care Trust
Derby Hospitals NHS Foundation Trust
Doncaster Primary Care Trust
East Lancashire Primary Care Trust
Greenwich Teaching Primary Care Trust
Haringey Primary Care Trust
James Cook University Hospital
John Pounds Medical Centre (Dr Luis Castilla)
Lambeth Primary Care Trust
Leeds Primary Care Trust
London-wide Local Medical Committees
Manchester Local Medical Committee
National Public Health Service for Wales
Nene Valley Surgery (Dr Geoff Nicholson)
Newham University Hospital NHS Trust
NHS Employers
North East Strategic Health Authority
North Lincolnshire & East Yorkshire Local Medical Committee
North Manchester General Hospital
North West Wales NHS Trust
Pan London End of Life Programme Managers Group
Pontypridd & Rhondda NHS Trust

Portsmouth City Teaching Primary Care Trust
Redbridge Primary Care Trust
Sandwell & West Birmingham Hospitals NHS Trust
Sheffield Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South Birmingham Primary Care Trust
South Gloucestershire Primary Care Trust
Southampton University Hospitals NHS Trust
Southville Surgery (Dr Peter McCartney)
Swansea NHS Trust
Tameside & Glossop Acute Services NHS Trust
The Devonshire Practice (Dr Nick O'Donnovan)
The Health House (Dr A Allcock)
The Little Surgery (Dr Fields and Dr Livingstone)
The Surgery (Dr Chris Wayte)
University Hospital Birmingham NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Vesper Road Surgery (Dr Pat Geraghty)
Wakefield Local Medical Committee
Western Cheshire Primary Care Trust
Yeovil District Hospital NHS Foundation Trust

Local/Central Government

Birmingham City Council Bereavement Services
Blaenau Gwent Registration Service
Bradford Registration District
Cheshire County Council
Chippenham Register Office
Department of Health – Health Inequalities Unit
Flintshire Register Office
Halton District Council
Lancashire Registration Services
Local Authorities Coordinators of Regulatory Services
Local Government Association
Peterborough Register Office
Plymouth City Council Registration Service
Registration and Celebratory Services
Rotherham Metropolitan Borough Council & Partners
Royal Courts of Justice
Sandwell Register Office
Sheffield City Council

Sheffield Register Office
Society of Registration Officers
South Gloucestershire Registration Service
Swindon Borough Council
Welsh Assembly Government
Wiltshire County Council

Funeral Industry

Chilterns Crematorium
Crematorium Society of Great Britain
Federation of Burial and Cremation Authorities
Institute of Cemetery and Crematorium Management
National Association of Funeral Directors
National Society of Allied and Independent Funeral Directors
H. Porter and Sons Funeral Directors

Professional and Regulatory Bodies

Academy of Medical Royal Colleges
Association of Public Health Observatories
British Medical Association
Coroner's Officers Association
Coroners' Society of England & Wales
Faculty of Public Health of Royal College of Physicians
General Medical Council
Medical Defence Union
Medical Protection Society
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Radiologists

Religious/Faith Groups

Mr Solomon Adler (Manchester Jewish Community)
Shenzad Bashir (Burton on Trent Muslim Community)
The Board of Deputies of British Jews
Susan Cohen (Leeds Jewish Community)
Manchester Beth Din
Sheffield Jewish Congregation
UHC Synagogue (Leeds)

Individual Healthcare Professionals

Dr David G Atchison (Medical Referee)
Dr D S Basavaraj (Medical Referee)
Jo Bohan (Registered Nurse)
Mr James M. Dunlop (Medical Referee)
Dr Matthew Flynn (Consultant, Histopathology)
Dr Harvey Gordon (GP)
Dr Carolyn Hall (GP)
Dr Vicki Howarth (Consultant Histopathologist and Director of Mortuary Services)
Dr Duncan Keeley (GP)
Dr Philip Kloer (Consultant, Respiratory Physician)
Dr Pierre-Antoine Laloë (Anaesthetic SHO, Heart of England NHS Foundation Trust)
Dr Stephen Leadbetter (Forensic Pathology, Wales College of Medicine, Cardiff)
Professor Sebastian Lucas (Dept of Histopathology, St Thomas' Hospital)
Dr Graham Martin (GP)
Dr Rory O'Conor (Consultant in Public Health)
Dr Gordon Pledger (Medical Referee)
Dr John Russell (GP)
Dr Richard Wilson (Honorary Consultant Paediatrician)

Private Individuals/Other

Action Against Medical Accidents
Association of Anatomical Pathology Technology
The Bereavement Advice Centre
Bereavement Services Managers Association
British Lung Foundation
British United Provident Association
Cheshire Constabulary
Childhood Bereavement Network
College of Health Care Chaplains
Coroner's Court Southern District of Greater London
Coroners' Courts Support Services – Westminster
CRUSE Bereavement Centre
Mr Nick Dean (Worcestershire County Council)
Diabetes UK
Mr M Halpern
Mr Andrew G. Hastings
Help The Aged
Jewish Care
Mr Tom Luce

Kirsty Macpherson and Julie Baker
Marie Curie Cancer Care
National Concern for Healthcare Infections
North London Hospice
Lady Justice Smith and Mrs Justice Swift
St Ann's Hospice (Dr Alison Phippen)
St. Lukes Hospice (Dr Charles Daniels)
Stuart Taylor and David Thewlis
Sudden Adult Death Trust
Unite the Union
University of Leicester
Victim's Voice
Mr Nicholas Williams

Annex B: Death Certification Stakeholder Working Group – Terms of Reference and Membership

Part of the DH Professional Regulation and Patient Safety Programme

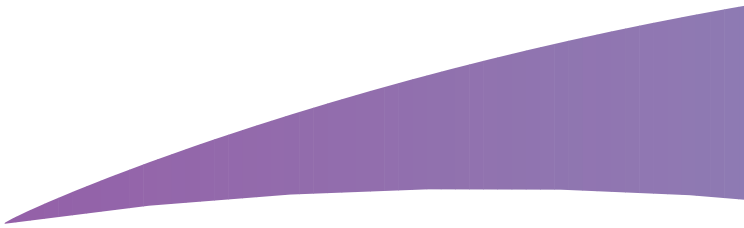
Terms of Reference

The purpose of the Working Group is to:

1. provide direction on progress of the Death Certification Project and to take overall responsibility for key decisions on deliverables;
2. take responsibility for ensuring that planning for each stream of the project has been thorough, risks identified and addressed, and timetables for delivery are met;
3. work with the Chief Medical Officer's Business Support Team and contribute, as required, to small work-teams responsible for developing and documenting guidance and other products in support of key deliverables; and
4. act as 'field experts' giving guidance on the practical implications of proposals.

Membership of the Death Certification Stakeholder Working Group

Name	Organisation
Dr Bill Kirkup (Chair)	Associate Chief Medical Officer, Department of Health
Giles Adey	Local Government Association
Simon Bennett	Programme Manager, Department of Health
Chris Dorries	HM Coroner Sheffield (Coroners' Society)
Dr George Fernie	Chairman, British Medical Association Forensic Medicine Committee
Prof. Peter Furness	Vice-President, Royal College of Pathologists
Christine Hurst	Coroner's Officers Association
Debbie Kerslake	Cruse Bereavement Care
Debbie Large	Coroner's Officers Association
Ceinwen Lloyd	General Register Office
Prof. Sebastian Lucas	Royal College of Pathologists
Nigel Lymn Rose	National Association of Funeral Directors
Duncan McCallum	Federation of Burial and Cremation Authorities
Mini Mishra	Scottish Government
Tim Morris	Chief Executive, Institute of Cemetery & Crematorium Management
Heather Neagle	Department of Health for Northern Ireland
Dr Peter Old	Associate Medical Director, NCAS
Mervyn Pilley	National Society of Allied and Independent Funeral Directors
Dr Gordon Pledger	Medical Referee (Newcastle)
John Pollard	HM Coroner South Manchester (Coroners' Society)
Dr Cleo Rooney	Office of National Statistics
Dr Douglas Russell	Director of Clinical Leadership, Tower Hamlets Primary Care Trust
Anna Slatter	Welsh Assembly Government
Stephen White	Cremation Society of Great Britain
Jess Yuille	Ministry of Justice



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