CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 25 October 2018

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Tracey Cresswell
Sheila Gill
Cllr Jasbir Jaspal (Chair)
Cllr Milkinderpal Jaspal
Cllr Asha Mattu
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Dana Tooby

In Attendance
Cllr Sohail Khan

Witnesses
Margaret Collins – Black Country Coroner's Lead
Dr. Julian Parkes GP (RWHT)
Elaine Roberts (Patient Services Manager – RWHT)
Arshad Khan (Al-Mu'min Funeral Services)
X 2 Representative from Sandersons Funeral Services

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
Dr. Ankush Mittal (Public Health Consultant)
Martyn Sargeant (Head of Public Service Reform)
Dr. Majel McGranahan (Public Health Registrar)
Julia Goudman (Business Development Manager)
Arif Sain (Equalities Contractor)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
An apology for absence was received from Cllr Martin Waite.

2 **Declarations of Interest**
There were no declarations of interest.

3 **GP Experience**

Dr Julian Parkes GP outlined his experiences of the death certification processes. He stated that Primary care was a list based system meaning that patients were registered with a practice and the practice took responsibility for their patients. The Alfred Squire Road Practice had 8400 registered patients. The average GP in England was responsible for 1850 patients. There were approximately 100 deaths per year from patients registered at the Alfred Squire Road Practice. Deaths in Primary Practice tended to fall into four distinct categories:

1) Sudden death where the patient had not recently been seen.
2) Deaths in Hospital.
3) Deaths at home but expected, the patient was often receiving palliative care for Cancer.
4) Deaths in Compton Hospice or following discharge from hospital to a nursing home, which was not their usual residence.

An audit of deaths in September 2017, over a three-month period, showed there had been a total of 25 deaths, 4 deaths were sudden and unexpected. The breakdown was as follows: -

- 12 deaths occurred in Accident and Emergency or as inpatients at Newcross Hospital and one at another Hospital.
- 2 deaths occurred at Compton Hospice.
- 3 deaths were in a residential or nursing home.
- 8 deaths at home, with 3 of those being sudden and unexpected, with the remaining 5 being on the Palliative Care Register and expected to die.

Dr Parkes commented that it was required by law that a Doctor notified the cause of death and not the fact of death. The specific circumstances of the death would affect whether a GP could issue a Medical Certificate of Cause of Death (MCCD). He outlined the circumstances where a death would have to be reported to the Coroner, as detailed in his written report which had been circulated with the agenda. He also outlined the formal procedures required if a patient was to be cremated.

A Member of the Panel enquired if it was still permittable to write, “old age” on the Medical Certificate of Cause of Death. Dr Parkes responded that Doctors tried to avoid the use of term as much as possible, but there were certain circumstances where it was permissible to still use the term.

Cllr Sohail Khan commented that GPs out of hours availability was vitally important. Contacting a deceased person’s GP out of hours, from experience, he found to be problematic. In response, Dr Parkes outlined that GPs were contracted to work from 8am - 6:30pm, five days a week, excluding bank holidays. There were out of hours GPs or paramedics who could confirm death after the closing hours of the surgery. Normally they would inform the family that they would need to contact the deceased person’s GP surgery during opening hours to arrange for a Medical Certificate of Cause of Death to be issued. An appointment with the Registrar could not be made until they had the Medical Certificate of Cause of Death. An out of hours GP would not be able to issue the Medical Certificate of Cause of Death unless they had seen the person in the last 14 days prior to death.

Cllr Khan stated that his expertise was in Muslim burials, where there was an expectation for burial to be 12-18 hours following the death of a person in palliative care. If a Medical Certificate of Cause of Death could not be obtained until the GP Surgery was open, then there was potentially a delay in the process, should the death happen out of hours. The delay could be significant if it happened on a Friday evening. Dr Parkes commented that it was an issue where religious need and the law were not connected. There were certain circumstances such as a GP being away on holiday for two weeks, who had been looking after a patient, where they would contact the Coroner to see if they would be permitted to issue a Medical Certificate of Cause of Death. But even this scenario would cause a delay in the process.

4 **Internal process for issuing Medical Certificate of Cause of Death (MCCD) - Royal Wolverhampton Health Trust (RWHT)**

The Patient Services Manager outlined the internal processes for issuing a Medical Certificate of Cause of Death at Newcross Hospital within the Royal Wolverhampton Health Trust. If a person died on a ward at hospital the deceased's relatives, if present, would be issued with a bereavement leaflet. The leaflet detailed the processes which needed to take place following a death. They were asked to contact the Bereavement Office on the following working day between 10am - 4pm, so the stages in the formal process could be properly explained.

The Patient Services Manager remarked that the Ward was expected to call the deceased's GP to notify them of the death, but not the cause of death. A Member of staff from the Ward would then enter the patients administration system and log the patient as deceased. They would then send the patient file to the Bereavement Office. The file would normally be received by the Office on the next working day. Should the person have died on a Friday, it would not normally reach the Bereavement Office until the following Monday. Once the Bereavement Office had safely received the Patient File, they would ascertain which Doctor or Doctors needed to be contacted to complete the Medical Certificate of Cause of Death. If the Bereavement Office knew the patient was to be cremated, they would ask the Doctor to complete the first part of the cremation form at that stage. It was however true to say that at this stage they may had not heard if the patient was to be cremated and families sometimes changed their minds, often due to financial reasons.

The Patient Services Manager stated that once the Medical Certificate of Cause of Death had been completed, the Bereavement Office contacted the relatives to arrange for collection of the certificate. The family could then contact the Registry Office to officially register the death. If the Patient was to be cremated, the Bereavement Office would continue to arrange for the necessary cremation paper work to be completed. The second part of the cremation form had to be completed by a Doctor who had been registered for five years.

The Patient Services Manager stated that the Trust did have a "Rapid Release Policy", which had been used within the Hospital, it formed part of the "Management of the Deceased Patient Policy." She had known the "Rapid Release Policy" to be used at weekends. She was happy to circulate the policy to the Panel along with the Bereavement Leaflet. There was always an on-call Director and an on-call Manager

working for the Trust, 24 hours a day, 7 days a week, who all knew about the "Rapid Release Policy". The Patient Services Manager commented that deaths referred to the Coroner would naturally normally cause a delay in the process for families.

A Member of the Panel asked about the number of staff working in the Bereavement Office and if they faced delays in obtaining the appropriate Doctor to complete the necessary paper work. In response, the Patient Services Manager confirmed there were four members of staff who worked in the Bereavement Office but they were not all full-time. She did not believe they were short of staff. On average there were seven deaths a day at Newcross Hospital. Delays in obtaining Doctors were sometimes caused due to a Doctor having worked nights, or a Junior Doctor being on their study day. The Trust had a target within their policy of issuing a Medical Certificate of Cause of Death within 72 working hours of the patient dying. Regular audits were completed and up to 90% of certificates were issued within 72 working hours. Those that hadn't been issued within 72 working hours were generally deaths which had been referred to the Coroner.

The Head of Public Service reform stated that given there was a statutory target of certifying a death with the Registration Service within 5 calendar days, whether the Patient Services Manager thought a RWHT Trust target of issuing the Medical Certificate of Cause of Death within 72 Working Hours was appropriate. The Patient Services Manager responded that she was aware of the 5-calendar day statutory deadline for the registering of a death. The Trust used working days as the Bereavement Office was not open at weekends. She understood the difficulty of the statutory deadline counting weekends and Bank Holidays as part of the five days.

A Member of the Panel asked if the Bereavement Leaflet given to relatives of the deceased contained reference to the "Rapid Release Policy." The Patient Services Manager responded that there was no reference to the policy within the Bereavement Leaflet. People tended to find out about the policy by talking to the nursing staff on the ward. Cllr Khan commented that he was not aware of the "Rapid Release Policy" at the RWHT. He was aware of Birmingham's and other areas, having worked in Funeral Services in the past. He asked if it was available to view online, as he thought it needed more publicity. Dr Parkes responded that it was an internal policy, which he was sure could be made available to the Panel. The Panel recommended that more publicity be given to the "Rapid Release Policy" at the RWHT and desired to receive assurances that it was up to date and working effectively.

A Member of the Panel commented that it was important to record patients' medical notes accurately to ensure there was a good audit trail, to help ensure the prompt issuing of the Medical Certificate of Cause of Death and assist during Coroner referral cases.

A representative from Sandersons Funeral Services commented that the area which they often received a delay was with receiving the correct documentation for a cremation, which was often received after the Medical Certificate of Cause of Death. It was distressing to families when they could only give a timeframe of when the cremation would be, rather than a fixed date. He asked if there was any way for the Medical Certificate of Cause of Death, to be completed together with the Cremation forms. The Patient Services Manager responded that from the 1 December 2018 that would be normal practice at the RWHT. From this date there would also be a

new Bereavement Centre at Newcross Hospital, which would have a Registrar desk and Medical Examiners staff. There would also be waiting and meeting rooms. The Medical Examiner would scrutinise the patient file, which she thought would arrive quicker to the Office than at present. The family would be offered the opportunity to question the Medical Examiner about the care of the deceased. The process would be more streamlined than previously. A Member of the Panel remarked it was important to communicate the changes to all relevant stakeholders.

A Member of the Panel asked how many Medical Certificates of Cause of Death were completed by the RWHT with 24 working hours of the patient being deceased. The Patient Services Manager responded that she believed it was in the region of 50-60%. Approximately 92% of certificates were completed within 72 working hours. Members asked for the RWHT Audit information on the time taken for the issuing of the Medical Certificates of Cause of Death to be provided to the Panel.

A Member of the Panel asked if there were times in the year where there were more deaths at the Hospital and therefore more demand on Bereavement Services. The Patient Services Manager responded that there was always an increase in deaths during the winter months.

5 **Registrar's Experience**

The Business Development Manager summarised the points contained in the briefing note that had been distributed. Legally deaths had to be registered within five calendar days, which included Weekends and Bank Holidays. Deaths had to be registered within the District where they occurred. A death had to be registered by a qualified informant who was usually a relative. When a relative was not available they could accept someone who was present at the death, the occupier of the house or an official from a public building where the death occurred, or the person making the arrangements with the Funeral Director.

The Business Development Manager commented that there were a number of reasons a death might have to be reported to the Coroner by the Registration Service. This included if the Medical Certificate of Cause of Death detailed an unnatural death.

The Business Development Manager remarked that in order to register a death the Registrar was required to see the Medical Certificate of Cause of Death from the qualified informant. Once this had been seen and the Registrar was content with the certificate being legally valid, they could issue a form which enabled the burial to take place. If the Coroner had been involved, the Coroner issued a separate form, rather than the Medical Certificate of Cause of Death.

The Business Development Manager detailed the latest statistics on the issuing of the Medical Certificate of Cause of Death and the registration of a death. 69% of Medical Certificates of Cause of Death were currently signed within two calendar days in Wolverhampton. 29% of deaths last year had been referred to the Coroner. 95% of Customers who contacted the Registration Office were offered an appointment within two days. This had slipped in January, due to the high demand for registration appointments. 71% of deaths not referred to the Coroner were registered within five days. The Registration Service performance target was 90%. The Registration Service was facing increased pressure from the Home Office to improve performance in this area. 28% of deaths that were referred to the Coroner,

where no post mortem or inquest was required, were registered within five calendar days. Where a post mortem was required, only five per cent of those deaths were registered within seven days.

The Business Development Manager commented that in the last two years there had only been one formal complaint made about the Registration Service. This had been in relation to a customer believing that the Service could not offer an appointment within a reasonable timeframe. They regularly measured customer service satisfaction through surveys. 98% or more of people said they were satisfied with the service they had received from the Registration Service. They had recently been asking a further question to customers, where the registration of the death had taken longer than five days, if they had been happy with the time taken. In September 2018, 94.1% had said they were happy.

A Member of the Panel asked if there had been an increase of cases, where there were no known relatives of the deceased. The Patient Services Manager responded there had been an increase in these cases, and the hospital arranged the funeral. The Business Services Manager commented that she had not noticed an increase in cases, but it did occur. The Council had made the funeral arrangements, if the person had not died in hospital. They were required to advertise to make people aware of the death.

Cllr Sohail Khan stated that in his experience the Registration Service had been very accommodating when an appointment was required promptly for religious reasons. He asked if there was a formal policy to ensure a rapid Registrar's appointment when a burial was required promptly. The Business Development Manager responded that there was a Registrar on call, Saturdays, Sundays and Bank Holidays, with the exception of Christmas Day and Easter. The Registrar was able to issue the "Green Form" in emergency situations, such as for specific religious reasons, to allow a burial to take place before the formal registration. They could not do this if the body was to be cremated. The On-Call Registrar could be contacted on the telephone between the hours of 8am-9am at Weekends and Bank Holidays (except Christmas Day and Easter). She remarked that it was expected from 1 December 2018 to have a Registration Office based at Newcross Hospital, which would allow for a more efficient service for families.

Cllr Sohail Khan asked if the On-Call timeframe was sufficient. The Business Development Manager responded that for the usage so far, she had not been made aware of any problems. She was of the view that it might not be the case in the future and considered that the timeframe probably did need consideration as to whether it should be extended. She had been having conversations with Bereavement Services on the matter who dealt with the staff at the Crematorium who prepared the graves. Cllr Khan commented that he thought the On-Call timeframe was inadequate. His experience was that other Registration Services across the country normally had an On-Call timeframe of 8am-12pm or 8am-1pm. The Business Development Manager commented that she had recently done a benchmarking exercise across the West Midlands Districts and the majority did operate the On-Call Service, 8am-11am or 8am-12pm. She was going to continue consultations with Bereavement Services to see if the timeframe could be extended.

The Consultant in Public Health asked if there was a pathway or system in place to ensure families were aware of the On-Call Registrar Service. He gave the example

of a family in a Hospital who's relative had just died on a Friday evening requiring a prompt burial, he wondered how they would be made aware of the service. The Patient Services Manager responded that the Bereavement Booklet given to relatives contained the numbers to contact the Registrar. She thought that if this number was called it would give the details for the On-Call Service. The Consultant in Public Health responded that he thought this was worthwhile checking, as it was a critical step. If people were fully aware of the On-Call Service, it would give a true picture of the demand for the service. A Member of the Panel commented that many residents believed the Council would not open until 9am, and so would probably call too late. The Business Development Manager commented that the existence of the On-Call Service was mainly communicated to the local Funeral Directors, who would signpost the customer to call the number. A Member of the Panel commented that it would be useful to review the policies, procedures and how information was shared by the Registration Service.

The Scrutiny Officer asked if the Registration Service had cases where the Medical Certificate of Cause of Death had been incorrectly completed by a Doctor. She confirmed that this did happen on occasion and in such circumstances, it would have to be referred back to the Hospital or to the Coroner.

Dr Parkes commented that in his experience delays could occur in booking a time slot for a cremation at the Crematorium. He was aware of people waiting up to three weeks during the winter season. A representative from Sanderson Funeral Services commented that sometimes they were told there would be a two-week delay at the Crematorium but when they went to the site, they found that there were slots available. He expressed an interest in understanding why there were delays at the Crematorium. The Chair stated that this was an area which the Panel could explore in the future and asked for it to be added to the recommendations.

Cllr Sohail Khan commented that the Funeral Directors he had spoken to recently had referred to delays being caused by a backlog at the Mortuary, in addition to paperwork delays and booking a time slot at the Crematorium. He made a general comment that the whole process needed to be made more efficient. A representative from Sanderson Funeral Services commented that one of the main causes of delay was due to paperwork and agreed that it needed to be more streamlined to reduce stress for families. The Chair stated that one of the recommendations should be for the Health Scrutiny Panel, working with relevant partners, to investigate how the official paperwork processes could be more streamlined.

A Member of the Panel asked about how the date of death was determined on the Medical Certificate of Cause of Death and on the official registry entry. Dr Parkes responded that on the Medical Certificate of Cause of Death, the date would be the same day the doctor certified the death. The Business Development Manager stated for the official registry entry the date was taken from the informant and so could differ to the Medical Certificate of Cause of Death, in certain circumstances. As an example, if a person had died at 11pm but a Doctor did not visit until 2am, whilst the Doctor would certify the death as the day after the person had actually died, the informant could give the date of actual death for the registry entry. The Medical Certificate of Cause of Death was normally provided to the Registrar by the family in a sealed envelope and so it was not normally seen by the family until the registration appointment. The Registrar was required to ask the informant registering the death, as a specific question, the date of the death. Several Members of the Panel felt that

the process needed to be clarified as they were of the belief that the family had to use the date that was on the Medical Certificate of Cause of Death. The Panel agreed to add it to the list of final recommendations. The Coroner's Lead for the Black Country remarked that the Coroner would always use the certified time of death given by a Doctor and not from what the family had said.

A Member of the Panel asked if the date of death in the official death registry entry could be corrected. The Business Development Manager responded that it was possible to correct the register, but it was a formal process which required evidence. The correction request had to be submitted to the General Registry Office based in Southport, who made the decision.

A representative from Sandersons Funeral Services remarked that it would be useful for families or next of kin to have all the relevant information on the processes following a death collated as one document, which could be given to them when their relative had died. Cllr Sohail Khan commented that practices varied amongst GPs, with some being more accommodating than others. A central document would therefore be useful. The Consultant in Public Health commented that there was potentially a need for a combined partnership-based information resource which could assist families following a death. He cited several areas it could cover, such as "Rapid Release Policy," explaining the Medical Certificate Cause of Death processes and registering a death requirements. It could cover all the processes from the death right up to cremation or burial.

The Head of Public Service Reform stated that there was clearly value in collaborative working regarding the provision of information. He requested that the Panel give some consideration to what key information the families required. He was mindful of not overloading families with information during what was often an emotional and difficult time. Certain information such as a "Rapid Release Policy" would be irreverent to many families. He understood that families relied heavily on Funeral Directors for guidance and in some cases, it was more important for them to have certain information rather than the families directly. A Member of the Panel felt that it was important to cover all eventualities, particularly given the diversity in the Wolverhampton area. They commented that Funeral Directors were often not involved until a certain stage in the process and it was vital to have key information at an early stage. There was a discussion about how much information should be given to families with differing views given. A Member of the Panel commented that a visual pathway, simplifying the process, would be of value. The visual reference could be supported with more detailed information.

The Patient Services Manager commented that in addition to the Hospital booklet, they also gave out a Government Booklet at the Hospital, which was titled "What to do after a death." She felt it was important to consider these documents in full before commencing work on any new resource. Cllr Sohail Khan commented that all the information needed to be publicly available all year round so people were well educated and prepared.

6 **Coroner Office Experience**

The Coroner's Lead for the Black Country outlined the Coroner's Service in Wolverhampton. It was the first time they had been asked to attend a Council Scrutiny Panel. Wolverhampton was one of the four areas covered by the Black Country Coroner, the other three being Sandwell, Dudley and Walsall. On average the Office dealt with 1200-1300 deaths from Wolverhampton per year. It was a small team of ten people, which included the Coroner. Every year they dealt with approximately 4,500 deaths.

The Coroner's Lead for the Black Country stated that since November 2015, they had introduced a new computer system called "Civica Coroners". The Coroner, Mr Siddique was appointed in September 2014 and had been very supportive of the move away from paper systems to electronic. A Portal had been added to the system in the latter part of 2016, which led to significant efficiencies. It allowed GPs and Hospital Doctors to report deaths 24 hours day, seven days a week into the Coroner's system. The Portal was also linked into Funeral Directors and Registrar's. The introduction of the system had significantly improved efficiency and had revolutionised the way the Coroner's Office worked. The Black Country area was one of the first Coroner's areas to go live with the Portal system. There were many Coroner areas in the country still awaiting to launch the Portal system. The Black Country Coroner's Service was considered a centre of excellence and were regularly consulted about the system.

The Coroner's Lead for the Black Country remarked that they operated a triage system in the Coroner's Office. As a death came through into the Coroner's system, there would be an initial triage exercise. If a death could be actioned quickly, a simple Form A would be issued. The Coroner by law had to investigate all deaths including the simple cases. Some cases required an investigation or an inquest. The Coroner Office Team was split in two different categories, those that dealt with community deaths and those that dealt with inquests. She stated that for all deaths referred to them, they always spoke to the family. This was not the case for all Coroner's in the Country. She felt it was important as it helped to keep a level of independence to the process.

Cllr Sohail Khan asked about the out of hours repatronisation phone service. The Coroner's Lead for the Black Country responded that they tried to mirror the service with the Registrar's, some of which were open 8am-1pm at Weekends and Bank Holidays. The Assistant Coroner's were available between these times and the four Registration Services that fell within the jurisdiction had their contact details.

Cllr Khan asked if the Coroner's Service, working alongside Registrar's, could have an out of hours service (where there were staff in the actual Coroner's Office) at Weekends and Bank Holidays. There was a discussion about an out of hours service. The Coroner's Lead for the Black Country said that at the present time they would not be able to carry out the investigations required. She gave the example of if a post mortem was required or a digital autopsy. These would be carried out by a pathologist, who were independent to the Coroner's Service. The resources could also not be justified to meet the needs, as it was rare for a death to be reported at Weekends. Cllr Khan commented that demand could increase in the future and it was important to make preparations. Discussions with Funeral Directors across the Black Country had led him to believe that a full out of hours Coroner's Service was

required. The Coroner's Lead for the Black Country offered to report his comments back to the Coroner.

The Coroner's Lead for the Black Country remarked that they did their best to accommodate families, but they had to ensure legal processes were followed, which included ensuring there was a correct cause of death. They always tried to explain the processes to families to ensure they had a good understanding and kept them up to date.

The Chair asked how long the processes normally took for a post-mortem. In response, the Coroner's Office Lead for the Black Country commented that they worked on a guideline of three days. The examination normally took place on the third day, where the cause of death would normally be known.

7 **Al-Mu'min Muslim Funeral Services**

Cllr Sohail Khan stated that in the Islamic faith it was a religious requirement to bury the body as soon as possible. There was an understanding though that the country was governed by laws that had to be followed before a body could be buried. In the Islamic Faith, the Funeral Directors were expected to take 90% of the burden away from families. It was paramount for organisations to work together to ensure a smooth and efficient service for families. He thought it was important for a standardised policy to be in place to help with families who had specific requirements for the deceased. It was important to plan for the future. He had some concerns about the new Medical Examiner Role, which he thought could potentially cause an added delay if a rapid release was required.

A Member of the Panel commented that the Muslim population was increasing and so it was important to ensure that mechanisms were in place to ensure as quick a burial as possible. It was very distressing if families were not able to bury the deceased quickly.

The representative from Al-Mu'min Funeral Services thanked the Registration and Coroner's Service for their accommodating behaviour in the past. He commented that if processes could be more streamlined in the future, then families would receive a more efficient service from them. He thanked the Panel for the invitation that had been extended to him to attend the meeting.

A Member of the Panel commented that it was important to have an item on burial places in the Wolverhampton area, added to the future Scrutiny Work Programme.

8 **Sandersons Funeral Services**

The representative from Sandersons Funeral Services thanked the Panel for asking them to attend and contribute to the meeting. He commented that they had a good relationship with all the relevant stakeholders. He stressed the importance of the family's needs. He remarked that in his experience things did not always go smoothly when there was a request by the family that did not fit into normal procedure. There were often delays in faith-based questions and if a repatrionisation was required. It was important to have a cohesive system to ensure that families received an efficient and professional service. Communication was important and people needed to have information available to them so they were fully aware of the polices in place.

9 **Next steps - Recommendations and Agreed Actions**

The Health Scrutiny Panel made the following recommendations:

Resolved:

A) That the RWHT circulate the "Rapid Release Policy" to the Panel along with the latest Bereavement Leaflet and the Government Booklet – "What to do after a death".

B) That more publicity be given to the "Rapid Release Policy" at the RWHT and to receive assurances that it is up to date and working effectively.

C) The RWHT Audit information on the time taken for the issuing of the Medical Certificates of Cause of Death be provided to the Panel.

D) That consideration be given to how communication can be enhanced to relatives of the deceased about the On-Call Registration Service, where a prompt burial is required.

E) That consideration be given to extending the On-Call Registration Service timeframe (currently 8am-9am) at Weekends and Bank Holidays (excluding Christmas Day and Easter).

F) That the Crematorium booking system, waiting times and delays particularly during the winter season, be added as a potential future item to the Health Scrutiny Work Programme.

G) That the Health Scrutiny Panel, working with relevant partners, investigate how the official paperwork processes surrounding death can be made more streamlined.

H) That Registrar's ensure there is absolute clarity given to a person registering a death, that the date of death used in the register entry can differ to that on the Medical Certificate of Cause of Death, in certain defined circumstances.

I) That a review be completed on the current resources given out to families following a death and suggestions made for improvement, such as a simple one-page flow chart.

J) That an assessment take place in due course, on how the new Medical Examiner Role and new Register Office being implemented from 1 December 2018 at Newcross Hospital, effects the expediency of the formal processes after death.

K) That an item is added to the future Scrutiny Work Programme on burial places within the Wolverhampton area.

Meeting closed at 12:15pm.

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