Written evidence submitted by the National Association of Funeral Directors (TCS0055)

About the NAFD

Established in 1905, the National Association of Funeral Directors (NAFD) is a trade body which represents the interests of funeral firms, champions high standards of care for deceased and bereaved people and provides a regulatory framework for funeral business within its membership.

The NAFD prides itself on its inclusivity, welcoming members from across the broad spectrum of the industry, ranging from small independent, often family-owned businesses to large PLCs and cooperatives. NAFD represents more than 4,100 UK funeral homes, as well as international firms and suppliers to the sector – providing advice, advocacy, education, and support to help them meet the highest professional standards. NAFD supplier members include funeral planning companies and crematoria.

A founding member of the Deceased Management Advisory Group (DMAG), the NAFD campaigns and advises on a wide range of funeral and bereavement issues, helping to shape the public policy landscape in all four UK nations. We provide funeral consumers with advice on choosing a funeral director; we deliver a comprehensive framework of training and qualifications to help funeral service employees provide compassionate and exemplary professional care; and we host regional and national events that bring the profession together, including the biennial National Funeral Exhibition (NFE) – one of the world's leading funeral sector events.

DMAG was formed in March 2020, at the start of the Covid-19 pandemic, and includes representatives from each of the following organisations: The Association of Private Crematoria and Cemeteries (APCC); Federation of Burial and Cremation Authorities (FBCA); Funeral Suppliers Association (FSA); Institute of Cemetery and Crematorium Management (ICCM); National Association of Funeral Directors (NAFD); National Society of Allied & Independent Funeral Directors (SAIF); and The Cremation Society.

Funeral care is delivered through a partnership of three distinct providers: funeral directors, cemetery / crematoria operators and suppliers to the death care sector. Any significant increase in capacity can only be delivered if there is a high degree of communication and co-operation between all three groups of providers. DMAG was formed for this purpose and enabled a co-ordinated response from the death care sector to the myriad of issues the Covid-19 pandemic raised.

DMAG met daily during the course of the pandemic, and representatives from the Ministry of Justice, Scottish Government, Welsh Government, and the Northern Ireland Assembly attended most meetings, with representatives from Public Health England/UK Health Security Agency, Department of Health and Social Care, the Cabinet Office, and other departments also attending when the agenda required their input. DMAG secured the trust of all four governments in the UK as the key body to liaise with on death management issues.

Within NAFD's membership are funeral businesses that provide all varieties of funeral services, including attended and unattended (direct) cremation and burial funerals, NAFD members include businesses that are contracted to provide services on behalf of Coroners, Local Authorities (public health funerals), hospital trusts (such as management of baby and NVF contracts), and can provide for all cultural requirements, in addition to suppliers to the sector.

Introduction

NAFD is pleased to submit evidence to the Justice Committee Inquiry into the coroner service and changes made since the publication of the 2021 report. NAFD has much to offer in terms of insight and intelligence from our category A funeral home members. NAFD membership covers the whole of the UK and represents approximately 80% of the funeral sector. We regularly survey members to track capacity issues across the death management pathway and to highlight the impact of various systemic delays and bottlenecks on bereaved people. The vast majority of category A members interact with their local coroner services on a regular basis and so we have a good overview of the current service provision and in particular of the severe regional variation that is occurring.

It is our opinion that the whole system is lacking in capacity, exacerbated by the turbulence of the pandemic and the evolving policy environment - including the implementation of the statutory elements of the long-awaited medical examiner scheme (to come into effect in April 2024), and that the impact on bereaved people of the consequences of this is not fully appreciated or understood.

Delays across the death management pathway and the impact on bereaved people

NAFD surveyed its funeral home members in England ahead of drafting this submission and the comments and recommendations included below are informed directly by the responses we received from our members, all of whom are operational funeral directing businesses, in every region of England, delivering every kind of funeral care to a variety of diverse cultural and religious communities.

The most recent NAFD member survey demonstrates that there has been little improvement in the experience of bereaved people since 2021, from the perspective of the impact on the death management pathway and the operators involved in throughput at different points. In summary, delays in the release of deceased people by the Coroner continues to be a problem, with 64% of respondents reporting delays were either a little worse or had not changed over the last six months, and 12% reporting delays had got a lot worse.

Delays across the death management pathways can have a severe impact, both operationally for the public and private sector stakeholders, but also for grieving families and friends. Where the death is unexpected, and is to be referred to the coroner, this situation is exacerbated significantly. When asked the following question *'In 2021, the Justice Committee made recommendations to put bereaved people at the heart of the Coronial Service and reduce delays in the release of deceased people. In your view, how much progress has been made towards these goals?'* 34% of respondents acknowledged some progress had been made but over 60% said no progress had been made and/or that there had actually been some regression. Only 5% considered that significant progress against the overall objective of putting bereaved people at the heart of the coronial service had been made since 2021.

The regional spread of funeral businesses - which reflects the reality of modern life and communities- means that funeral directors are often required to deal with multiple coroner services covering several different areas. When asked about *'significant regional variation in practice and performance'* nearly 70% of respondents said they could identify regional differences.

Further details on the exact nature of the delays and the causes, is included below in the answers to the Committee's questions. The overarching delays are, in our opinion, a result of a lack of capacity across the entire death management pathway. This is a situation frequently reported to us and one

that is appearing to deteriorate. This situation has not improved since the pandemic, and in some areas can be seen to be worsening.

NAFD considers that the development of the long-awaited Medical Examiner (ME) scheme and the implementation of the statutory elements of the scheme (from April 2024) is adding to the delays being experienced. Under the new arrangements, all non-coronial deaths will be scrutinised by a Medical Examiner. However, the progress towards that aim in primary care varies currently from area to area. Anecdotal evidence suggests that in some areas the system is operational in primary care and working well, in others there is little or no awareness, although this appears to be changing swiftly post new year. When asked, 44% of respondents agreed or strongly agreed that the rollout of the Medical Examiner locally was adding to the capacity challenges in the Coronial service. Of further concern, is the 38% of respondents who had 'no opinion'. Given the changes to the scrutiny of deaths, process and paperwork that will be brought about by the new system in April this year, this is a concerning statistic and suggests that funeral practitioners lack awareness of and involvement in the forthcoming changes in their local area. Given the fragmented nature of the whole death management pathway, from death to funeral and disposal, it is essential that all impacted agencies and partners are fully involved at every stage of implementation, to protect the public - bereaved people - from the consequences of a disjointed, delayed, and overstretched system.

Questions

NAFD is keen to support the work of the Justice Committee in ensuring that bereaved people are at the heart of the coronial system. The impact of delays, a lack of information, and poor communication on the mental health of grieving people cannot and must not be underestimated. Whilst we applaud this most recent effort of the Committee to examine how well the system is working for bereaved people, we consider that further questions about the operational aspects of the throughput have been missed from the list of questions posed We have taken the liberty of providing this information here in the above statement. It is NAFD's opinion that this information will be of significance to the Committee's assessment of how well the system is working for bereaved people and should be taken into account. The most significant issues are; delays impacting in various ways on grieving families; unacceptable variations in the level of service regionally; poor communication with bereaved families, and other stakeholders across the UK death management pathway. NAFD appreciates that there is no easy solution to the address all of the above given the evolving policy and operational circumstances. More detail is contained below.

- *What progress has been made towards the goal of placing bereaved families at the heart of the Coroner Service.*

NAFD survey data suggests that the funeral directing sector does not consider significant progress has been made towards the goal of putting the experience of bereaved people at the heart of the coronial service. The largest group of survey respondents said no progress had been made, or there had been some regression. Quotes from the survey responses are attached below.

'The entire system to establish cause of death, be it via the coronial or medical referee route, is under staffed and under-funded, which is adding to the delays experienced by families and making visitation in chapels viewing rooms much more difficult. How can this be deemed to be putting the bereaved at the heart of a process that we all knew was about saving money' (Kent)

- *What progress has been made by the Government in implementing those of the Committee's earlier recommendations which it accepted in September 2021.*

The Government accepted six of the Committee's 2021 recommendations, with a further 11 where it committed to undertake further work. NAFD considers that of these accepted recommendations, little improvement to the experience of bereaved people can be observed. Progress may have been made towards the implementation of those recommendations (such as merging areas), but that has not demonstrably improved the situation for bereaved people. Over 38% of survey respondents considered that some progress had been made, with another 38% considered no progress had been made, with only 6.6% saying considerable progress had been made, which is disappointing.

In 2021 the Committee recommended that the Coroners and Justice Act 2009 be amended to make it easier to merge coronial areas, and to improve consistency of service. It is NAFD's opinion that this action has made little difference in those areas and has often caused additional confusion across the sector and has negatively impacted communication with families and stakeholders.

'Our Coroners area has just merged, with staff [now] working across a greater area. Issues that we highlighted to the relevant authorities including the Ministry of Justice are now becoming apparent even though guarantees [were made] that they would not be. Due to the greater geographical area and colleagues within the coroners service working in separate areas it often feels disjointed. In addition, both funeral directors and families cannot get a hold of the coroners system. They choose to email more and more and this makes the service more robotic and makes families feel more removed'. (West Midlands)

Although we usually work with the Birmingham and Solihull Coroner…we do seem to have a quicker response when dealing with other Coroners such as Warwickshire, and Nuneaton. (West Midlands)

Our now new larger coronial area has only one public mortuary as the council chose to close the South Staffordshire one pre merger. We are therefore running a larger coronial area with the same number of pathologists, APT's and fridge spaces. Stoke on Trent Council has also agreed to facilitate the use of a third party company to use the public mortuary as a base for non invasive scanning PMs. Whilst this method definitely benefits the deceased, and the condition of them due to the non invasive nature, it does not assist with storage capacity. As bodies are brought in from out of the area (Derby) for the use of the scanner, this can then result in "Our" bodies being left in a mortuary awaiting a space to be free to be taken in to allow for the post mortem. This could be the hospital mortuary or an FD's. This can at times be up to 6 weeks, meaning that families do not have the chance to say their goodbyes. (Stoke on Trent)

The shortage of pathologists and access to postmortem arrangements across the country is an increasing issue and does not appear to have been impacted positively by government and NHS actions since 2021.

'I must comment I feel sorry for families in the south of the county for two reasons, one their loved one is being taken far away to enable a PM, and this isn't aligning with families wishes. Secondly, when someone passed away suddenly in the community in the North of the county they are taken directly to the public mortuary, whereas in the south they are taken to the families chosen FD. This then puts those families in the south at a greater disadvantage as they have to wait for a "Space" to become available so they can be accepted at the mortuary. People who die after them but die in the north of the county will often "Jump them in the queue" as they gain admittance straight to the mortuary.' (Stoke on Trent)

- *What progress has been made by the Government in responding to those of the Committee's recommendations which it was unable to address in September 2021.*

Oversight and consistency are key to the delivery of an efficient and effective service and both appear to be lacking in the delivery of the coroner services. NAFD members regularly report frustrations over regional variation and consistency of service delivery. In addition, issues related to the care of deceased people are frequently flagged to NAFD. Where concerns are serious enough and attempts to address locally have not proved successful, NAFD has itself reported issues directly to the Human Tissue Authority (HTA) and/or to the Ministry of Justice on behalf of our members. If the service is going to continue to operate without a dedicated coronial inspectorate, and the service is not to be remodelled as a single unified coroner service for England and Wales then the government must take immediate action to address the inconsistencies across the country, with a focus on experienced of bereaved people. This must include an awareness of the impact of poor and fragmented 'deathcare' on grieving families and loved ones.

- *Given that the Government has rejected the Committee's recommendation to unite local coroner services into a single service, what more can be done to reduce regional variation and ensure that a consistent service operates across England and Wales.*

Delays to the service must be addressed as a matter of urgency. The reasons for delays across the entire death management pathway, UK wide, is multifaceted and varies in severity from region to region. In 2023 NAFD published a report *'Picking up the Pieces'* that revealed the extent to which delays and capacity crises in the UK's fragmented death management services were leaving funeral directors unable to protect bereaved families from a system that is struggling to cope with the needs of the nation. The report included feedback from more than 1,000 funeral homes across the UK about the increasing difficulties they are experiencing, with issues including delays in the Coronial system and in the release of death certificates from doctors, lack of appointments at Registry Offices, mortuary capacity crises and increased wait times for funerals. All these separate influences contribute to an increasingly strained death management pathway being navigated by bereaved people and funeral directors. The mental health impact of such delays on grieving people cannot be underestimated.

In terms of consistency, the differences from area to area can be severe. With some respondents advising that their local service works well, however nearly 70% of respondents could identify differences from region to region.

'We do not find any delays, the coronial procedure in our area seems to work very well. We are told in advance if a case is expected to take longer than normal.' (Worcestershire)

'Generally, once the Coroners Officer has been assigned to the family, they appear to be kept up to date and their questions are answered. On a number of occasions the Reading Coroners office have liaised with our office prior to conversation with the client (where it is appropriate and necessary to do so).' (Berkshire, Surrey, Hampshire)

'On the whole we deal with the one coroner, however I recently had to deal with an out of area coroner. The bereaved family in this case lived in Spain, still this coroner phoned the family multiple times and left a number that the family could reach them on. This has reassured the family and made them feel like their loved one matters. Out of our local coroners I often hear families saying well we know they are busy at the moment, there is a back log, giving the families [the impression] that their loved one is just another deceased in the system and another case in their back log.' (West Midlands)

'The delays seem to be at the 1st stage of referral to Coroners. Birmingham Coroners is the worst, where families may wait 2 weeks before the Coroner looks at the case'. (West Midlands)

'WALSALL CORONERS MUCH QUICKER THAN BIRMINGHAM'. (West Midlands)

Members report that delays can occur from one county to the other, and also that it can be difficult to get to speak to a coroners officer to establish further information. This is very frustrating for funeral directors when the reasons for, and length of, delays are varying from region to region, yet the bereaved clients all need to receive case specific information.

'Staff not trained correctly in all areas of death procedure especially repatriation cases. They pass cases between each county district ie Blackpool and Lancashire.' (Lancashire)

'Things are now taking longer and getting a deceased collected to go to the coroner is really bad as we have to join the queue and having [a national direct cremation provider] in my area is causing horrendous issues.' (Southampton)

'Delays in receiving clearance from the coroner and also the time in Doctors issuing Cremation 4 forms where required.' (Manchester)

'There is often a delay in getting a decision by the coroner that a post mortem is required and this then delays the release. Once the Postmortem has taken place release is normally within a sensible time span'. (West Midlands)

'Taking at least 7-10 days for a body to be released, even if they just need to speak to the GP'. (Cornwall)

It is NAFD's opinion that the capacity of coroner services is being impacted by increased GP referrals. When asked *to what extent do you agree that GPs are adding to the capacity challenges in the Coronial service by being over-cautious/making additional referrals to the Coronial Service*, just over half of survey respondents agreed or strongly agreed. It is also the opinion of NAFD that the implementation of the statutory elements of the Medical Examiner scheme is having an impact on GP referrals at this time.

'THE TIME THAT IS TAKEN JUST TO DECIDE WHETHER A POST MORTEM IS REQUIRED IS RIDICULOUS.' (South West)

'We find that the only delays in this service derives from the GPs with being over-cautious and making additional, unnecessary referrals. The main issue however is the delay in sending the actual referral across to the Coroner office. We contact the Coroners office to chase an update to find they are unaware a referral is coming'. (Worcestershire)

'We have seen an increase in the number of deaths being presented to the Coroner. A large number resulting in the coroner asking GPs to issue [MCCD].' (Birmingham and Solihull)

'MEs - Although this is not fully operational in our district at present, we have had our first case this week, which resulted in 10 days before the medical certificate was issued.' (West Midlands)

'In my opinion GPs are not trained correctly in respect of completion of MCCD's and the use of the Coronial Service.' (Sheffield and Rotherham)

'Doctors are not attending care homes when residents are on end of life care meaning that more cases are being reported to coroners for no reason.' (Cambridgeshire)

'We believe there are several factors affecting this process which varies from surgery to surgery. It is common for us to be chasing the surgery for paperwork, to be told the death has been referred to the Coroner, for us then to speak to the Coroners office and be told they haven't had contact with the surgery. When you call the surgery back, you get a completely different response. We have also found the Drs are not aware of the process – asking us what do they do? On many occasions, funerals have been delayed because the surgery has not followed the correct processes at the early stages. Neither is it unusual for us to have to chase the surgery for paperwork once the death has been referred back to them – even having to say the funeral risks being cancelled without the correct paperwork.' (Berkshire, Surrey, Hampshire)

'Quite often elderly people pass away of natural causes, we have to wait a couple weeks just for the Coroner to pass back to GP. This causes delays in preparing our deceased so families can view their loved ones before they deteriorate and delays funerals. We also have capacity issues because the deceased are spending too much time in our care. (Dorset and Wiltshire)

'In general GPs not having seen the deceased within the designated time period, in being able to complete the Cause of Death. This is then discussed with coroner and causes delays in having it completed.' (North East)

'Our community hospital [is] back and forth with coroner deciding if reportable or not has resulted in delays. Not contactable or communicative with families.' (Durham)

'Since entering the Winter Period, deaths referred to the Coroner can take up to 3 weeks to be looked [into]' (Birmingham)

'Can take up to 3 weeks then [referred] back to GP.' (Kent)

The Impact of delays and the overall lack of capacity cross the entire death management pathway has an operational impact on funeral directors, on the condition of the deceased and on the grieving families. Choice to view is often removed due to the condition of the deceased person once released.

'When we first became funeral directors, bodies [deceased people] came to us fairly quickly with eyes closed, mouth support in place and no tubes, cannulas, catheters etc. or any other medical equipment still attached to them. It has become our job now to remove all this, reassure the bereaved families constantly that someone will be in touch. In a lot of cases the coroners do not get back to the families fast enough. The 5 day rule does not exist any more.' (Lancashire)

'One of our areas can take so long to release that viewing, even with embalming, can be problematic and distressing for families (more so that otherwise) – (Manchester)

'We are dealing with very distressed families daily in regard to the condition of the deceased. Unfortunately, once the coroner is involved with a death you know you won't be issued a release for at least 2 weeks which then leads to a high chance the condition of the body would be bad and so can't be seen. We spend a lot of time consoling and communicating with families and trying to explain why things take so long but it still doesn't help in their eyes'.

'Our local coroners mortuary, although modern doesn't keep natural changes at bay as well as when the deceased are brought into our care. I believe this is because our fridge is kept cooler and at a

more stable temperature. Also our fridge is regularly thoroughly cleaner which doesn't happen at the coroners mortuary, probably due to constant heavy use.' (Shropshire)

'Deceased being moved from hospital morturies in poor condition to sub-contracted funeral homes without the proper facilities. Have collected deceased not kept in cold storage hence condition worse than should be'. (West Sussex)

'In some instances we are experiencing delays of weeks until we are able to carry out hygienic treatment which severely impacts the presentation of the deceased. In instances where we have carried out a home or nursing home transfer under a statement of intent which is then referred to the coroner via the medical examiner this is massively increasing pressure on our own mortuary facilities as the coroner in most cases leaves the deceased in our care whilst they carry out their investigation.'

'Bodies kept by the coroner for long periods are almost always NOT in a satisfactory condition as they are stored in large cold rooms not in individual fridges and because of that temperature control is not efficient and because of that it's not always possible to present a body for paying of respects'.

'When we, as Funeral Directors have to inform our families that they are unable to view their loved-one due to decomposition where the deceased person has been left in Coronial care, sometimes up to three weeks. This is just not fair.'

- How Coroners respond to the requirements of faith burials and funerary practices, especially in relation to early release of bodies and provision of non-invasive autopsies. Could more be done to ensure a consistent and satisfactory approach across England and Wales?

Survey respondents responded that this is the area where the coroner services do seem to be fairly proactive - in regard to meeting cultural and religious requirements. However, given the capacity issues detailed above greater communication is required with all stakeholders, to explain the process and specific circumstances and to avoid the view that some people are 'jumping the queue'. Improving public understanding is key and we would encourage the Chief Coroner and all other relevant individuals to take time to understand how best to communicate decisions with funeral directors, families and relatives of the deceased person.

- Whether there is evidence that inquests are taking too long to be completed, and if so why, and what can be done in response.

We cannot comment on the inquest process itself, but we do consider that the length of time a deceased person is in the system, from death to release, should be considered beyond the decision to undertake an inquest. The coroner will release a deceased person once they have completed a postmortem examination and no further examinations are required. There are delays, as described above and inconsistency at this stage, a lack of pathologists, stretched services and a severe lack of capacity in digital autopsy. Survey results suggest that operational arrangements are not efficiently organised, that more local services are required, and that more use should be made of digital postmortems.

'Very antiquated facilities at Brighton and Hove City Mortuary. Brand new mortuary at Royal Sussex County Hospital in Brighton, which is not used for PMs.'

'We have a bereaved family whose father died unexpectedly at home. It took so long to carry out the PM and release the body that their mother, who had hoped to see him to say goodbye, but wasn't fit enough to go to the hospital mortuary to do so, has now died'.

'Localised post mortems [would help reduce delays], which take place within days rather than weeks'.

- Whether the Coroners' Service has recovered from the challenges of the Covid-19 pandemic, and what lessons can be drawn from it.

The experience of the death management sector during the pandemic is useful for policy makers and should be considered here, particularly the learning captured on the impact of interrupted funeral care on the grieving process. The experience of bereaved people during the pandemic was quite unlike any other time, with people unable to have the interaction with their loved ones that they desired. Sadly, our evidence suggests that the delays and capacity issues are creating a situation where bereaved people are still experiencing these difficulties, post pandemic.

'The ability to be able to pay last respects, view the deceased (whatever terminology is preferred) is a key part of the grieving process for many families and is (for some) a step towards acceptance. It is very difficult to have conversations with families where we "advise" that viewing their loved one would be unwise due to deterioration. The very notion of this, can suggest a lack of care - that their loved one has deteriorated because no one has been able to care for them while a coroner's investigation was ongoing. This is combined with families experiencing a sense of their loved one being abandoned - lost in a system somehow - a system which doesn't prioritise their care or take into account that their family might wish to see them. There are complex emotions involved, not all families will feel all these things but in my (nigh on) 45 years of working in the funeral profession, I have never seen these sort of circumstances have anything other than a negative effect on the grieving process'.

During the pandemic, NAFD and others argued strongly that the digital transmission of paperwork was essential to speed up throughput. This was enabled and has continued post pandemic. However, the use of digital communications for all communication with bereaved families is mentioned frequently in responses to the survey, and the extent to which this is helpful and/or appropriate must be considered. Many funeral businesses have commented that email is overused, impersonal and that telephone access has been restricted by coroner services.

'They are mostly insisting on everything being emailed. The days of being able to talk to a coroners officer or coroner's admin team are going so it can take much longer to solve any issue. It might make it easier for them, but it slows things down for us and I can't help but feel it's far less efficient.' (Cheshire and Manchester)

'It can take 2 weeks to get a reply to an initial email (they will not answer the phone) and that is before their assistants have even opened a case.' (South East London)

'We are still getting complaints from families regarding coroners process and their lack of clear communication.'

'Being able to verbally communicate with coroners offices is our main issue, every coroner should be more available by phone and not hide behind emails.' – (London)

- Whether there are any other changes to the way the Coroner Service operates that could be made to improve its effectiveness.

The entire death management process needs greater capacity. The coroners service does not work in isolation and relies on the cooperation of other agencies and bodies in both the private and public sectors. Where communication is open and frequent between these agencies, NAFD members report better outcomes.

'I feel that we are used to open communications in our area and find neighbouring areas difficult. For a more consistent service I believe that the funeral director should be notified of the referral, to which Coroner Office and details of the Coroner's Officer handling the case. This could easily be handled with in an automated email system.' (Worcestershire)

'Deceased must be released quicker - Families struggle to understand why everything takes so long to come to conclusion, and when it is an unexpected death, this adds to their trauma.' (Cornwall)

Delays in the release of deceased people must be monitored and addressed. With clear time frames published and guidelines for GPs. Unnecessary referrals as well as delayed initial referrals are creating a snowball effect of delays for families. Evidence suggests that the new Medical Examiner system is resulting in GPs making more referrals, putting pressure on an already stretched system. More support is needed for GPs, funeral directors, and others at a local level as they navigate this new system.

'*Centralise responsibility for the coronial service with, say the Ministry of Justice and remove from unitary authorities.*'

NAFD is supportive of the creation of a single unified service, and we agree with the Committee that there is 'unacceptable variation in the standard of service between coroner areas', and that this has not improved since 2021. NAFD is also supportive of the creation of a Coroner service Inspectorate, and the public reporting of levels of service provided to bereaved people.

Where good practice is identified there must be clear mechanisms for this to be shared and promoted widely, particularly when the experience of bereaved people is improved. Clear, consistent, and compassionate communication with grieving people is absolutely essential. Understaffing and inadequate training within coroner services has been highlighted as a particular problem by our members, again this should be assessed and steps taken to ensure that everyone that has interaction with bereaved people is adequately equipped to do so.

For more information please contact

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