

Funerals market investigation

The role of intermediaries in the process of choosing a funeral director

30 January 2020

This is one of a series of consultative working papers which will be published during the course of the investigation. This paper should be read alongside the [Issues Statement](#) published on 8 April 2019 and other working papers published.

These papers do not form the inquiry group's provisional decision report. The group is carrying forward its information-gathering and analysis work and will proceed to prepare its provisional decision report, which is currently scheduled for publication in April/May 2020, taking into consideration responses to the consultation on the Issues Statement and responses to the working papers as well as other submissions made to us.

Parties wishing to comment on this paper should send their comments to Funerals@cma.gov.uk by 27 February 2020.

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The Competition and Markets Authority has excluded from this published version of the working paper information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. [Some numbers have been replaced by a range. These are shown in square brackets.] [Non-sensitive wording is also indicated in square brackets.]

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Executive Summary

1. In our Issues Statement we said that we would consider the role of intermediaries, such as care homes, hospices and hospitals, in influencing consumers' choices.¹ The evidence we have gathered to date is set out in this working paper.
2. In this working paper, we note that:
 - (a) It does not necessarily follow that unless a death is sudden and/or unexpected, people will plan the funeral ahead of the death or make their choice of funeral director based on an objective assessment.
 - (b) In general, where care homes or hospices need to arrange for a funeral director to collect the deceased, the funeral director is chosen by the family. However, there is evidence of cases of the deceased being moved from care homes or hospices either without families' consent or with families finding it difficult to assert their own preferences, with this perhaps not always being justified by practical reasons.
 - (c) Although some care homes, hospices and hospitals have informal arrangements for the removal of the deceased to a funeral director's premises at the request of the care provider, we have identified few such arrangements at this stage.
 - (d) There is evidence that some staff in care homes, hospices and hospitals provide recommendations to their residents and the relatives of their residents, although this does not appear to be common practice. There is evidence however that some funeral directors seek to build relationships with care providers, and we have been made aware of new initiatives that could have a distorting effect on the competitive process.
 - (e) In relation to coroners' contracts, where the funeral director takes the deceased to the coroner's premises, it may have an opportunity to make contact with the bereaved, and this may give it an advantage in terms of influencing the bereaved's choice of funeral director. This is supported by evidence that some funeral directors have bid for coroner contracts below cost. We do not however have evidence on whether customers that a funeral director might gain in this way pay higher prices than other customers. Coroner contracts are won by independent funeral directors as well as by the largest providers.

¹ [CMA Funeral directors and crematoria services market investigation – statement of issues \(April 2019\)](#), paragraph 76.

Introduction

3. We have examined the extent to which certain circumstances of a person's death – whether the death was expected, where the death occurred, the actions of intermediaries (in particular, care homes, hospices and hospitals, and the involvement of the coroner) – may influence the choice of funeral director.
4. This paper is organised as follows:
 - (a) It first summarises our understanding of how some key circumstances of a person's death can affect the time available for, and nature of, the choice of funeral director;
 - (b) it examines the roles which may be played by care homes, nursing homes, hospices and hospitals in end of life care and planning, and the extent to which this may have a bearing on the choice of funeral director;
 - (c) it then considers whether competition may be adversely affected through the involvement of care homes, hospices, hospitals and by any formal or informal arrangements they may have with funeral directors; and
 - (d) it ends with an assessment of how competition may be affected by the involvement of coroners (or, the Procurator Fiscal in Scotland).

Circumstances of a death

5. The circumstances of a death can affect the process of choosing a funeral director. One mid-size funeral director told us 'The context of a death can have a great bearing on client behaviour, beginning with whether it was a sudden or anticipated death.'

Whether a death is expected

6. For many people, death is expected: it is not sudden in around 70% of cases. A 2018 survey carried out by a large funeral director ([redacted]) found that for [redacted]%, death was sudden and completely unexpected, for [redacted]% there was a short period of illness and for [redacted]% there was an extended period of illness.
7. In cases where a death is expected, a choice of funeral director may have been made before death and potentially communicated to a care provider. We have been told by funeral directors that, for people in a care environment, end-of-life plans may be in place which might include details of a preferred

funeral director.² Care providers have also told us this, although the percentage of residents that have stated a preferred funeral director on admission appears to vary across care homes.³

8. It does not necessarily follow that unless a death is sudden and/or unexpected, people will plan the funeral ahead of the death or make their choice of funeral director based on an objective assessment: the immediate period preceding a death can be very busy, distressing, and stressful, making it difficult for people to make choices, as illustrated by two funeral customers we spoke to, who had gone through this process. One customer explained that ‘We moved [my father] into a care facility, so it was not a hospice, but they did have other people with ongoing and quite demanding treatments, so we moved him in there, so he was literally just round the corner from me, but he was undergoing treatment still, so, although he sort of deteriorated quite rapidly, unfortunately he died without a will or having any funeral plans arranged. We hadn’t even discussed anything further than I knew that he would want to be cremated because my mum and my brother were, but when everything actually happened, it was sooner than we expected. We were planning to get everything done in the upcoming weeks, but it happened slightly quicker than anticipated. So, we didn’t really have anything in place or even had the appropriate conversation with him.’
9. Another customer described her experience as follows: ‘At the time of my husband’s death I had been sat beside his bed for eight days, I had had very little sleep and I did not know if I was coming or going. Plus, I then ended up with bronchitis and pharyngitis [...] The reason we had not made any funeral arrangements was because my husband had signed a body donation with an organisation who welched on it at the last minute. When he died, they said “No”, because he had Alzheimer’s.’
10. Amongst respondents to the Market Investigation consumer survey who had compared funeral directors, most had not done so until after the death of the deceased person.⁴
11. When death is unexpected, this will also tend to make the process of choosing a funeral director harder. For example, at its hearing, the National Society of Allied and Independent Funeral Directors (SAIF) told us that ‘In the case where a sudden death had occurred, particularly a death of a young

² See paragraph 41 and corresponding footnotes.

³ See paragraph 30 and 31.

⁴ CMA Market Investigation consumer survey, Tables 85-87, Question FD14. Base: all who compared funeral directors (n=48). Just six respondents said they had first compared the services of two or more funeral directors prior to the death.⁵ [Summary of hearing with SAIF, 18 July 2019.](#)

person, because of the level of shock it may be several days before the family is in a position to make any decisions. In such circumstances, they might seek advice from friends, family or local GP for guidance'.⁵ This is further illustrated by case studies from our Market Study consumer research where immediate relatives of the deceased were too shocked to make decisions, instead relying on other relatives to do so.⁶

The place of death

12. When the death occurs in a care home (around 22% of deaths) or a hospice (6% of deaths),⁷ an immediate removal of the deceased by a funeral director is usually necessary, because these settings may have limited or no body storage facilities. The Human Tissue Authority (HTA) told us that it thought it unlikely that care homes would have refrigerated storage for bodies, and hospices may have limited or no refrigerated body storage facilities.⁸
13. The need for a funeral director to remove the deceased as soon as possible was also discussed at a round table with 'progressive' funeral directors, who told us that some care homes and hospices do not have any mortuary facilities.⁹ A large funeral director ([redacted]) told us that 'in the event of someone passing away at home or at a nursing home or hospice, customers normally instruct a funeral director (which could be a funeral director that is recommended, they are aware of or is the closest) quickly to take the deceased into their care. This is done prior to making any formal arrangements for the funeral... [this approach] reflects the need for a decision to be taken quickly on the removal of a body where the death takes place at home or in a nursing home or hospice due to the lack of appropriate facilities to store the deceased'.

⁵ [Summary of hearing with SAIF, 18 July 2019.](#)

⁶ [Market Study Qualitative Research report October 2018](#), case studies 3 and 5.

⁷ [Public Health England Palliative and End of Life Care Profiles for 2018](#). Public Health England's Classification of place of death guide defines a 'care home' as including residential and nursing homes, run privately, by the NHS or by local authorities; 'hospice' includes many charitably funded independent hospices, such as Sue Ryder homes and Marie Curie Centres, and specialist palliative care centres. The guide notes that some hospices are located within NHS hospitals, which may not be clearly identified on the death certificate, in such circumstances the place of death is usually recorded as 'hospital'. Also, hospices increasingly work in the community, but information on who was caring for the patient at the end of their life is not recorded on the death certificate. The guide states that, as a result, mortality statistics underestimate the true number of people who receive hospice care at the end of their life.

⁸ [The HTA is the regulator for human tissue and organs](#)

at present, including public and hospital mortuaries. The HTA pointed out that in its usage, the term 'mortuary' usually refers to a place in which post mortem examinations are carried out, as distinct from somewhere that is only a 'body store', and that funeral directors may use the term mortuary in reference to the area where embalming appears on the premises.

⁹ [Roundtable with 'progressive' funeral directors, 21 August 2019.](#)

14. We have heard from customers that if the choice of funeral director has not already been made before the death, the decision can be very time-pressured when the death takes place in a hospice or care home.¹⁰ One funeral director who took over arranging a funeral from another funeral director told us that its customer, who had not even considered choosing a funeral director when her husband died in a hospice, had been told by the hospice at 1.30 in the afternoon that he needed to 'be gone' by 5pm. The customer ended up making a knee-jerk decision when the hospice called at 5, and subsequently changed funeral director as her experience with the initial funeral director was poor. Our Market Study consumer research found that a group of respondents were under time pressure for practical reasons if the deceased's body needed to be moved quickly (typically if they died at home or in a care home).¹¹
15. As noted above, even where the decision about a funeral director is made before death, customers may be doing so at a time which is nonetheless very difficult. For example, the decision might be made at the point of moving into a care home. The CMA found in its Care Homes market study that choosing a care home is often an extremely difficult decision for people to make, often made at a point in their lives when they are particularly vulnerable. The Care Homes market study consumer research found that there was often very little prior consideration of care needs and options by prospective residents, their representatives and their families. Frequently, decisions on care are faced for the first time following a sudden illness, injury or loss of a carer meaning they are often made with urgency under extremely distressing circumstances.¹² Under such circumstances, it may be difficult for people to shop around for a funeral director, and unlikely that they do so.
16. Similarly, when a death takes place at home (around 24% of deaths),¹³ although there is no requirement for immediate removal,¹⁴ this situation is likely to place pressure on the family to contact a funeral director for removal¹⁵ (unless the removal is carried out by a funeral director on behalf of the coroner in cases where they are involved). We heard from one funeral customer whose relative died at home during a hospital home visit. The customer was told by the visiting 'medical professional' that she was able to certify death and that the body had to be moved immediately, and the

¹⁰ As described by certain funeral customers we spoke to.

¹¹ [Market Study Qualitative Research report October 2018](#) paragraph 4.3.6.

¹² [CMA Care Homes market study, November 2017](#).

¹³ [Public Health England Palliative and End of Life Care Profiles for 2018](#).

¹⁴ See eg [advice from Cancer Research](#).

¹⁵ As the findings from paragraph 4.3.6 of our [Market Study Qualitative Research](#) indicate.

customer therefore felt under pressure to choose a funeral director with insufficient time to make an informed choice.

17. When the death occurs in hospital (around 45% of deaths)¹⁶ or other care setting with body storage facilities or a mortuary (the HTA noted that some hospitals have body storage facilities and do not have mortuaries), the bereaved are likely to usually have a little more time to consider their choice of funeral director since we understand that most hospitals have body storage facilities and/or mortuaries. SAIF confirmed that if a death occurred in hospital, the deceased would be cared for in the hospital mortuary until the body was moved to the funeral director of the family's choice.¹⁷ A large funeral director ([X]) told us 'For deaths in hospital, there is arguably more time for families to make their decision in relation to which funeral director to use, since hospitals generally have mortuaries in order to store the deceased.'¹⁸
18. However, some hospitals can experience capacity issues at their body storage facilities/mortuary, or have no facility at all, and in this case may instruct a funeral director to store the deceased on their behalf. The HTA said that its understanding is that mortuaries are more likely to operate at or near capacity during winter periods, and at this time bodies could also be stored for longer periods. It carried out a study on capacity in HTA-licensed mortuaries in 2015.¹⁹ The study noted that in their contingency arrangements, establishments may use temporary storage including transfer to funeral directors. It noted that 60% of mortuaries had to invoke their contingency arrangements at least once during the year and that around one quarter of establishments may transfer bodies to funeral directors for contingency storage.

Arrangements with care providers and coroners' contracts

19. In addition to comments about time pressures, we also received some submissions about, and heard criticisms in relation to, formal and informal arrangements that specific funeral directors have with care providers (including care homes, nursing homes,²⁰ hospices and hospitals), arguing that

¹⁶ [Public Health England Palliative and End of Life Care Profiles for 2018](#).

¹⁷ [Summary of hearing with SAIF, 18 July 2019](#).

¹⁸ The very small number and size of contracts that the large funeral directors have for providing mortuary facilities to hospitals (as summarised in the later section on the role of care homes hospices and hospitals) is also consistent with this.

¹⁹ [Storage capacity and contingency arrangements in mortuaries: guidance for designated individuals in HTA-licensed establishments, November 2015](#).

²⁰ References in this paper to 'care homes' also include 'nursing homes'.

these may be harming competition between funeral directors. Similarly, we have received submissions about the effect of police/coroner contracts.²¹

20. When the coroner is involved after a death – for example, if the death is sudden and unexplained²² – families are likely to have additional time to choose a funeral director.²³ In its hearing, SAIF indicated that the time taken by coroners’ offices to investigate cases is increasing, although it noted that this does not preclude funeral arrangements being made during that period.²⁴ In 2018, 41% of all registered deaths were reported to the coroner (in England and Wales), and post-mortems were carried out in 39% of those cases.²⁵
21. The broader role which care homes, hospices and hospitals may have in influencing customers’ choice of funeral director, the role of formal and informal arrangements with care providers, and the role of coroners are discussed in more detail below.

Role of care homes, hospices and hospitals

22. In our Issues Statement we indicated that we would consider the role of intermediaries, such as care homes, hospices and hospitals, in influencing consumers’ choices.²⁶
23. Given consumers’ position of vulnerability, and the fact that some consumers may need to make decisions under considerable time pressure when a death occurs in a care home or hospice, staff in these settings can be influential in consumers’ decision making.²⁷ More generally, the advice of care homes and hospices as a trusted advisor is something that families may value deeply.
24. We have sought to test how influential such staff are in consumers’ decision-making, including through discussions with care provider representatives (some of whom sought further information from their wider membership), individuals with experience and/or expertise in the care sector, questions asked in the Market Investigation consumer survey, and interviews with people who contacted us about their experience of arranging a funeral. We

²¹ [Co-op response to CMA interim report](#), 4 January 2019, paragraph 2.9; [Fairer Finance response to the CMA’s statement of scope for its funeral market study \(page 2\)](#); [Dignity response to the CMA’s issues statement, paragraph 5.25](#).

²² <https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner>.

²³ See eg [information on the Dignity website](#).

²⁴ SAIF noted that the risk in making arrangements is they might need to be cancelled if the delays are extended.

²⁵ [Ministry of Justice’s annual coroner statistics report](#).

²⁶ [CMA Funeral directors and crematoria services market investigation – statement of issues \(April 2019\)](#), paragraph 76.

²⁷ [CMA Funerals market study: final report and decision on a market investigation reference](#) (paragraph 3.9); see also [Market Study Qualitative Research report October 2018](#), case study 6.

have also sought evidence on the existence of formal and informal referral arrangements between care providers and funeral directors through a call for evidence aimed at funeral directors ('call for evidence') and other means,²⁸ in light of concerns expressed to us about the existence of such arrangements.

Care providers' perspective

25. We have spoken to a number of care provider organisations to better understand the nature of information relating to funeral choices that is discussed with, or provided to, people in their care (or their relatives), in the later stages of people's lives. The picture that emerges is that information/support to assist people in choosing a funeral director and arranging a funeral is not routinely disseminated across all types of care provider, and where it is provided, it is not in a standardised form. That said, discussions about funeral arrangements and choice of funeral director may take place in the context of formal end of life care planning processes/discussions.
26. We have heard from these organisations that, in general, care providers are unlikely to recommend particular funeral directors, although they may provide a list of funeral directors. The National Care Forum (NCF) sent a survey of questions supplied by the CMA to its members. It received 21 responses (a 20% response rate). One question asked: 'Does any information you provide include recommendations for particular funeral directors?'. The NCF told us that 'Overwhelmingly, respondents said they do not include recommendations for funeral directors.' Another care provider representative suggested that care homes are unlikely to become involved in choosing a funeral director as a result of a clamp-down by the Care Quality Commission (CQC) on care providers getting involved in the financial or legal affairs of residents, with involvement in choosing a funeral director seen as part of that 'no-go' area.

²⁸ While noting that informal arrangements in particular are very difficult to evidence (for example because they may relate to specific staff in a particular care home), during the Market Investigation we have: (a) Carried out a call for evidence targeted at funeral directors asking about such arrangements ('call for evidence'), which was publicised by SAIF, the NAFD and The Good Funeral Guide to their respective members. In response we received comments relating to around 42 (alleged) formal and informal arrangements. The number shown relates to the number of arrangements implied by the responses received, rather than the number of responses received, although some responses mentioned the existence of such arrangements in general, rather than naming specific care providers – these responses have been counted only once in the total shown. (b) Received submissions from funeral directors about informal arrangements between funeral directors and care providers (in addition to the responses to the call for evidence); (c) Asked questions in information requests and hearings to the large funeral directors and trade associations.

Role of the Care Quality Commission in end of life care services

27. The CQC inspects and rates end of life care services in hospitals, community health services and hospices, and assesses quality of end of life care as part of its approach in other settings, including care homes and GP practices. Amongst many other factors, the CQC's frameworks seek to address how people who may be approaching the end of their lives are supported to make informed choices about their care; they also examine whether people's decisions are documented and delivered through personalised advance care plans.²⁹ The frameworks do not, however, focus specifically on supporting people with funeral planning or making funeral choices.
28. The CQC's sector-specific guidance for hospices for adults³⁰ assesses whether those close to the patient are offered information on how to access bereavement support; whether staff have an understanding of the practical arrangements needed after the death of a family member; and whether people's spiritual, religious, psychological, emotional and social needs are taken into account. It also assesses whether the service provider ensures that care after death includes preparing the body for transfer to the mortuary or funeral director's premises.

Care homes, nursing homes and hospices

29. An individual with experience and expertise in the care sector told us that most of the conversations care home staff have with people about funerals or about their funeral plans arise in the context of end of life care and care plan arrangements, and that such conversations are likely to take place in the first couple of weeks after someone is admitted to a care home. The individual noted that the discussions tend to be about the general sort of funeral people would like to have rather than particular funeral directors. She also suggested that care home staff are unlikely to initiate discussions about specific funeral directors. She did not believe that care home staff give recommendations on the choice of funeral director, as this is a personal matter – in her experience, they do not feel comfortable recommending a particular funeral director.

²⁹ See CQC's assessment framework [Key lines of enquiry, prompts and ratings characteristics for healthcare care services](#). This assesses how acute and community health service patients who may be approaching the end of their life are supported to make informed choices about their care. The CQC's [Acute core service – end of life care](#) assesses what emotional support and information is provided to those close to people who use services and whether people are given the opportunity to create an advance care plan. This is underpinned by the [Bereavement Care Service Standards](#), a professional standard developed by Cruse and the Bereavement Services Association, which provides a practical tool against which to benchmark what services such as hospitals and hospices offer. The standards set the criteria for what clients, carers etc can expect from bereavement care services.

³⁰ [Sector specific guidance for hospices for adults](#).

30. 20 members of the NCF indicated the percentage of current residents that stated a preferred funeral director when admitted to one of their care homes (it should be noted that some care providers who were surveyed provide services for vulnerable people of working age, as well as older people). The results are set out in the Table below.

Table: Percentage of residents that stated a preferred funeral director

<i>Number of residents</i>	<i>What is the percentage (%) of current residents that stated their preferred funeral director when admitted?</i>
55	0
Respondent skipped question	Respondent skipped question
41	5
126	10
50	10
970	15
41	20
4	25
48	25
110	25
74	25
58	30
51	30
44	38
58	60
66	75
23	75
47	90
58	95
57	98
47	100

31. A care home provider and member of The Registered Nursing Home Association (RNHA) indicated that a pre-admission assessment question is asked to all new residents of his homes to find out whether they have a pre-paid funeral plan, or a preferred funeral director - he suggested that most do. If an answer is not recorded at that stage, the question is asked at the start of the end of life planning stage, or at 'best interest' assessment stage. There is generally no other involvement in terms of helping the resident choose a funeral director or asking about their choice of funeral director. The representative we spoke to noted that care home operators do not want to be seen to favour any particular funeral director, although they may sometimes provide a list of local providers. Another care home said that 50% of its residents had indicated a preferred funeral director.
32. Similarly, Hospice UK (HUK) suggested that the nature of any advice given by their members is likely to be of a general nature, rather than a recommendation for a particular funeral director, noting that they are cautious about any preferential relationships. HUK also pointed out that 80% of hospice care is in people's homes, therefore, the majority of funeral arrangements will be made from people's homes.

33. The National Care Association told us that providers do not get involved in arranging funerals, as that is not their remit. In exceptional circumstances, if a provider is asked about a funeral director in the locality, they may know of directors in the locality they may signpost people to.
34. The NCF told us that there may be occasions after the death of a resident when there is no family or other person to arrange the funeral, in which case the care home will decide what to do in terms of arranging the funeral.
35. The RNHA said that a care home might use a different funeral director to the one identified by the resident or their relatives if someone dies at the weekend, and the body is to be moved out of the area to the preferred funeral director (often to the area the resident previously lived). In particular, especially in rural areas, there can be issues with getting a second GP to certify the death, meaning the body will need to be kept locally until certification. This can generate an additional fee to be paid to the first funeral director.
36. Despite the general views expressed above, it seems clear that information provision may vary widely at a local level. For example, HUK noted that the activities of hospices are very decentralised, with 220 charitable hospice providers across the UK. It also said that some hospices may produce information at a local level.

Hospitals

37. We understand from NHS England that all hospitals (in England) have bereavement offices which provide information and support to bereaved families and relatives. The information is developed at Trust level, rather than centrally. Bereavement booklets/guides are routinely produced by palliative and end of life teams, and include information on issues such as death registration, arranging tissue donations and contacts for bereavement offices. It is standard practice to include advertisements for a range of local funeral directors in those booklets. We are aware of examples of advertisements by funeral directors and other organisations being included within such booklets in return for funeral directors contributing to the cost of printing and publication of the booklet, or collectively funding the booklets, along with examples of Trusts stating in their booklets that the Trust does not endorse any of the organisations included.
38. An independent consultant in palliative and end of life care was of the view that hospitals (and hospices) do not normally recommend a particular funeral

director.³¹ Another specialist consultant explained that hospitals provide bereavement leaflets and that those typically contain advertisements for funeral directors, but this is open to all funeral directors and is transparent.

Consumer survey and other evidence

39. The Funerals Market Investigation consumer survey found that only 4% of all respondents³² found out about the funeral director they used from care home, nursing home, hospice or hospital staff.³³ It also found that only 1% of all respondents reported that a recommendation by such staff was the most important factor when choosing a funeral director.³⁴
40. Evidence from Dignity and Co-op points to more frequent involvement from such staff: [X]% of Dignity customers in 2018 got contact details for their funeral director from a nursing home, hospital or doctor, and Co-op research suggests that, across the market, for around [X]% of customers the main reason for their funeral director choice is a recommendation from a care home, hospice, hospital or doctor.³⁵ The importance that the large funeral directors may place on attempting to gain recommendations from, or business via, intermediaries is discussed at paragraph 71.
41. As noted above, care homes and hospices will usually have in place end-of-life plans which may include details of the family's preferred funeral director, and this view is supported by information provided by NAFD, SAIF and Funeral Partners.
 - (a) The NAFD said: 'When a patient is admitted to a nursing home or they begin to receive palliative care, best practice is to ask them to nominate a funeral director.'
 - (b) SAIF told us: 'If you have someone who is clearly coming towards the end of their natural life and they are in a professional care environment, whether that be a hospital, a hospice, or a nursing home, the chances are - and this would be led by the organisations that monitor those standards of care - that that organisation will have clarity, because they will ask the family up front, "If anything happens, who should we ring?" The family will

³¹ Additionally, the NAFD said that Hospice/hospital bereavement offices...have different policies. Typically, they will point to a bereavement guide with advertising for local funeral businesses in and suggest contacting three to get indicative prices and an idea of one that is preferred. Where officers feel strongly about one business or another, they may offer an opinion if one is sought.

³² Base: all UK adults age 18+ involved in making at need burial or cremation funeral arrangements since J/A/S/O 2017 who used a funeral director (n=279).

³³ CMA Market Investigation consumer survey, additional analysis of data at Question FD4.

³⁴ CMA Market Investigation consumer survey, additional analysis of data at Question FD6a.

³⁵ For Co-op, this figure is around [X]%.

then have a prompt to think about this and come up with an answer, so that it is on the patient's care documentation that if anything happens, the deceased will go to X.'

(c) Funeral Partners said that 'in general terms and across the business nationally, deaths which occur in hospital, or a private residence, would normally have first contact self-initiated directly by the customer. By contrast, deaths which occur in a nursing home, hospice or care facility would tend to be initiated by an intermediary (care facility staff acting on the recorded instructions of the family as to their chosen funeral director to be notified in the case of their loved one's death).' It also told us 'it is normal practice for all care facilities to take instruction from the family at the commencement of care as to what to do in the case of the person in care passing away'.

42. In our Market Investigation consumer survey, 8% of respondents overall said that staff at the care home (4%), nursing home (3%) or hospice (1%) contacted the funeral director about collecting the body of the deceased from where they died,³⁶ although this was usually done following consultation with someone known to the deceased.³⁷ However, in three cases, an unrelated third party³⁸ had decided which funeral director to contact without any reference to someone the deceased knew.

43. Information submitted by Co-op, Dignity and Funeral Partners also indicates that care homes and hospices will sometimes make the first contact with a funeral director.

(a) Co-op estimated that in approximately [X] % of cases the deceased comes into their care via formal or informal arrangements with intermediaries.

(b) Dignity said that 'Generally the first contact with the funeral director is initiated by the customer but on occasions a third party (such as a care home) may request that the funeral director brings a deceased into care.'

(c) Funeral Partners provided analysis showing that for a sample of 100 at need funerals, 59% of first contact was self-initiated by the customer, and 41% of first contact was initiated by an intermediary (20% by a nursing

³⁶ CMA Market Investigation consumer survey, Tables 115-117, Question FD18. 43% of respondents contacted the funeral director themselves and 36% said a relative of the deceased had made contact.

³⁷ CMA Market Investigation consumer survey, additional analysis of data at Questions FD18, FD19a and FD19b.

³⁸ Care/nursing home staff: n=2; coroner/Procurator Fiscal: n=1.

home, 21% by a hospice). This is based on the most recent 100 funerals at a [redacted] branch (which was chosen at random).

44. In addition to what we heard from care providers (see paragraphs 29 to 36) we have also heard from funeral directors that some care providers will often have their own preferred local funeral director that they will call in instances where:
- (a) The family's preferred funeral director is 'too far' for the doctor to travel to issue the death certificate (a process which may not take place for several days). As noted above, the NAFD stated that GP practices prefer that their deceased patients are not moved too far away if they will be required for certification purposes. We have also been told that 'there is often a delay of a few days before the doctor issuing the cause of death certificate sees the deceased and subsequently there is a need for the body to be kept in appropriate climate controlled facilities. The body is therefore held at the premises of the funeral director to allow the doctors to conveniently complete their legal duties and issue certification in the locality of the place of death.'
 - (b) The family's wishes are not known, and/or they cannot be contacted. One large funeral director ([redacted]) stated that there were many informal arrangements in the sector to deal with such occurrences (and more widely around transfer of the deceased), while another one ([redacted]) said that it was very rare that it would collect and take a deceased into its care without any contact from the deceased's family. This would happen on the rare occasion where someone dies in a nursing home, care home or hospice and where the family of the deceased, or the deceased themselves, have not (prior to death) specified a chosen funeral director, and where, following death, the care facility were unable to contact the family to take instruction, and where the care home do not have facilities to hold the deceased.'
45. Some of the submissions we received indicate that some care homes, nursing homes and hospices may be selecting or organising the transfer of the deceased to the care home's preferred provider in all or most cases, rather than in only the circumstances outlined in paragraph 44. For example, a funeral director submitted that 'In recent years it has become a common scenario for some community hospitals, hospices and care homes to have either formal or informal arrangements with a local funeral director to remove a deceased patient or resident to their premises at the point of death.' Another funeral director told us that 'It is lucky if we even get a call, because most nursing homes will just call their set funeral director; they will have a relationship with the local funeral director, for example, and they will just call

them and not really give the family any choice, it will just be “This is our funeral director that we use in this situation”.

46. In relation to hospitals, it seems that the hospital does not usually contact a funeral director on behalf of the family³⁹ – the deceased is instead usually moved to the hospital storage facility or mortuary. However, our call for evidence highlighted two means by which a hospital may be influential in customers’ choice of funeral directors:
- (a) One funeral director who responded to our call for evidence identified a hospital where ‘The bereavement officer guides families towards a particular firm.’ And, as noted above, hospital bereavement services can be influential by providing a list of funeral directors;⁴⁰ and
 - (b) In some cases hospitals do not have mortuaries or facilities to store the deceased (or have limited body storage space – see paragraph 18) and formally contract with a specific funeral director to provide this service or have informal arrangements with funeral directors to do so.
47. We have therefore considered the potential impact of arrangements between funeral directors and care providers on the choice of funeral director by consumers.

Theories of harm

48. Below we set out some theories of harm relating to care homes and hospices’ arrangements with funeral directors. They are described relative to a benchmark where arrangements between care providers and funeral directors exist only to the extent necessary, and shopping around and competition is not unnecessarily prevented/undermined by the presence of these arrangements.
49. We explain the harm that may arise from these arrangements by first describing the potential effect on competition stemming from the deceased being moved to the care provider’s choice of local funeral director (which we consider might sometimes be necessary), and then explaining how

³⁹ In our Market Investigation consumer survey 3% said that staff at the hospital contacted the funeral director about collecting the body of the deceased from where they died. [FD18]

arrangements between funeral directors and care providers might worsen these effects.

50. Based on the responses to our call for evidence (and a small number of submissions made to us directly), the potential effects on competition and consumers which may arise (to at least some extent) from circumstances where the deceased is moved to the care provider's choice of local funeral director, include:
- (a) Switching costs: those customers who subsequently choose to use a different funeral director may incur additional costs, such as for transport of the body from the first to the second funeral director.⁴¹ There may also be distress caused by the need for the additional move. These costs may in turn lead to higher funeral prices paid by customers who switch and may deter switching in the first place (see point b).
 - (b) Customer lock-in: in these circumstances, customers may be likely to continue to use the funeral director chosen by the care provider to carry out the subsequent funeral arrangements, to avoid the distress of moving the deceased twice and/or paying higher costs as a result of having to pay for the additional removal (see point a); the extent to which customers consider and compare funeral directors prior to making a choice may therefore be lower than would otherwise be the case (although relative to an already low likelihood of customers comparing funeral directors); this may in turn lead to detriment for the consumer through higher prices or using a funeral director for the funeral that is less well matched to their needs. For example, funeral directors that remove the deceased in cases where instructions do not arise from the family sometimes appear to charge the family or its preferred funeral director for the subsequent transfer to another funeral director⁴² (though not always).
51. It has been put to us that the potential detriment to consumers described above can be worsened by arrangements between care providers and funeral directors, because:
- (a) they result in moves to the care provider's choice of local funeral director (rather than the family's choice, if they had had the opportunity to make such a choice) occurring more often than is necessary.⁴³ Responses to

⁴¹ See Funeral director sales practices and transparency working paper.

⁴² This has led to one funeral director 'start[ing] to advise other funeral directors and care/nursing homes that any cost in these circumstances will need to be covered between the funeral director and the care/nursing home when neither the deceased representative or my company have given instruction for the collection to take place.

⁴³ In addition to the potential detriment caused by the effect of this on competition, there may also be direct harm via distress caused to the bereaved where the deceased is moved unexpectedly or to a non-preferred funeral

our call for evidence suggest that this may sometimes be the case, eg removals without consent, telling families that they have a ‘designated funeral director’, or ‘families find[ing] it difficult to assert themselves’;

(b) the funeral director chosen by the care home may have higher prices than if the family were choosing the funeral director (within the constraints of the care providers’ requirements, eg for the funeral director to be close enough for the doctor to attend). We have received representations that this is the case.

52. In relation to hospitals, in cases where the deceased is removed to a funeral director, the theories of harm are similar to those set out above for care homes and hospices. One additional source of harm may arise in cases where the hospital pays the funeral director for the storage service – in this case the quality of the procurement process may also lead to harm if the hospital pays more as a result of a non-competitive process.

Analysis

53. Below we set out our analysis of how often these arrangements occur and their possible effect on consumers’ shopping around, as well as:

(a) The extent to which the deceased may unnecessarily be moved to a funeral director of the care home’s choice (rather than the family’s);

(b) the extent to which funeral directors impose costs or make it more difficult for consumers to switch or shop around;

(c) our views on whether and when care homes might tend to choose funeral directors with higher costs or lower quality;

(d) the prevalence and possible harms from hospital arrangements for the removal of the deceased;

(e) the importance funeral directors place on attempting to gain recommendations from intermediary organisations;

(f) the existence of referral fees and inducements.

54. The responses to our call for evidence and submissions we received highlight possible informal arrangements at around 19 care homes and 12 hospices across the country. However, some respondents have made generalised

director – one funeral director told us that ‘two families we have worked for in the past have come to us quite distressed saying that they wanted to use us but that [X] had collected and was in possession of the body despite their clear instructions to the nursing home.’

comments about these arrangements being common – for example, one funeral director told us ‘most nursing homes will just call their set funeral director.’ The NAFD said that ‘Anecdotally these arrangements are very common. Firm evidence is hard to find, as most are informal agreements rather than formal contracts. Given the number of deaths that occur in these locations, it is possible that the influence is significant but quantifying this is virtually impossible.’ Others have suggested they are less prevalent than in the past (see paragraph 80 below).

55. We have also sought to gather evidence from Co-op, Dignity, and Funeral Partners. They have told us that they have only a limited number of informal arrangements with organisations, including care homes and/or hospices.⁴⁴

The extent to which the deceased may be unnecessarily moved to a funeral director of the care home’s choice

56. On the question of whether care providers are recommending or choosing a funeral director more often than necessary, we have limited evidence, although some of the responses to our call for evidence suggest that some care homes may be doing so, for example, by recommending families to instruct specific funeral directors to carry out the removal as a matter of course. For example, one respondent told us that a care home ‘tells bereaved families that their designated funeral directors is [redacted]. Which is a very expensive [redacted] funeral home’. A funeral customer we spoke to told us that she and her husband, who died in a care home, had not chosen a funeral director when he died. She explained that when he died, the care home said: ‘We use [redacted] [funeral directors]’ and advised her to ‘go home get some sleep and we will sort it all out’. And, as set out in paragraph 45, some of the submissions we received suggested that some care homes, nursing homes and hospices may be recommending or organising transfer of the deceased to the care home’s preferred provider in all or most cases.
57. On the other hand, information from care provider representatives, the submissions from the large funeral directors set out above, and the Market Investigation consumer survey evidence suggest that such practices are not common.

⁴⁴ For the year 2018, Co-op indicated it has [redacted] informal arrangements with care homes and hospices; Co-op indicated that it carried out [redacted] removals in connection with these arrangements, gaining at least [redacted] funerals from them. Dignity listed [redacted] informal arrangements with a variety of organisations (eg hospitals, medical schools, maternity unit, local authorities). This includes [redacted] hospices which account for approximately [redacted] removals between the two. Funeral Partners identified [redacted] informal contracts ‘where there has been no formal bidding process, or a formal contract has not been issued’. These cover local authorities, coroners, hospices and hospitals.

The extent to which funeral directors impose costs or make it more difficult for consumers to switch or shop around

58. The extent to which these arrangements may directly contribute to customers shopping around less or choosing a different funeral director than they would have done is not clear. The NAFD said that ‘Consumers don’t tend to change funeral director, so early contact with the bereaved family increases the likelihood that they will stay with that funeral director. Once a funeral director has been instructed with a collection, many families feel that it would be complicated to change.’
59. Co-op provided information which indicated that for those (relatively few) informal arrangements where Co-op was able to estimate the number of funerals gained as a result, the number of funerals gained was around [~~8~~] % of the number of removals.⁴⁵ Dignity and Funeral Partners told us that they did not systematically record the number of funerals gained as a result of such arrangements.
60. Our Market Investigation consumer survey asked whether the funeral director that collected the body of the deceased person (either after it was released by the coroner/Procurator Fiscal or from where they had died) had also made all the other arrangements for the funeral. The majority of respondents, 81%, said that the same funeral director did make all the other arrangements.⁴⁶ Of those, 74% said the reason they decided not to use a different funeral director business was because they were already using the funeral director they wanted to use, 22% said they did not feel any need to/it wasn’t necessary, 4% did not want to delay the funeral arrangements, 2% could not face/did not want the additional emotional upheaval, 1% had no idea this was something you could do, 1% did not want to incur additional costs and 1% indicated these were the wishes of the deceased.⁴⁷
61. Some of the comments in reply to our funeral directors call for evidence imply that customers may feel uncomfortable changing funeral director or may feel obliged to use the initial funeral director.

Financial costs to the consumer

62. In relation to the issue of financial costs to the consumer as a result of such removals, Co-op told us ‘we would only charge the family if we were asked to arrange the funeral...If the first contact is from a hospice or nursing home

⁴⁵ Informal arrangements with hospices, hospitals and care homes only.

⁴⁶ CMA Market Investigation consumer survey, Tables 139-141, Question FD21.

⁴⁷ CMA Market Investigation consumer survey, Tables 145-147, Question FD22b.

then no charge is levied at all'. A submission we received commented that [redacted].

63. Dignity indicated that where they have collected a body from a care home etc, and the family chooses another funeral director, Dignity will not impose any charges on the family, but will charge that funeral director for collecting the deceased and bringing them into care. Dignity noted that 'It does not always manage to recover its fees in these circumstances as this largely depends on the practice and attitude of the new funeral director.'
64. Funeral Partners noted that it has a charge 'that we apply to third party funeral directors who request we collect the deceased and bring them into our care on their behalf. The standard charge for this service is £[redacted]. This charge could also be applied if we had been asked by a third party, such as a nursing home, to bring a deceased into our care if the family subsequently chose to use another funeral director to carry out the funeral.' Funeral Partners also said that 'Local arrangements with specific third-party funeral directors may exist where a different fee as agreed with the third-party funeral director.'
65. We received a submission from a funeral director stating that a hospice in [redacted] 'has an arrangement with the local [redacted] & local [redacted] to alternate to take the deceased into their care. Apparently both firms 'profess' to do this as a service to the community. I was asked to organise a funeral for a lady that had been taken into [redacted] care – they then proceeded to tell me their charge would be £[redacted]. This means the family would be paying twice for their relative to be collected, although they hadn't given permission for this to happen'. The implication here being that, even though the funeral director may be charged, the cost may ultimately be passed onto the family.

Whether care homes choose funeral directors with higher costs or lower quality

66. Turning to the question of whether care homes might tend to choose funeral directors with higher costs or lower quality, we firstly note that some funeral directors and the trade bodies have suggested that care home and hospice staff have good experience and evidence about funeral director quality (such as the respectfulness of staff) and that their recommendations may therefore be helpful (and by implication pro-competitive). Linked to this, SAIF told us that some funeral directors hold open days for care home staff to advertise their quality.
67. However, we have also heard concerns from funeral directors that some care homes have arrangements with expensive funeral directors, denying families the opportunity to choose 'better value' funeral directors.

68. We are not able to reach a view on this issue, given the evidence that has been presented to us.

Hospital arrangements for the removal of the deceased

69. In relation to the prevalence and possible harms from hospital arrangements for the removal of the deceased, evidence from Co-op, and Funeral Partners suggest that such arrangements are not common. Dignity clarified that in their experience, it is rare for hospitals to make first contact with a funeral director.
70. However, responses to our call for evidence and a small number of direct submissions did include comments which argued that harm arises from the arrangements that exist, because:
- (i) Families are unwilling to move the deceased, perhaps in part because they think there will be extra costs, or they ‘feel obliged’;
 - (ii) The funeral director carrying out the hospital service (ie removal and mortuary storage) sometimes contacts the family, giving them an opportunity to offer their funeral directing service. We have also heard criticism of occasions where the funeral director instructed by the hospital has made contact with the bereaved to offer their services to carry out the entire funeral, with one respondent arguing that the contracted funeral director ‘shouldn’t be aware of personal details of the deceased’s relatives to enable them to make contact. This is a severe breach of GDPR rules.’ In contrast, some of the responses (from funeral directors carrying out these contracts) say that they do not approach the next of kin, or that they make clear to the customer that they can choose a different funeral director. All three largest funeral directors highlighted restrictions on their ability to advertise that they are the hospital contractors or to contact the bereaved.

The importance of recommendations/endorsements from intermediaries

71. In our view, internal documents from Co-op, Funeral Partners and Dignity highlight the importance they place on attempting to gain recommendations from, or business via, intermediary organisations. For example, Dignity has told us that they will occasionally purchase advertising space in literature provided by intermediaries to patients. [✂].
72. Co-op has stated that its strategic approach ‘has been to move away from material "donations" or support, to a relationship-based approach. Building strong bonds with our Network so we can ensure greater understanding of our role, developing their knowledge and continuation of care’.

73. In 2018 a funeral director ([redacted]) developed an end of life care planning document ([redacted]) to be offered to NHS Trusts, hospitals, care homes and bereavement services free of charge, in exchange for that funeral director signposting its [redacted] at-need funeral services to palliative care patients.
74. [redacted].
75. Samples of a draft end of life care planning document were provided by the funeral director ([redacted]) to [redacted] NHS Trusts and [redacted] care home groups. However, the funeral director ([redacted]) has told us that none of these organisations decided to adopt the [redacted] document and it was never published.
76. A palliative care consultant at one Trust said that handing out the document was not about giving people choice and the service together refused to hand the document out to patients. One reason why the consultant refused to do so was that she ‘did not have a sense of quality control.’ She noted that the people she cares for in the area are generally poor and should have the maximum choice when choosing their funeral options and she did not have that assurance with the proposed system.’

Existence of referral fees and inducements

77. We have received a small number of submissions that funeral directors have provided local care providers with inducements in order to win business. One submission stated: ‘On the subject of backhanders, I heard that an FD provided the hospice in [redacted] with £5000 of electronic goodies for their nurses’ Xmas raffle’ and we were told about a donation in kind having been made to a care home where a relative worked which, it was claimed, amounted to a conflict of interest.
78. Co-op told us that it does not generally make direct or indirect payments or donations to third party intermediaries in exchange for referrals, although it noted that [redacted].⁴⁸
79. Dignity told us that ‘it does not have a practice of making payments or donations to care homes, nursing homes, hospices, or other organisations that may require removal / transport of the deceased. However, regional or area managers / individual branches may choose to make small charitable donations to these organisations.’⁴⁹

⁴⁸ [redacted]

⁴⁹ Dignity continues: ‘For example, donations by branches in the North East region totalled around £[redacted] in 2018, with individual donations values of around £[redacted] Scotland regions [redacted] in 2018.’

80. Rowland Brothers Funeral Directors told us that, while payments for referrals used to happen, the introduction of the Bribery Act [2010] curtailed these practices. Rowland Brothers said: ‘Certainly various large organisations had to stop that, otherwise they would find themselves in jail for a few years. It does not stop them buying nice beds and nice TVs and running bingo evenings and things like that for the residents.’

Clause 9.2 of the NAFD Code of Practice

81. Clause 9.2 of the NAFD’s Code of Practice stated: ‘Members shall not solicit funeral instructions, nor employ any person to do so, nor shall they offer or give reward for recommendation.’ In February 2019, the NAFD removed clause 9.2 from its Code of Practice, as indicated in the latest version of its Code of Practice.⁵⁰
82. In its November 2018 Interim report, the CMA found that the interpretation by some funeral directors of this clause, and the slowness of the NAFD to clarify its position on the interpretation of the clause, risked distorting the market for comparison websites (since it appeared to deter some funeral directors from joining comparison websites).⁵¹ While the CMA did not ask the NAFD to remove clause 9.2 from its Code of Practice, in March 2019 the NAFD advised the CMA that it had decided to permanently remove clause 9.2 from its Code of Practice. The NAFD explained that ‘Following our meeting with you in December 2018, at which you raised concerns about the potential for paragraph 9.2 to cause market disruption, the NAFD Executive Committee voted to extend the partial suspension of paragraph 9.2 and to remove it from our Code of Practice entirely.’
83. Co-op told us that ‘until recently [any donations made to a nursing home or hospice as a direct or indirect result of a transfer] would have been in contradiction to section 9 of the NAFD Code of Practice.’ Dignity submitted that ‘the solicitation of funerals from third parties is prohibited by the NAFD Code of Practice, and as a member of the NAFD, Dignity does not engage in such practice...Dignity is not aware of this being an issue in the industry.’
84. It is possible that the existence of Clause 9.2 up until recently (and a similar, extant clause in SAIF’s Code of Practice⁵²) explains the relatively limited

⁵⁰ <https://nafd.org.uk/wp-content/uploads/2019/10/Code-of-Practice-leaflet-amended-Feb-2019.pdf>

⁵¹ [Funerals market study interim report and consultation, 29 November 2019](#)

⁵² <https://saif.org.uk/wp-content/uploads/2018/03/Code-of-practice-updated-March-2018.pdf> Clause 2.2 states ‘Members shall not solicit or offer any inducement of any nature for instructions for funeral services or any other associated services (ie: pre-paid funeral plans, memorials etc); nor shall they engage or reward any other party - whether an individual, a partnership, a company or other formal or informal association or group - to do so on their behalf.’

number of specific referral arrangements involving fees or other inducements that we are aware of. We consider that it is possible that the removal of Clause 9.2 could result in new arrangements being instigated by funeral directors.

85. Irrespective of why clause 9.2 was removed from the NAFD Code of Practice, such practices may have a significant impact given the vulnerability of the people involved and the position of influence of those making the referral.⁵³

Summary of key findings

86. Overall, the evidence we have examined so far indicates that:

- (a) In general, where care homes or hospices need to arrange for a funeral director to collect the deceased, the funeral director is chosen by the family. This view is based on what we have been told by care provider representative organisations, large funeral directors and the trade associations, and is supported by our Market Investigation consumer survey responses.⁵⁴
- (b) There is evidence – from our funeral directors call for evidence and from submissions made directly to us – of cases of the deceased being moved from care homes or hospices either without families’ consent or with families finding it difficult to assert their own preferences, with this perhaps not always being justified by practical reasons.
- (c) Dignity, Co-op⁵⁵ and Funeral Partners have told us that they have very few informal arrangements with care providers. The CMA considers that this may be driven by these arrangements being extremely informal and not centrally recorded.
- (d) In relation to hospitals, the evidence so far – which is from the large funeral directors and a small number of direct submissions and our call for evidence – suggests that arrangements for removal from hospitals to a funeral director’s premises are affecting very small numbers of families at the moment, but it is possible that the impact on affected customers could

⁵³ The fact a care provider has received an inducement to make a recommendation/referral, would likely be ‘material information’ for the purposes of consumer law (the Consumer Protection from Unfair Trading Regulations 2008).

⁵⁴ The totality of the evidence is also consistent with the Market Study consumer survey evidence which found that only small proportions of consumers chose a funeral director on the basis of a recommendation or because the deceased was already in their care.

⁵⁵ Co-op noted that its submission on this point is based on the information they were able to collate, which may not be complete.

be significant.⁵⁶ It is also possible that these arrangements might become more common in future if hospital mortuary facilities become more capacity constrained, or are closed.⁵⁷

- (e) There is evidence that some staff in care homes, hospices and hospitals provide recommendations to their residents and the relatives of their residents, although our survey evidence indicates that this is not common practice and this is supported by the evidence we received from care providers. Evidence from the large funeral directors ([redacted]), ([redacted]) and ([redacted]) indicates that they carry out marketing activity designed to build relationships with, or generate business via, care providers. The CMA considers that such care providers are seen as influential in driving the choice of funeral director. Although one of the main trade association's code of practice has in the past included restrictions on payments, donations or other inducements to third party intermediaries for recommendations, such restrictions have been removed from its Code of Practice and we have seen evidence that some of the larger suppliers are seeking to deepen their relationships with intermediaries in a way which may have an impact on the competitive process.

87. We also note that these issues (pertaining to consumer choice being removed or limited by intermediary and funeral director behaviour) in part arise and are exacerbated by the broader problem already identified as inherent in this market, ie lack of transparency and shopping around.

Police and coroners

88. When a death is sudden or unexplained it must be reported to the coroner in England, Wales and Northern Ireland. The Scottish equivalent to the coroner is the Procurator Fiscal. Coroners are judicial office holders. They are completely independent and are appointed directly by the Crown. A coroner has qualifications and substantial experience as a lawyer, a doctor, or sometimes both. Coroners are members of the judiciary and are not employed by the local authority. However, the local authority does fund the coroner's

⁵⁶ See, for example, paragraph 70.

⁵⁷ The HTA's [2015 survey on capacity in HTA licensed establishments](#) considered future pressures on storage capacity (from paragraph 72). It states that 'whilst some establishments did not need to use contingency arrangements last winter, subsequent changes indicate that they may need to in future years. Significant changes within NHS Trusts, such as the reconfiguration or expansion of services, and within local authorities, such as the closure of a public mortuary, may impact other establishments in the area. This may lead to bodies having to be moved to alternative storage facilities...In addition, the demographic of the United Kingdom is changing and the requirement for longer-term storage of bodies may increase across the country in coming years, as migrant populations increase and there are more cases where bodies require repatriation or families need to be located.'

service. Coroners have the power to have a body brought into the public mortuary and keep it there while they carry out investigations. It is in this context that local authorities (and in some cases the police) have ongoing contracts or informal arrangements and ad-hoc agreements with funeral directors to provide services to the coroner or the Procurator Fiscal.⁵⁸ The distinction between formal and informal is not always easy as there is a spectrum in how these contracts are agreed (see Annex A). We consider that the distinction between informal/formal is not important for the theories of harm set out below, although it may be a consideration when designing remedies, to the extent that any remedies may be required.

89. A death is reported to the coroner if:⁵⁹
- (i) no doctor saw the deceased during his or her last illness;
 - (ii) although a doctor attended the deceased during the last illness, the doctor is not able or available, for any reason, to certify the death;
 - (iii) the cause of death is unknown;
 - (iv) the death occurred during an operation or before recovery from the effects of an anaesthetic;
 - (v) the death occurred at work or was due to industrial disease or poisoning;
 - (vi) the death was sudden and unexplained;
 - (vii) the death was unnatural;
 - (viii) the death was due to violence or neglect;
 - (ix) the death was in other suspicious circumstances; or
 - (x) the death occurred in prison, police custody or another type of state detention.
90. In total, 41% of all registered deaths in England and Wales were reported to the coroner in 2018 according to the Ministry of Justice's annual coroner statistics report.⁶⁰ Of these, 39% required a post-mortem, corresponding to 16% of all registered deaths in England and Wales in 2018. At present we understand that a funeral director on behalf of the coroner is generally

⁵⁸ https://secure.manchester.gov.uk/info/626/coroners/5530/general_information_about_the_coroners_service

⁵⁹ Government's "Guide to coroner service" – page 13 paragraph 3.2.

⁶⁰ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810303/Coroners_Statistics_Annual_2018.pdf

involved in providing transport to the coroner's mortuary in cases where a post-mortem is required. Contracts can also be to transport and store the deceased at the funeral director's own mortuary in the event that: the death was on the weekend, the coroner's mortuary is over capacity or the death is not deemed suspicious but initial investigations are still ongoing. Some coroners also have separately tendered contracts that provide transport from the coroner's mortuary to the funeral director's storage facilities.

91. Given the unavoidable extra step of transport to the coroner's mortuary the total cost of the funeral from place of death to place of rest is higher than without the coroner's involvement (eg because of extra transport and storage). This extra cost is not directly placed on the bereaved but instead this service is contracted by the council. Our focus on coroners' contracts is intended to assess if there is potential harm to competition and consumers beyond the increased total cost of service.
92. We received some complaints about the operation of coroners' contracts, and have used this to inform our thinking about possible harm to consumers that could arise from how the contracts are procured or operated.

Theories of harm

93. The below theories of harm are described relative to a well-functioning market in which coroners' contracts exist only to the extent necessary, and shopping around and competition is not unnecessarily prevented/undermined by the presence of these arrangements.
94. Theory of harm 1: local authorities are not procuring these services as competitively as they could, meaning that they pay higher prices.
95. Theory of harm 2: The nature of the consumer's contact with the funeral director (eg during the removal or storage of the deceased) linked to the coroner's contract means that consumers suffer, through:
 - (a) Customers shopping around less than they would do if funeral director behaviour, or the operation of the coroners' contract, were different (eg if consumers were not aware of the identity of the funeral director contracted by the coroner, meaning that their decision about which funeral director to use for the funeral were not affected). This reduction in shopping around in turn means that the customer does not choose a funeral director that is better matched to their preferences than the funeral director who has been contracted by the coroner. The reduction in shopping around might be exacerbated by the use of potentially harmful

sales tactics while customers are most vulnerable.⁶¹ Some of the contracts that we have received prohibit soliciting behaviours to varying extents. However, we have received evidence of local authorities not including or not enforcing non-solicitation or similar terms in their contracts. For example, we have heard of an instance of a funeral director who has the contract with the coroner for the removal of the deceased spending extended periods with the bereaved, offering viewings in the funeral director's chapel of rest, making registrar appointments for the bereaved and contacting the bereaved by phone. We understand that this contract strictly forbids touting;⁶² or

(b) Funeral directors price discriminating against these consumers due to the tendency to shop around less after already engaging with the contracted funeral director.

96. Theory of harm 3: the nature of the procurement process means that the funeral directors that win the contracts provide higher prices/worse service for the bereaved. We received a submission stating that 'coroner removals should not be offered at uncommercial rates to secure funerals [since] these practices distort decision-making and risk pointing customers toward higher priced and/or poor value operators.'⁶³ This could occur in the following scenario:

(a) Funeral directors provide coroner's contracts below cost in order to gain access to customers and through their contact with the bereaved, convert a high proportion of them into funeral customers;

(b) these consumers end up paying higher prices than they would in a well-functioning market, in which funeral directors did not experience a high conversion rate from holding the coroner's contract. This increased price is because the funeral directors that are incentivised to provide below-cost bids are funeral directors with higher margins and thus higher prices, or are funeral directors that price discriminate against these consumers.

97. We also considered whether there might be a plausible theory of harm related to foreclosure of rivals. For customers to suffer via this route, funeral directors that hold coroners' contracts would have to gain enough additional customers

⁶¹ One funeral director told us: "The coroner uses local funeral directors to carry out the removal of the deceased when a death occurs unexpectedly outside of the hospital/hospice environment. This means that family members or friends are in even more of a state of shock and particularly vulnerable."

⁶² There is potentially also an argument that harm to the consumer might occur from particularly intrusive/invasive sales practices which might cause extra grief, which the consumer would not have experienced if these sales tactics were not implemented.

⁶³ [Co-op Group Limited in response to the CMA's Statement of Issues](#) paragraph 5.25.

to damage the viability or efficiency of other local funeral directors, such that the other funeral directors go out of business or charge higher prices and competition is weakened in the area. Given the scale of coroners' contracts relative to overall volumes, the evidence we have received on conversion rates (see paragraph 111) and our initial findings on local concentration in our Market Study,⁶⁴ a significant weakening of local competition through this route does not, at this stage, appear plausible and we have not considered it further. We also note that we have not received specific concerns on this point.

Analysis

98. To investigate these theories of harm, we sought information on the coroners' contracts of 134 local authorities as part of the questionnaires we had sent them on the operation of their crematorium. Annex A provides an overview of the local authorities' processes for contracting; it also assesses the relationships between: (i) the cost per removal and the number of bids received; (ii) the contract size and the number of bids; and (iii) the contract size (average removals per year) and the cost per removal. We also asked Dignity, Co-op and Funeral Partners for information on their formal/informal coroner contracts.
99. After collating and analysing the responses we found:
- (a) Some evidence of non-competitive procurement;
 - (b) some evidence of below-cost bidding; and
 - (c) large variations in the restrictions on solicitation.

Summary of analysis:

100. Of the 134 local authorities that have responded to our information requests, 103 answered the questions about coroners' contracts⁶⁵ and 68 of these indicated some kind of contract/procedure for coroner removals either managed by the local authority or somebody else,⁶⁶ 39 of which gave some detail on how the contract/procedure for coroner removals functioned. The

⁶⁴ Paragraph 4.53 of our Market Study states that 'based on our analysis [in the Market Study report] we believe that, in many local areas, people have a choice of several funeral directors. We acknowledge that there will be a number of areas in which people have limited or no choice, but we expect this number to be limited.'

⁶⁵ 29 LAs responded to the questions in relation to Public Health Funerals with 1 further response being too ambiguous to determine if they were referring to Coroner contracts or Public Health Funerals.

⁶⁶ Contracts were mentioned to be managed by other Councils, directly by the Coroner's office and one by the hospital.

average annual removals covered by coroner contracts from the local authority responses are 853 per year.

101. In addition to the local authorities that we did not contact (because they do not run crematoria),⁶⁷ there is some uncertainty around the 31 local authorities we contacted who did not provide any response to our questions on coroner's contracts. It is therefore not clear whether or how these local authorities procure funeral director services with regard to coroner investigations. However, in the context of other responses it is likely that it is either handled directly by the coroner's office, local police⁶⁸ or a different Council. It is also possible (although seems unlikely) that some local authorities do have coroner's contracts but misunderstood our questions.
102. In response to our information requests, Dignity, Co-op and Funeral Partners reported a total of [redacted] formal coroner contracts and [redacted] informal contracts. Co-op provided some annual removal figures for their coroner contracts and these ranged from [redacted] to [redacted] removals per year.

Theory of harm 1 – non-competitive tendering

103. More than three quarters of the local authorities that responded with numerical data⁶⁹ have substantial coroner's contracts (ie involving 100+ deaths per year). Most coroner's contracts have multiple funeral director bidders, but the bids of winning funeral directors vary widely.
104. Around two thirds of local authorities that gave details on how the contract functioned had either tendered or used a quotation exercise (see Annex A). However, there is some evidence that on some occasions these services are not being competitively procured. For instance, two local authorities did not have a contract or a clear process for procuring coroner removal services and one council uses a historic contract.⁷⁰ This appeared to be a more common occurrence in the past with several local authorities mentioning using historic contracts before their most recent tenders. Also, four contracts that were tendered did not attract a single bidder (and a further five only received one

⁶⁷ Given that we were already contacting a large number of local authorities as part of our crematoria work, we did not consider it necessary to separately contact other local authorities about their coroner contracts. There are 408 principal councils in the UK, if district councils and Scottish Councils are removed (as we understand from the responses we have received that a high proportion of them do not manage coroner contracts); this suggests that the remaining number of councils not contacted by us, who might run coroner contracts, is 184. We therefore consider that we have received a sufficient number of responses to enable us to reach views on the theories of harm that we have identified.

⁶⁸ Dignity told us: "The police will phone the nearest available FD from an approved list of FDs in their local area – this is known as a 'Police Contract' call."

⁶⁹ 26 out of 39 gave numerical data.

⁷⁰ One local authority told us: "[redacted] has a longstanding arrangement with a funeral director for the removal of bodies". It noted that it has not market tested the current contract since it falls below procurement thresholds and the company it uses provides excellent service.

bid). It is not clear why these circumstances arise or whether these local authorities end up paying higher fees.

105. Four out of the 39 are handled by the police using a rota system, one uses an approved contact list and two have set up an in-house removal service. It is unclear if using these alternative methods provide better outcomes overall, but some of these stemmed from a lack of interest from funeral directors in the tendered contract or from an unsuccessful tender exercise.
106. The information that we received from Dignity, Co-op and Funeral Partners were largely formal contracts ([redacted] out of [redacted]), and the nature of the informal contracts they have relating to coroners is unclear.

Theory of harm 2 – harmful behaviour by funeral directors that hold the contracts

107. In the responses from local authorities that we received, some of them provided contracts that had specific clauses banning solicitation to varying degrees. This does not mean that the remaining local authorities do not have such clauses as there was not a specific question asking them about any restrictions imposed as part of the contract. We were made aware that a clause of this type [ie banning solicitation] may not be being enforced and it is alleged that the contracting funeral director is actively using the contract to gain customers despite being strictly forbidden from doing so.
108. In the responses from Dignity, Co-op and Funeral Partners we received greater clarity on non-solicitation clauses. The restrictions included requiring unmarked ambulances and being prohibited to give any contact details. There were also some contracts where the providers did not mention any restrictions. Dignity's response mentioned restrictions for [redacted] out of the [redacted] formal coroner contracts. The remaining [redacted] may also have some solicitation restrictions but this can't be verified as we do not have the contracts for each of these. Co-op did not respond with details of restrictions for each contract but gave examples of some non-solicitation clauses. [redacted] out of the [redacted] formal coroner contracts in Funeral Partners' response mentioned non-solicitation restrictions; the remaining contracts may also have non-solicitation clauses but similarly we do not have the contracts to verify this.
109. There is evidence that at least some funeral directors are bidding for coroner's contracts at a price below the costs incurred in delivering them. We think this may indicate that they believe customers are relatively inert (and likely to use the first funeral director they are in contact with), meaning that the funeral director is certain to recoup costs from the contract by winning more funerals

or being able to charge higher prices. Our analysis of the pricing information we have obtained from the local authorities shows that:

- (a) The typical price for a removal is between £51 and £120.⁷¹ We do not have sufficient specific cost data to estimate what overall proportion of these contracts may have included bids below cost.
- (b) We have evidence of below-cost bidding from the 3 funeral directors who bid £0 to provide the service to the local authority and won the tender. Also, at one local authority, which uses a rota system, the funeral director does not charge the council if it undertakes the funeral.⁷² In Funeral Partners' response, [redacted] of their [redacted] contracts were provided at [redacted] and the remaining three were provided at £[redacted]. There was no evidence that any funeral director actually pays the local authority to carry out the service.

- 110. Below-cost bidding is evidence that funeral directors may be benefiting from providing this service beyond the payments they receive from the local authority. It is likely that this benefit is from a high conversion rate for carrying out the funerals for the families that needed the coroner's services (and any repeat business won as a result of supplying that funeral). Co-op did not provide information on their conversion rates [for carrying out the funerals for the families that needed the coroner's services] due to not centrally recording this information. Dignity also does not track this information but gave some estimates of conversion rates, provided by some regional managers, which varied from [redacted]% to [redacted]%⁷³ across regions. Funeral Partners provided some estimates of their conversion rate per contract, with the majority being between [redacted]% and [redacted]% with one outlier of [redacted]%.
- 111. In this context, below-cost bidding is not inherently harmful to the consumer (and has clear financial benefits to the contracting authority), but rather appears to be evidence that supports the theory that contact with the funeral director increases the likelihood that the bereaved person uses that funeral director for the funeral (and could be consistent with a competitive procurement process).
- 112. We did not obtain any evidence that would suggest that funeral directors price discriminate against the bereaved customers that have been gained through a coroner's contract. If we were to gather evidence on this, it would require acquiring the average funeral prices paid by the bereaved customers gained

⁷¹ Interquartile range of the LA responses based on 30 responses with pricing information.

⁷² The local authority told us that its rationale was to ensure that the funeral director does not receive payment twice.

⁷³ It is unclear if Dignity's figures cover all of the contracts they provided.

in this way and comparing those prices to the average funeral price paid by customers won in other ways.

Theory of harm 3 – higher-priced funeral directors winning the contracts

113. As discussed above, we have some evidence that some funeral directors are bidding below cost. However, for below-cost bidding to harm the consumer there must be a link between funeral directors bidding below cost and consumers paying higher prices:
- (a) Below-cost bidding itself does not cause funeral directors to charge the consumer higher prices, as at the point of setting the price for the consumer the funeral director has already incurred the cost of the coroner's contract (and so, in theory, the profit maximising price for the subsequent service is unaffected); but
 - (b) in theory there could be an issue if the funeral directors that charge final consumers higher prices are more likely to win coroners' contracts (because they have a stronger incentive to provide a low-priced bid).
114. In relation to this latter point, any funeral director that earns positive margins from the sale of funerals might be incentivised to provide the coroner service below cost. The extent of this incentive is driven by the proportion of coroner removals that lead to a funeral sale (as well as any repeat business), and the size of their margins on the funeral sale.
115. We have therefore considered how we could investigate whether certain types of providers are more likely to win coroners' contracts. By comparing the responses from local authorities to those from Dignity, Co-op and Funeral Partners, we found 11 out of the 39 local authorities that gave coroners' contract details contract in some capacity with the large providers. Therefore, 27 (excluding the local authorities that do not use any funeral director and choose in-house provision) must be provided by independent funeral directors. We note that this is broadly in line with the overall proportion of funerals that are served by independent funeral directors across the UK.

Summary of key findings

116. The key points arising from the above are:
- (a) We have some evidence relating to approximately a third of the coroners in the United Kingdom and their arrangements with funeral directors.
 - (b) Approximately 41% of deaths involve the coroner. Where the funeral director takes the deceased to the coroner's premises, there may be an

opportunity for the funeral director to make contact with the bereaved, and this may give the funeral director an advantage in terms of influencing their choice of funeral director. This advantage could be stronger if the funeral director also takes the deceased into their care as part of their arrangement with the coroner. However, we are not yet clear on the percentage of deaths in which the deceased is always taken into the care of the funeral director chosen by the coroner (but note that only 16% of deaths involved a post-mortem). The main source of possible harm from these arrangements is that they may reduce the incentive for the bereaved to move the deceased to another funeral director for the funeral service.

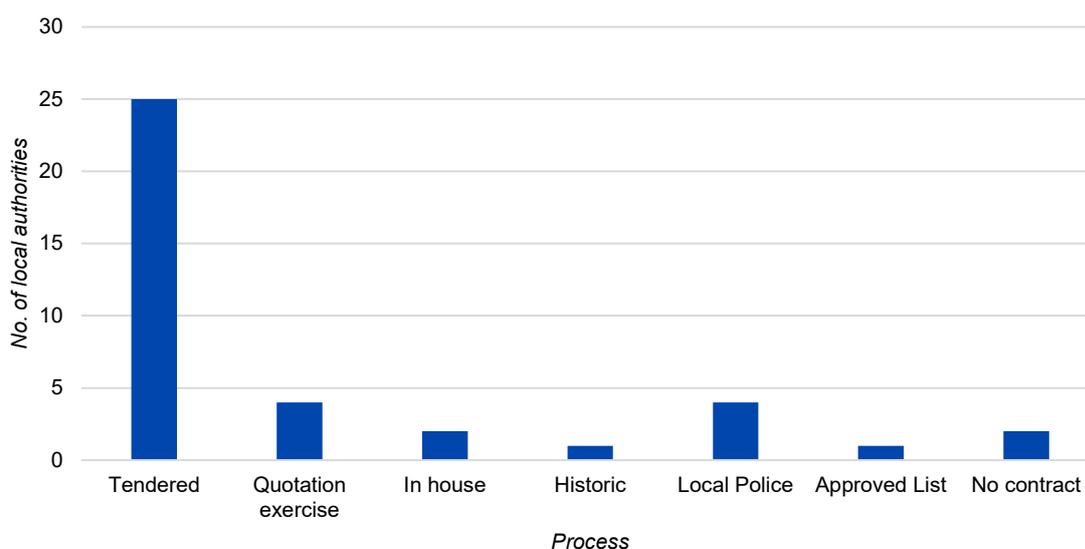
- (c) We know that some funerals are performed by the same funeral director who has an arrangement with the coroner, but conversion rates do not look very high, although we only have information on this from Dignity and Funeral Partners based on a fairly small number of contracts.
- (d) The fact that some funeral directors bid for coroners' contracts below cost suggests that there is at least some benefit to funeral directors from these contracts. We do not have evidence on whether customers gained through coroner contracts pay higher prices, but we know that many contracts are won by independents as well as by the largest providers.
- (e) We understand that many contracts have non-solicitation clauses, but we have received some evidence that such clauses are not always respected or enforced. In other words, despite these non-solicitation clauses, we have evidence of some funeral directors trying to approach the bereaved and encouraging them to employ them for the funeral.
- (f) We are aware of some local authorities that received few or no bidders for their contracts, although they have not provided much explanation as to why.

Annex A: Detail of the coroners' contracts analysis

Summary statistics about the coroner contracts

1. The analysis in this annex is based on local authorities' responses to questions on their coroners' contracts, which were asked as part of the questionnaires we sent them on the operation of their crematoria.
2. Figure 1 sets out the process for the award of coroners' contracts.

Figure 1: Process for contract



Source: CMA analysis

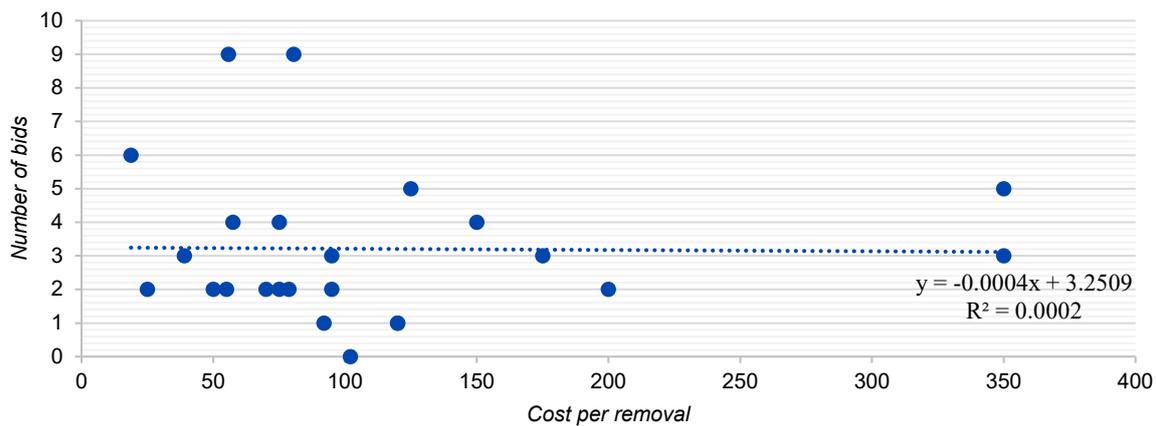
3. All the data where we did not have specific details on how the coroner contract functions was excluded.⁷⁴ Therefore, the analysis is based on the 39 out of 134 responses that gave specific details (this might be 2 or 3 lower as some responses were ambiguous on whether they were referring to coroners' contracts or Public Health Funerals).
4. The average number of deaths covered per year was 853 per local authority. The 25th percentile was 133 and the 75th percentile 1,217 (based on 26 contacts).⁷⁵

⁷⁴ Excluded responses relating to: Public Health funerals, no responses and Not applicable/other council responses.

⁷⁵ This data was very patchy, and there is an issue of lack of clarity on whether it was a public funeral or coroner contract.

5. The average number of bids was 2.7. The 25th percentile was 1 and the 75th percentile 3.25 (based on 32 contracts).⁷⁶
6. The assumed winning bid average equalled £98.31 per body. The 25th percentile was £51.25 and the 75th percentile was £120.00 (based on 30 contracts). Several assumptions were used to reach these figures.⁷⁷
7. As set out in Figure 2, there was no strong correlation between the cost per removal and the number of bids.

Figure 2: Cost per removal to number of bids relation



Source: CMA analysis

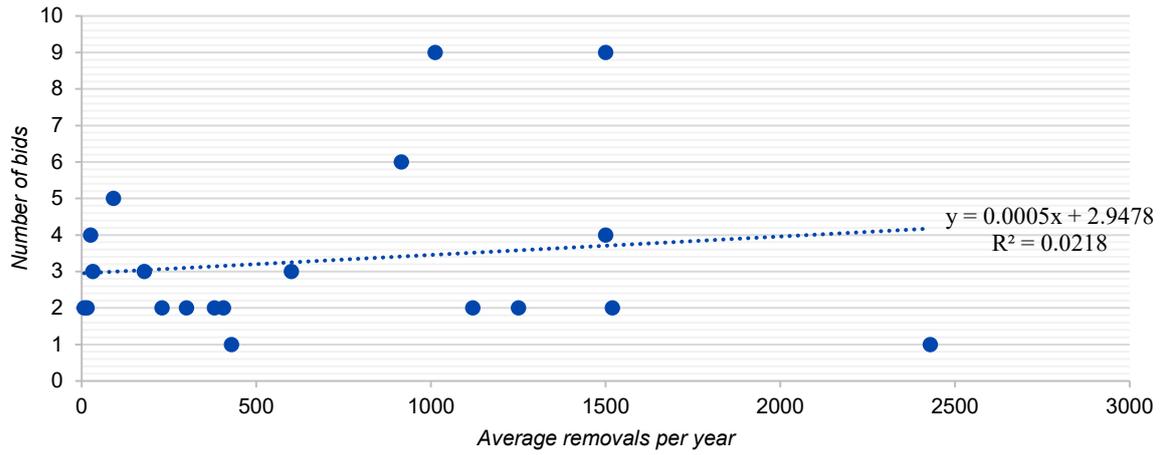
8. There was no strong correlation between the contract size and the number of bids, as set out in Figure 3.

⁷⁶ Four local authorities got no bids and used other methods such as in-house or help from the local police.

⁷⁷ Assumptions:

- a. when it was unclear who won the contract the cheapest bid was used
- b. when there were multiple "lots" we took an average
- c. if all contracts accepted, we took an average
- d. used the normal hour fee (if also gave out of hours cost)
- e. when given a range we took the average
- f. when no specific price per body (lump sum) we used their estimate per body cost.

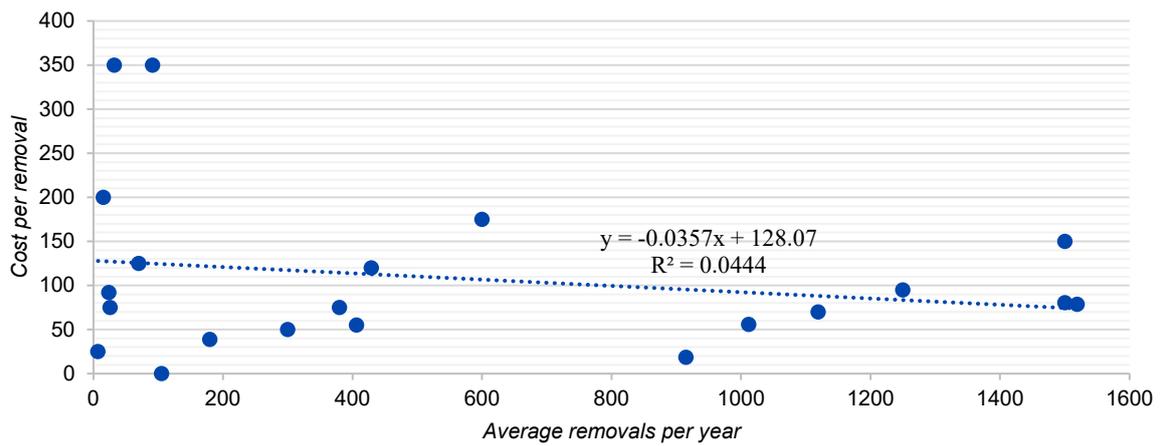
Figure 3: Contract size to number of bids relation



Source: CMA analysis

9. Figure 4 indicates that there was no strong correlation between contract size and cost.

Figure 4: Contract size to cost relation



Source: CMA analysis