HM Inspector of Crematoria Scotland

Annual Report 9 March 2015 – 30 September 2016

May 2017

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Introduction

This report has been compiled by HM Inspector of Crematoria Scotland for the purpose of providing Scottish Ministers with a resume of duties undertaken in the role of Inspector of Crematoria Scotland.
The report covers the period 9 March 2015 (date of appointment) to 30 September 2016.

Background

The appointment of an independent Inspector of Crematoria for Scotland was one of the 64 recommendations in the Report of the Infant Cremation Commission[1] headed by Lord Bonomy, (June 2014) and whilst there was provision for such an appointment in existing legislation (Cremation (Scotland) Regulations 1935) it had not previously been implemented other than on an ad-hoc basis.

Terms and conditions for the newly created role were therefore broadly based upon the findings of the Mortonhall Investigation Report[2] by the Rt Hon Dame Elish Angiolini (April 2014) and that of Lord Bonomy, with the initial appointment being for the period 9 March 2015 to 31 March 2017.

The role was envisaged to be part-time with what was estimated at the time of appointment to require a commitment of 90 days per year. That however has been found to be unsustainable with current commitment and the post has, therefore, been confirmed as a full time post. A full breakdown of specific duties undertaken together with a summary of findings follows.

For ease of reading the duties have been broken down into the following 4 headings:

- Introductory Visits and Media Interest
- Meetings / Liaison with Stakeholders/ Working Groups
- Complaint Investigations
- Inspections and Findings

Introductory Visits and Media Interest

On commencing in the role, contact was made by what was then 27 crematoria (since increased to 29), with introductory visits to each planned. These were carried out between 31 March 2015 and 22 September 2015, by which time one further crematorium had become operational.

These visits provided an opportunity to meet staff and be shown around the crematorium including witnessing a number of cremations. It was made clear to all staff that the visit was not to be regarded as an inspection, which would come later.

These visits proved to be very beneficial for a number of reasons including giving the Inspector an insight into the various procedures and processes in place, for what is

[1] http://www.gov.scot/Resource/0045/00453055.pdf
[2] http://www.edinburgh.gov.uk/info/20242/mortonhall_investigation/957/mortonhall_investigation_-_report

basically the same ultimate aim at each crematoria, that being to successfully carry out the cremation in accordance with the instructions of the applicant and in a way that is fully compliant with legislative and procedural guidance.

Whilst it was seen that there were many similarities in how this was achieved, as will be seen later in this report there were variations to the process.
Under the heading Complaint Investigations it will be seen that there were a number of cases where human error has resulted in catastrophic failings which inflicted further grief on families.

The appointment of the Inspector in March 2015 prompted a great deal of media interest, initially from Scotland, but later from England as well, following publication of the Shrewsbury Baby Ashes Report.

These were co-ordinated by Scottish Government Media with interviews for newspaper, television and radio given by both the Minister for Public Health and Sport and the Inspector.

The media coverage was very positive as regards the action taken by the Scottish Government in response to the recommendations of Lord Bonomy and was seen as going some way towards restoring public confidence in the funeral industry, particularly as regards cremations carried out in Scotland. It was widely reported that Scotland was leading the way.

Meetings / Liaison with Stakeholders / Working Groups

Being a member of the National Committee on Infant Cremation provided an early opportunity for the Inspector to meet and liaise with fellow members from all major stakeholders.

Meetings were also held with a number of others not on the Committee, including Scottish Environmental Protection Agency (SEPA), the Scottish Bereavement Benchmarking Group (SBBG), Mortonhall Multi-Agency Working Group, Police Scotland, and liaison with the Crown Office and Procurator Fiscal Service and the Funeral Furnishings Manufacturers Association (FFMA).

Evidence was given to the Scottish Parliament's Local Government and Regeneration Committee, and the Health and Sport Committee during its deliberations on the Burial and Cremation (Scotland) Bill. Following the Burial and Cremation (Scotland) Act 2016 being given Royal Assent on 28 April 2016, the Inspector has attended a number of meetings with the Scottish Government Burial and Cremation Legislation Team and the Cremation Regulations Working Groups.

He has attended as guest speaker, to speak about the role, at a number of events including the Institute of Cemetery and Crematorium Management (ICCM) Learning and Convention Exhibition 2015 near Scunthorpe, the Society of Allied and Independent Funeral Directors (SAIF) AGM in West Lothian, and the Caithness Edinburgh Association in Edinburgh. He was invited but was unable to attend the Federation of Burial and Cremation Authorities (FBCA) Annual Conference in 2015. He is due to attend the forthcoming Scottish Working Group on Funeral Poverty to

discuss his role and to hear their concerns about the costs attached to cremation in Scotland.

Complaint Investigations

From 15 March to 16 October the Inspector received 10 complaints. The following is a resume of complaints / incidents of note reported to the Inspector. Where these complaints contain identifiable personal information, they have not been set out in detail.

In every case details have been summarised and anonymised as not all investigations have reached a conclusion.

1. This complaint concerned plans to appropriate 'open space' within the grounds of a crematorium for the purpose of establishing a link road. It was made by a community council on behalf of local residents who objected to the disturbance and permanent removal of land on which ashes had been scattered or interred, the removal of memorials and metal residual materials, and raised a number of issues questioning the legality of such actions under the Humans Rights Act 1998.

2. This complaint concerned the mislabelling of ashes following the cremation of two adults.

3. This investigation concerned two sets of adult ashes having the same identification details affixed.

4. This complaint concerned issues surrounding the storage and handling of the ashes of one adult.

5. This complaint concerned the recovery of a greatly reduced and combined quantity of ashes following the cremation of two adults.

6. This investigation concerned ashes (adult) which were inadvertently interred within the garden of remembrance.

7. This complaint concerned the legality of a crematorium being allowed to operate in respect of its close proximity to a public highway and dwelling house.

8. This complaint concerned an ongoing dispute regarding a planning application for a new crematorium.

9. This investigation concerned information provided in an anonymous letter, (uncollected ashes of babies and adults) and has been referred to in the Report of the National Cremation Investigation (Page 295)[3].

[3] http://www.gov.scot/Resource/0050/00502116.pdf

10. This investigation concerns a number of uncollected ashes (babies) held by a funeral director and has also been referred to in the Report of the National Cremation Investigation (Page 179).

A detailed report was previously submitted to the Scottish Government in respect of No.s 1,2,3,4, 5 and 6 above.

Inspections and Findings

All 29 crematoria in Scotland have been visited on a minimum of two occasions, with a number of those that featured in the complaints or the Report of the National Cremation Investigation being visited on several other occasions.

A template was drawn up for each inspection, and was divided into 16 headings.

Due to the ongoing National Cremation Investigation copies of completed Inspections were not disseminated until after publication of the Report.
Copies of all 29 completed Inspections have since been sent to the respective crematorium managers for the information of their cremation authority.

Comment is made below on the collective findings, as they appear in the order of the headings:

1. All crematoria carry out cremations Monday to Friday with 19 routinely open on Saturday mornings. Special arrangements can be made with those not routinely open on a Saturday or bank holiday, albeit this is likely to incur additional costs. A number have staff on duty on Sundays to assist and provide access to the book / garden of remembrance.

   Times between services vary between 40 and 90 minutes depending on the number of cremations being carried out. The main issue highlighted by those with the shortest period between services is traffic flow and parking, particularly when back-to-back services have large attendances. As crematoria staff tend to have no direct contact with families prior to the service reliance is placed on the funeral director to advise on the expected number of attendees.

2. All staff who carry out cremations have been found to be accredited by either the FBCA or ICCM, with one crematorium no longer a member of either.

3. The majority of crematoria have their office either within the grounds or integrated within the main building. It has been observed that there was less of a delay in finalising computer records by those where the office is integrated, or within the grounds. Of note, it was seen that there was a total of 7 different computer systems currently in use throughout the 29 crematoria.

4. Statistics were obtained in respect of the total number of cremations carried out at each crematorium during the calendar years 2014 and 2015. A breakdown was requested in respect of adults, babies, infants, children, stillbirth, body parts, anatomical body parts, and pregnancy loss both individual and shared, however

due to the way in which the different computer systems were populated this would have proved time consuming for many, and as the requested purpose was to give the Inspector an insight into the level of experience in the different categories, and not for an accurate statistical analysis (which can be obtained elsewhere) the results were often initially more general e.g. under or over a particular age. Overall it was seen from the figures provided that for the calendar year 2015, the lowest number of adult cremations carried out at any of the 29 crematoria was 609 with the highest being 2718.

The recording on computer of shared pregnancy loss also differed, as whilst all recorded the number of cremations not all could extract the total number of pregnancy losses without referring to manual records (i.e. number of pregnancy loss contained within each coffin). Whilst not seen as an issue it could, without further check, indicate a much lower number of pregnancy losses cremated than was actually carried out. In almost all crematoria, there is no charge for the cremation of pregnancy loss. Whilst costs did not feature in the inspection, it is understood that where costs are levied, it is to the NHS and not bereaved families.

In respect of anatomical body parts, there were a number of queries following implementation of the Certification of Death (Scotland) Act 2011, as regards cremation of historical parts, and tissue which had been imported, however these have since been resolved.

5. Whilst all crematoria safeguard the continuity of identification throughout the process, there was a variation in the number of identity labels produced and subsequently affixed to the receptacles containing the ashes. As this was the cause of a number of the complaints referred to earlier, the Inspector highlighted these issues to management on each visit and during the inspections.

6. A check confirmed that ashes have been recovered in all cremations of infants between 1 January 2015 and 30 September 2016.

7. As the options available to the applicant as regards dispersal of ashes vary considerably between crematoria, the important point was to make sure that it was made clear to the applicant what these options were. The Inspector was satisfied that the requisite information was available either on supplementary forms and/or website, with an opportunity for the applicant to change instruction at any point prior to dispersal. The storage of ashes awaiting dispersal was also examined, particularly as this was also an area which resulted in one of the complaints referred to earlier.

8. The Inspection found there to be a total of 7 different makes (at time of purchase) of cremators in use (with 37 of the total 54 being Facultatieve) with a number of crematoria upgrading to larger cremators to facilitate increasing demand for these.

9. A dip sample of computer records and paperwork was carried out at all crematoria with checks to ensure accurate completion and that the instructions of the applicant were adhered to. There were no concerns noted in any of the 29 crematoria.

10. With one exception baby trays are in use at all crematoria. The exception being in a crematorium which operates an electric cremator and carries out a relatively small number of infant cremations, all of which resulted in the recovery of ashes. It was noted that there were a total of at least 39 baby trays in use or being trialled, with Teleshore (19) and Facultatieve (12) being the most commonly used make. The handling of the baby tray continues to cause concerns regarding Health and Safety in respect of its weight and heat retention.

11. Of the 10 crematoria which carry out shared cremations, a number had yet to finalise a contract as per the Code of Practice[4]. It was suggested to those that do not currently extend an invitation for families to attend a service for shared cremation to consider discussing this with NHS as the few that do have stated that a number of bereaved families have attended. It was noted that there is no standardised procedure as regards size, or number of pregnancy losses contained within each coffin. The terminology used also differs with some referring to the pregnancy loss being contained within coffins, whilst others refer to box, container or receptacle.

12. Metal extracts are only disposed of in accordance with the instructions of the applicant. Of the 29 crematoria, 17 currently are part of a recycling scheme, with a further 4 giving it consideration. Monies generated from the various recycling schemes tend to be donated annually to a charity nominated by the respective cremation authority. Metal extracts which are not recycled or collected by the applicant are interred in the gardens of remembrance. Only a small number of applicants have instructed collection of the metal extracts. Of note, it has recently been seen that there is an increase in the recovery of ceramic joints following cremation. As these tend to withstand the cremulation process intact, and by definition they are part of the ashes, (not being metal), the applicant needs to be consulted when the instruction is to scatter above ground.

13. Checks were conducted of all cremation authority websites to ensure that the Policy Statement on Infant Cremations[5] was publically available. In most instances they were found to be present, and where not it was brought to their attention and rectified. The Code of Practice and Cremation Practice Guidance documents were present and readily available to staff at all crematoria, with a number also including them on their website and displayed within the crematorium. Less obvious was the existence of an Operational Procedures Manual at a number of crematoria. The inspections confirmed that the crematorium's procedures were in accordance with the Policy Statement. Any minor discrepancies were dealt with by the Inspector at the time. However, as

[4] http://www.gov.scot/Resource/0049/00490188.pdf
[5] http://www.gov.scot/Resource/0049/00490441.pdf

crematoria are also very much reliant upon the professionalism, good practice and co-operation of other stakeholders it is generally accepted that there is room for improvement in communication between them. There is also a view that crematoria management could / should have more direct contact with the applicant prior to the intended service, something which rarely happens at present. It is acknowledged that this may only be feasible at smaller crematoria, or for particular cremations.

14. This section related to general observations of buildings, car park, grounds, gardens of remembrance, disabled access, security and health and safety. No major issues were noted, with a brief resume of the findings in respect of each included in the Inspection Report. Where crematoria were undergoing renovation / temporary closure, contingency planning was discussed.
Of note, and perhaps surprising only a small number of crematoria had acquired a defibrillator.

15. As part of the inspection, staff were asked to comment on any issues relative to their role, which they considered could be improved on a local or national level. The majority of comments related to funeral directors (items left in the coffin (items seen during visits and inspections included aerosol cans, mobile telephone, bottles, metal belts and toe caps, and metal staplers of a type used for lining coffins), not knowing combined weight of coffin and deceased before arrival at the crematorium, and incomplete paperwork. Further comments included a lack of clarity on whether or not a Form E1 from the Procurator Fiscal was applicable to the cremation application, a request for greater consultation with staff on matters such as planned changes to statutory documentation, and several stated that they should be made aware of the cause of death (prior to the most recent change with forms this information was included). As regards the last point, there was mixed opinion on whether it was a ‘need to know’ or ‘like to know’.

16. The final section in the Inspection Report was a summary of the findings in the preceding sections.

Conclusion

Whilst no-one can undo the past, a great deal can be learned from what has gone before.

Bereaved families have a right to expect that the instructions of the applicant will be adhered to, and it is the duty of the cremation authority to ensure compliance with that instruction.

Whilst that is the case in almost all cremations, there have been occasions, as referred to earlier, when it has not.

It is worthy of note that unless a complaint is made by, or on behalf of a bereaved family, the Inspector of Crematoria may not be made aware of any incident which

has resulted in uncertainty on the identification or loss of ashes following cremation, as there is no requirement for the cremation authority to inform the Inspector of any irregularities other than (per the Policy Statement) when it relates to the non-recovery of ashes following cremation of an infant.
Consideration should be given to making such a notification mandatory.

The following is a list of subjects referred to in this report, all of which it is considered can be progressed as part of the sharing of good practice. Those of particular relevance to infant cremation were also discussed at the National Committee on Infant Cremation Meeting on 28 October 2016.

Sharing of Good Practice – Matters referred to in this report

- Notification of irregularities (pages 8-9)
- Items left in coffin (page 8)
- Form E1 from Procurator Fiscal (page 8)
- Improved communication (pages 7-8)
- Defibrillators (page 8)
- Operational procedures manual (pages 7-8)
- Ceramic joints (page 7)
- Terminology used (page 7)
- Shared cremation services (page 7)
- Contracts (page 7)
- Computer records (pages 5-6)
- Identity labels on ashes (page 6)

This report has been made available to the Scottish Government Burial and Cremation Legislation Team, and Cremation Regulations Working Groups for any considered action.

Respectfully submitted.

Robert Swanson QPM
HM Inspector of Crematoria Scotland
31 October 2016

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