AGENDA ITEM 7

Report of the National Cremation Investigation

Agenda Item 7

Falkirk Council

Title: **Report Of The National Cremation Investigation**

Meeting: **Executive**

Date: **18th October 2016**

Submitted By: **Director of Development Services**

1. Purpose of Report

1.1 This report summarises the findings of the 'Report of the National Cremation Investigation' by The Rt. Hon. Dame Elish Angiolini DBE QC, published on 17th June 2016. It also provides information on the events that led to production of this report, and information on the investigation findings into cremation practices at Falkirk Crematorium and in an ancillary inspection of Falkirk Crematorium carried out by HM Inspector of Crematoria.

2. Recommendation(s)

2.1 The Executive is asked to:

(1) accept the general recommendations for all crematoria in the 'Report of the National Cremation Investigation' by Dame Elish Angiolini as summarised in section 4.2 of this report.

(2) note and accept the six conclusions of the 'Report of the National Cremation Investigation' by Dame Elish Angiolini in relation to cremation practices of infants and babies at Falkirk Crematorium in section 4.4 i) to vi)

(3) note the findings of the first annual HM Inspector of Crematoria Scotland as set out in his recent inspection report of Falkirk Crematorium.

3. Background

3.1 The Report of the National Cremation Investigation (NCI) was commissioned by the Scottish Government following a number of investigations into the retrieval or otherwise of ashes from the remains of babies cremated in Scotland. These investigations were launched because of allegations, in 2012, that ashes of miscarried, stillborn and neonatal babies were placed in a mass unmarked grave at Mortonhall Crematorium in Edinburgh. The parents of many of these babies had been advised that there were no remains following the cremations. This was at odds with parents whose babies had been cremated at other crematoria and who had received their babies' ashes.

3.2 The author of the report, Dame Elish Angiolini, was commissioned to carry out an independent investigation into historical practices at Mortonhall in January 2013. In April 2013 the BBC broadcast a documentary suggesting that similar

issues of non-production of ashes might exist in crematoria across Scotland. In response to growing evidence the Scottish Government established The Infant Cremation Commission (ICC), chaired by Lord Bonomy, in April 2013. This was asked to review current policies, guidance, practice and legislation in Scotland in relation to the handling of all recoverable remains (ashes) following the cremation of babies and infants.

3.3 As a direct result of recommendations from the Mortonhall Investigation Report and the ICC Report, the Burial and Cremation (Scotland) Bill was introduced in the Scottish Parliament in October 2015. This subsequently became the Burial and Cremation (Scotland) Act 2016.

3.4 Meanwhile increasing numbers of parents across Scotland had registered concern and enquiries whether their baby's cremation had produced ashes that has been buried or scattered without their knowledge. As a result of the nature and volume of these enquiries Dame Elish Angiolini was asked by the Scottish Government to conduct a further investigation into crematorium practices across Scotland. The 'Report of the National Cremation Investigation' presents the results of that investigation and can be accessed here: http://www.gov.scot/Publications/2016/07/6426/0

3.5 In general the terms of reference of the investigation were to:

- investigate the circumstances around the cremation of any infant or baby referred to the Investigation.
- report the results of the Investigation, particularly in relation to the likelihood of there having been ashes following cremation, and the whereabouts, if known, of any such ashes; and to
- conduct a more general investigation into practices and operations at any specific crematorium.

4. Considerations

4.1 Report of the National Cremation Investigation

4.2 It is clearly stated in the general conclusions and recommendations in the 'Report of the National Cremation Investigation' that Councils who operate crematoria must:

- Take full responsibility for securing a forward looking and proactive approach to the management of the crematorium, and their duties. This includes a renewed focus on customer service and standards of care.
- Introduce minimum standards of training for all staff, whose competence should be assessed periodically. Systems must be in place to ensure services are delivered consistently and are subject to regulation and inspection.
- Improve communication between crematorium staff, the NHS and funeral directors.

- Consult affected parents with regard to erection of a memorial to babies which have been cremated and their ashes have been disposed of without the knowledge of their parents.

4.3 Section 12 of the NCI report relates to Falkirk Crematorium and can be accessed here: http://www.gov.scot/Publications/2016/07/6426/12
A total of four cremations of infants or babies conducted at Falkirk Crematorium were referred to the Investigation. The earliest took place in 1993 and the most recent in 2005.

4.4 The six conclusions of the Investigation relating to Falkirk Crematorium are in section 12.8 of the NCI report and are summarised below:

i) The Investigation was impressed by Falkirk Crematorium's history of returning ashes of babies to their parents.

ii) Despite not having previously used a tray for retention of baby's ashes Crematorium staff had observed the Mortonhall and Bonomy recommendations and had implemented a tray retention procedure. Staff had taken advice from other crematoria, thoroughly researched what was available and had demonstrated a willingness to respond to changing times.

iii) Staff had been proactive in producing a form with additional information for funeral directors to ensure the Instructions for Ashes were clearly set out.

iv) The cremator operators and the crematorium manager had undertaken refresher training. This was not routine across all crematoria.

v) The four cases from this area referred to in the Investigation (see 4.3 above) all related to non-viable foetuses and there was evidence of confusing and inaccurate messages from NHS staff and funeral directors to parents.

vi) In three cases referred to the Investigation crematorium staff had been given instructions which were contrary to the parents' wishes. These instructions were provided by NHS staff or the funeral directors under the mistaken understanding there would be no ashes. The ashes had been interred at the crematorium when the families would have wished to have these returned. The families had to wait years to find out the truth. The provision of incorrect information to parents highlighted the need for improved communication and joint training across agencies to ensure such misunderstandings do not occur again.

4.5 Report from Inspector of Crematoria inspection at Falkirk Crematorium

4.6 On 20 April 2016 HM Inspector of Crematoria Scotland carried out the first of what will be annual inspections of procedures and practice at Falkirk Crematorium and other crematoria under the Burials and Cremation (Scotland) Act 2016.

4.7 The administration procedure and process was examined from point of first intimation to disposal of the ashes, with checks carried out on paperwork and

computer records. All were found to be of a good standard with emphasis placed on ensuring the process minimised the risk of human error.

4.8 The cremation process and all related documentation were all found to be of a good standard with great attention to detail, and with a number of safeguards to minimise the risk of human error resulting in the mislabelling of ashes.

4.9 As regards disposal of ashes instructions on documentation was found to accurately reflect the disposal outcome, with provision made allowing for a change by the applicant prior to disposal.

4.10 The overall conclusion was that the crematorium was well run. Good practice was observed in respect of safeguards to ensure compliance of the applicant's instructions and continuity of identification throughout the cremation and ashes handling process.

5. Consultation

5.1 None

6. Implications

Financial

6.1 There are no financial implications arising directly from either report. Costs for training can be met from existing budgets.

Resources

6.2 The ongoing training programme for staff will have be augmented.

Legal

6.3 The Executive is advised that three families have raised actions in the Court of Session against the Council with regard to alleged malpractice in disposal of babies' ashes. This is denied. These cases are ongoing.

Risk

6.4 The Council must comply with the requirements of the Burial and Cremation (Scotland) Act 2016 as non-compliance may result in an offence being committed.

Equalities

6.5 An equality and poverty impact assessment was not required for the production of this report.

Sustainability/Environmental Impact

6.6 It was not necessary to complete a sustainability assessment prior to compiling this report.

7. Conclusions

7.1 The Council's crematorium is well run, and neither the Report of the National Cremation Investigation nor the inspection by HM Inspector of Crematoria Scotland identified any failings in procedures. Indeed the former report commends various aspects of the Council's management of the crematorium. Senior managers will ensure ongoing training for staff with regard to procedures and customer service and standards of care.

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Appendices
None

List of Background Papers:

The following papers were relied on in the preparation of this report in terms of the Local Government (Scotland) Act 1973:

'Report of the National Cremation Investigation' by The Rt. Hon. Dame Elish Angiolini DBE QC, 17 June 2016.

www.gov.scot/Resource/0050/00502116.pdf

Report by Robert Swanson QPM, HM Inspector of Crematoria Scotland on inspection at Falkirk Crematorium 20 April 2016