SECOND ADDITIONAL CIRCULATION

ABERDEEN
CITY COUNCIL

To: All Members of the Council

Town House,
ABERDEEN, 15 August 2016

COUNCIL

The undernoted item is circulated in connection with the meeting of the **COUNCIL** to be held here in the Town House on **WEDNESDAY, 17 AUGUST 2016 at 10.30am**.

FRASER BELL
HEAD OF LEGAL AND DEMOCRATIC SERVICES

B U S I N E S S

GENERAL BUSINESS

7(a) National Cremation Investigation (Pages 3 - 84)

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ABERDEEN CITY COUNCIL

COMMITTEE	Council
DATE	17th August 2016
LEAD OFFICER	Chief Executive
TITLE OF REPORT	National Cremation Investigation
REPORT NUMBER	OCE/16/032
CHECKLIST COMPLETED	Yes

1. PURPOSE OF REPORT

At its meeting on 29th June 2016 the Council received a statement by the Chief Executive following the publication on 27th June 2016 of the report of the National Cremation Investigation. The Council resolved to note that the Chief Executive would submit a report on the matter to the Council meeting on 17th August 2016.

This report fulfils that commitment, informs elected members of the Chief Executive's findings following her review of the National Cremation Investigation report and advises members of the actions she has taken to date.

2. RECOMMENDATIONS

That Council resolves:

i) To note and fully accept the findings of both the National Cremation Investigation led by Dame Elish Angiolini and the findings of the Infant Cremation Commission led by Lord Bonomy;

ii) To instruct the Chief Executive to continue to monitor the completion of the remaining actions to be undertaken by the Council, as well as the actions arising from the recent inspection undertaken by the Inspector of Crematoria Scotland and to provide further reports to the Council as necessary;

iii) To instruct the Chief Executive to constitute formally the inter-agency Bereavement Services Group with formal terms of reference and to assume the chairmanship of the group;

iv) To note the findings of the Inspector of Crematoria Scotland set out in his recent inspection report and to note that future inspection reports will be submitted to the Communities, Housing and Infrastructure Committee and to note that any complaints being upheld by the Inspector of Crematoria Scotland will be reported to the Audit, Risk and Scrutiny Committee in the same way as complaints upheld by the Scottish Public Services Ombudsman are reported;

v) In light of the legal framework being due to change considerably following the work of the Infant Cremation Commission, instruct the Chief Executive to arrange an elected members' briefing on the statutory duties to be placed on the Council as a result of the Burial and Cremation (Scotland) Act 2016 (and any regulations made thereunder) once the said provisions are in force;

vi) To instruct the Chief Executive to develop an Assurance Map for the Council in order that a full understanding is developed as to which Council services are subject to independent external inspection;

a. On completion of the Assurance Map, to instruct the Chief Internal Auditor to review it for omissions in assurance and to determine how the Internal Audit Workplan could address the gaps;

b. To request the Audit, Risk and Scrutiny Committee to consider any proposed revision of the existing Internal Audit Workplan, following the Chief Internal Auditor's review of the Assurance Map;

c. To instruct the Head of Public Infrastructure and Environment to develop a suite of compliance measures which should be routinely reported to both Communities, Housing and Infrastructure Committee and the Corporate Health and Safety Committee to evidence continued compliance by the crematorium service, as well as providing a suite of performance measures evidencing comparison with external benchmarks where available;

d. In order to ensure a more proactive assurance framework across the Council, to instruct each Director to bring to the attention of the appropriate service committee any significant service failures from across Scotland and for each committee to instruct the Director regarding the level of testing of the relevant Aberdeen City Council systems they require;

vii) To note that at the instigation of the Chief Executive a process is underway to consider how operational and strategic responsibility had been managed in relation to Aberdeen

Crematorium and that she is considering what action, if any, should flow from this;

viii) To note the Chief Executive's engagement with a number of affected families and to request the Chief Executive to continue to engage with affected families where requested, offering them as much support as possible;

ix) To note the Chief Executive's engagement with faith and non-faith groups, bereavement charities and a number of families to determine the form of an appropriate memorial, accepting that the Council must never forget the pain and upset it has caused grieving families;

x) To support the Chief Executive's efforts to shape the culture of the organisation positively;

xi) To note that the Chief Executive will share this report and the Council's decisions in relation to it with the Scottish Government Minister for Public Health.

3. FINANCIAL IMPLICATIONS

There are no financial implications arising directly from the recommendations.

4. OTHER IMPLICATIONS

One of the recommendations contained within the report of the National Cremation Investigation states "a criminal sanction should be created to prohibit the cremation of a non-viable foetus, stillborn baby or infant with an unrelated person unless there is express written consent from the next of kin of the baby. There must also be express written consent from the next of kin of the unrelated person or it must be compliant with the testamentary intention of the unrelated person". The introduction of a criminal sanction would require the Scottish Government to introduce this through law.

The legislative framework currently in place includes limited provision for criminal sanctions. However, it is a matter for Police Scotland to determine whether they intend to investigate the matters contained with the National Cremation Report with a view to criminal proceedings.

In the event of additional criminal sanctions being introduced, the Head of Public Infrastructure and the Head of HR must ensure that all staff and management (present and future) of the crematorium service fully understand the implications of criminal sanctions and their personal responsibility under the law.

The Burial and Cremation (Scotland) Act 2016 received Royal Assent on 28 April 2016 but is not yet in force. There is no firm timescale for the coming into force of this Act but indications are that this may not happen until around June 2017.

5. BACKGROUND

At the Council meeting on 29th June 2016, I advised members that I had received the final report from the National Cremation Investigation on 27th June 2016. I advised members that I had formally instructed the Head of Legal and Democratic Services and the Head of HR to review the report fully and to advise me what further action I required to take. I undertook to report back to Council in August on the findings of my review.

1.0 Introduction on the National Cremation Investigation

On June 17th 2014, the then Minister for Public Health, Michael Mathieson MSP, established a National Investigation into infant cremations in Scotland. This National Investigation was led by Dame Elish Angiolini DBE QC and its terms of reference were,

- to investigate the circumstances around the cremation of any infant or baby referred to the Investigation team by bereaved parents or others, including the work of crematoria, hospitals and NHS Boards and Funeral Directors as necessary;
- to report back to the bereaved parents or others the results of that investigation, particularly in relation to the likelihood of there having been ashes following the cremation, and the whereabouts, if known, of any such ashes;
- to conduct a more general investigation into practices and operations at any specific crematorium where case-specific investigations give rise to more general concerns;
- to report back to the Minister at the conclusion of the National Investigation.

The report was published on 27th June 2016. I have summarised the Aberdeen chapter within the national report for members within this background section.

2 .0 Aberdeen (Hazlehead) Crematorium

Chapter 6 of the report[1] considers the matters pertaining to the Aberdeen Crematorium.

The Introduction[2] states the two main issues:

[1] Page 56 to 108 of the Report of the National Cremation Investigation (NCI)
[2] Page 56 to 58 of the NCI

a) That infants may have been cremated along with an adult.
b) That Aberdeen was not returning ashes from infant cremations. Aberdeen was using the same electric cremators between 1995 and 2010 as Parkgrove Crematorium at Friockheim which has returned ashes since opening in April 1993.

The following sections of the Chapter refer to eight specific areas before reaching a conclusion.

2.1 Management

Section 6.2 refers to Management and comments are made on four management areas.

2.1.1 Structure

Part i is about structure and states that **"***The post of Crematorium Manager has responsibility, among other things, for management of the crematorium and its staff, development of policies and strategies, management of finance and maintenance of standards"*[3].

The report repeats in this section that *"The Crematorium Manager was responsible for staff and the immediate operation of the crematorium"*[4].

This section details that the previous Crematorium Manager being in post from 1993 to 2014, having been employed by Aberdeen since 1986. Also, the report details that there were significant changes between 2002 and 2010 with the Crematorium Manager having five line managers.

The section further details that the new role of Performance and Development Manager created in February 2013 and was filled in June 2013. This was described in the report a *"significant change for the crematorium"*[5] (ref: 2.1.2 Management Approach).

There were no main comments in this sub-section of the report.

2.1.2 Management Approach

In this section Dame Elish *states that "management approach appeared to focus on budgets and finance rather than policy or practice"*[6]. Dame Elish also stated in this section that there was no overall strategic management of the crematorium.

However, Dame Elish does state that a significant change for the crematorium was the appointment of the Performance and

[3] Page 58 of the NCI
[4] Page 58 of the NCI
[5] Page 60 of the NCI
[6] Page 59 of the NCI

Development Manager to fill what was seen as too wide a management span.

This section also states that the Environmental Manager and those above him had remote and ad hoc involvement in the management of the crematorium or the staff.

The section also states *that "despite issues about infant cremation coming to public attention following the media coverage about Mortonhall Crematorium in December 2012, no changes in practices were instigated at Aberdeen until November 2013 and July 2014*[7]*"*

Dame Elish comments in this section that at this time and historically the crematorium was seen by senior managers as a successful business that was well managed and with very few complaints from next of kin[8]. This could be interpreted that the Council were placing too much reliance on the Crematorium Manager.

The main comments in this section of the report are:

a) **Lack of Strategic Management**
b) **Senior Managers with very wide and extensive areas of responsibility leading to remote and ad hoc management of the service.**
c) **Slow to make changes to practices and policies following media coverage on Mortonhall Crematorium.**
d) **Senior Management placed too much reliance on the Cremation Manager.**

2.1.3 Management Response to Emergence of Issues at Mortonhall Crematorium in December 2012

Dame Elish states in this section that senior managers had been unaware that Aberdeen Crematorium did not give ashes to the next of kin for babies nor that practices taking place at Aberdeen differed from other crematoria[9].

Dame Elish also states that managers only made periodic visits to the Crematorium; there was absence of Strategic Management of the services and a reliance on D Snow.

Reference is made in this section that managers only paid attention to the Crematorium when details of Mortonhall appeared in the media and that no action was taken to change working practices until November 2013.
There are comments that Aberdeen City Council did not compare practices with other crematoria, or those which were producing ashes, across Scotland:

[7] Page 61 of the NCI
[8] Page 62 of the NCI
[9] Page 63 of the NCI

- Cessation of use of Baby Trays in past (1990's) due to "Health and Safety reasons not challenged nor evidence produced.
- Acceptance by Council that the crematorium did not produce baby ashes for many years[10]
- Failed to clarify what age or stage ashes would be available.
- Failed to ascertain how those crematoria producing ashes were doing so.

The main comments in this sub-section of the report are:

a) Lack of awareness of Strategic Management
b) Senior Management placed too much reliance on the Cremation Manager with little other managers making periodic visits.
c) Slow to make changes to practices and policies following media coverage on Mortonhall Crematorium.
d) Slow to check what practices were on-going in other crematoria.

2.1.4 Audit Requested by Aberdeen City Council management

This section refers to the PwC LLP audit commissioned by Aberdeen City Council. It details the report's recommendations and comments on the scope, findings and subsequent actions.[11] The report states that the audit scope was limited and did not look at the cremation operational process but traced a sample of cremations of babies and infants under the age of two through the records and administrative process.

This section also states that the "*audit report describes its work to "undertake a data collection exercise and review the current procedures in operation to better inform the Council Officers' understanding of arrangement and practices"*[12].

It further comments that the PwC LLP report was only based on the documentation available but there was no evidence that Aberdeen looked to seek an audit of actual cremation working processes by a suitable qualified cremation industry expert or body such as the FBCA. This section of the report also comments that there was no evidence of challenges being made following the PwC report into why there was an historic change from the production of ashes to none being recovered *or "despite these inconsistencies what the council understood to be the position, no formal investigation was carried out at that time nor was a more probing audit commissioned"*[13].

The main comments in this section of the report are:

a) The audit was limited in scope.

[10] The first recorded instance was in 1992.
[11] Pages 67 to 69 of the NCI
[12] Page 67 of the NCI
[13] Page 69 of the NCI

b) The audit did not look at the crematorium processes.
c) Failure of Aberdeen to seek an audit of actual cremation working processes by a suitable qualified cremation industry expert or body such as the FBCA.
d) Slow to make changes to practices and policies and continued until prompted by Lord Bonomy.

2.2 Policy Guidance and Training

This section of the report refers to written and procedures and training in the section 6.3 Policy Guidance and Training[14].

2.2.1 Written Procedures

Dame Elish states that operational practice and policy at Aberdeen Crematorium was derived by word of mouth from more experienced peers or Supervisors and that prior to Mortonhall the council had no written guidance on practice and procedures available for staff even at the time of the interview of staff February 2015 by the Investigation despite:

- the recommendations of Lord Bonomy in his report of May 2014;
- the Mortonhall Investigation Report April 2014;
- the PwC LLP internal audit recommendation of July 2013;
- interest expressed by the Scottish Parliament; and
- press and extensive media coverage of the issues surrounding the cremation of babies throughout the period 2012-2014.

The report states that *"General written guidance on cremation was provided by the FBCA. This guidance provided the basis for certification of Cremator Operators. The subject of infant and foetal cremation is discussed very briefly in the Scheme"*[15].

In this section the report states that "*Members of staff were still working on drafting the crematorium's first operational Procedures Booklet in early 2015*"[16].

It also continues "*In particular, there were no local written instructions for Cremator Operators about how best to achieve the recovery of ashes for infants or any discussion about what type of ashes should be considered appropriate for recovery"*[17].

The main comments in this section of the report are:
a) No written guidance on practice and procedures available for staff.

[14] Pages 70 to 75 of the NCI
[15] Page 71 of the NCI
[16] Page 72 of the NCI
[17] Page 72 of the NCI

b) Slow to produce written guidance on practice and procedures and make available to staff.
c) No written guidance or instructions for Cremator Operators about how best to achieve the recovery of ashes for infants or what type of ashes should be considered appropriate for recovery.

2.2.2 Training

The findings of this section are that training has historically mainly been in - house training on general cremation practices. Also that staff had little opportunity to visit other crematoria.

Details of training taken from statements were:

a) The previous cremation manager was trained in-house but also attended external training. This training was two weeks at Linn Crematorium followed by an examination.
b) Confirmation from some staff that there were opportunities for them to request training through the appraisal system.
c) In the late 1990's some staff were sent on training courses to Harrogate or Sutton Coldfield, although the Harrogate course did not cover the cremation of infants or non-viable foetuses.
d) Training was given when the electric cremators were installed in 1995 to train operatives on its use. This training focused on the functionality of these cremators and not the process of cremation.
e) Cremation training from at least 2001 had been carried out in-house with no specific training on the cremation of infants, still-borns or non-viable foetuses.
f) From at least 2001 an external examiner from the FBCA attended to carry out a practical examination after the Cremator Operator had carried out fifty cremations. There does not appear that any part of the examination referred to the cremation of babies.
g) When gas cremators were provided by Facultatieve in 2010 there was training in the use of the machines, but not the process of cremation. Part of this training process is to go through the Operations Manual with the Operators who have to sign each section to say they have read and understood it. This would include the section on infant cremations.
h) Other training was available such as manual handling and first aid but there was no continuous training provided in relation to cremations.

This section of the report states "also despite the complexities and difficulties of this particular aspect of cremation operations, there has been little by way of any local or national written guidance for Cremator Operators at Aberdeen. The absence of any practical formal training over these years to attempt to support staff in recovering remains from infants or foetuses is a significant concern[18]".

[18] Page 76 of the NCI

The main comments in this section of the report are:

a) That Training has historically mainly been in - house training on general cremation practices with no special training for baby cremations.

b) That historically no or little opportunity to compare practices by visiting other crematoria.

2.3 Crematorium Process and Equipment

The section refers to cremation process and equipment in the section 6.4 Cremation Process and Equipment[19].

This section considers the changes to the cremation process for babies over a number of years based on the type of equipment used. These were:

- cremation first thing in the morning when machines were being preheated ready for the first adult cremation of the day.
- cremation last thing at night by raking forward the ashes of the last adult to be cremated and placing the infant coffin in the cremator at the same time and leaving overnight.
- placing an infant coffin at the side of or on top of an unrelated adult coffin and cremating both bodies together.

2.3.1 Cremation Equipment and How It Affected Cremation Processes

This section refers to the period 1995/6 to 2010 when the Parkgrove Electric cremators were in use at Aberdeen. Statements from the staff indicated that they did not recover ashes of babies or non-viable foetuses due to the belief that there were no ashes for infants.

The sub-section also refers to the period following the installation of the gas cremators by Facultatieve in 2010. When there was failure to recover the recover ashes from infants up to the age of eighteen months to two years of age continued until the process was changed in November 2013.

The main comments in this section of the report are:

a) Failure to achieve the recovery of ashes of babies or non-viable foetuses.

b) Slow to implement changes to the cremation process to obtain ashes following Mortonhall in 2012.

[19] Pages 70 to 75 of the NCI

2.3.2 Cremation of babies and non-viable foetuses along with unrelated adults.

This section refers to the period 1995/6 to 2010 when the Parkgrove Electric cremators were in use at Aberdeen. Statements from several Cremator Operators at that time described the process.

They *"explained that an adult cremation would take place and when that cremation was almost complete, the ashes of the adult would be raked forward to the edge of the hearth at the rear of the Cremator. They reported that the baby's coffin would then be placed into the chamber and the cremation would take place there with the adult's ashes still in the cremator. This was often done last thing at night and all the ashes were raked down the following morning. The Investigation was told that the Operators now accepted it was possible that baby ashes were mixed up with the adult ashes when the cremations were carried out this way"*[20].

The section refers, in the main, to shared cremations of infants pre-2010 although there is reference that the practice of shared cremations of NVF's with adults took place up to the report in the media of Mortonhall in Dec 2012.

It is stated that Lord Bonomy had been misled by staff when he visited Aberdeen Crematorium and PwC LLP had not been given the correct information about processes in place.

2.3.3 The Anonymous Letter

This section refers to the anonymous letter and states that "The practices referred to in the letter have been borne out by the evidence obtained in this Investigation[21]".

2.3.4 Baby Trays

This section refers to the use of baby trays.

From statements taken in the investigation there is a view that baby trays were used in the past and evidence show that ashes were returned to families up until 1996. However, it is not clear if this was with the use of "baby trays".

The earliest date that baby trays were thought to have been withdrawn was 1989 although a cremator operative who worked at the crematorium between 1997 and 2005 recalled using a tray but said that there were no ashes left in the tray following the cremation process.

[20] Page 78 of the NCI

[21] Page 83 of the NCI

The Crematior Operators who commenced in 2001 do not recall a tray in use.
The reasons given that trays had been withdrawn from use was that they were considered a Health and Safety risk.

The use of baby trays was introduced in November 2013 (for still born babies and infants) and July 2014 (for Non-viable foetuses).

2.3.5 First Recovery of Remains

This section refers to a cremation of a non-viable foetus shortly after Mortonhall and without the use of a baby tray. Operatives thought that they saw little bones. No one was able to confirm what happened to the ashes.

2.4 Administration and Record Keeping

The section 6.5 the report considers "Administration and Record Keeping"[22] and considers two main areas.

- Bereavement Services at Marischal College who receive and process all the required forms to allow a cremation to take place and where the Registrar is based.
- Computer operating system records on site at the crematorium

The Investigation states that it "*understands that the administration and record keeping systems at Aberdeen Crematorium have been changed since the time of the interviews for this Investigation"*.

The report recognises that the Facultatieve Cremators installed in 2010 has the ability to record all cremations carried out. The prime purpose for these reports is for emissions which are monitored by SEPA.

There were two cases identified for two cremations of babies where no entry was made in the computer operating system. From this omission the report infers that that each of these babies was cremated along with an unrelated adult.

The investigation looked at both the manual Registers of Cremation used prior to the introduction of the computerised record keeping system (BACAS) used from 1997 to the present.

The Investigation found that from one day to the next the outcomes for disposal of ashes changed from 'dispersed in the garden of rest' to 'no remains' without any change in the actual outcome having taken place. This means that the statutory Registers of Cremation, so far as it relates to stillborn babies neonates and infants at Aberdeen are wholly unreliable.

[22] Pages 89 to 94 of the NCI

The main comments in this section of the report are:

a) That the statutory Registers of Cremation, so far as it relates to stillborn babies neonates and infants at Aberdeen are wholly unreliable.

2.5 Communications

Section 6.6 the report considers "Communications"[23] and there are two main areas.

- Communications between families and NHS staff.
- Communications between Funeral Directors and families.

The report focuses on the state of distress of parents and that they were not given time to make decisions. "It would appear that on occasion parents were not warned that there may not be remains, that they were not given other options and that they were not always given a full and proper explanation of the choices".[24]

2.6 Impact of Mortonhall Investigation and the Infant Cremation Commission

Section 6.7 of the report considers the "Impact of Mortonhall Investigation and the Infant Cremation Commission"[25] and considers how Aberdeen City Council worked with Lord Bonomy and the ICC to enable the recovery of baby ashes. There is no reference to the Mortonhall investigation.

The report states that "*since the reintroduction of the tray in 2013 there has been a 100% success rate in obtaining ashes from babies, where ashes have been requested*."

2.7 Findings for Individual Cases

Section 6.8 of the report considers "Findings for Individual Cases"[26] and gives an overview of the thirty-seven cases of babies cremated at Aberdeen referred to the Investigation.

The report also refers to the committee report to Communities Housing and Infrastructure Committee dated 18 March 2015 on "Infant Cremation Commission Report and Recommendations" which gave an intention to "commence discussions with affected parents on their wishes for an appropriate local memorial.[27]

[23] Pages 95 to 103 of the NCI
[24] Pages 101 of the NCI
[25] Pages 102 of the NCI
[26] Pages 102 of the NCI
[27] Pages 105 of the NCI

3.0 Introduction on the Infant Cremation Commission

On 16 April 2013 the Minister for Public Health announced in Parliament the creation of an independent Commission to examine the policies, practice and legislation related to the cremation of infants in Scotland.

This Commission, chaired by the Rt Hon Lord Bonomy, reported its recommendations to the Scottish Government during June 2014. The recommendations made by the Infant Cremation Commission have been implemented by the National Committee on Infant Cremation.

Set out at Appendix 4 are the recommendations made by the Commission, the Scottish Government's response to each of them and an update on the Council's actions to date in relation to each of them.

4.0 Introduction on the Inspector of Crematoria Scotland Inspection

An Inspector of Crematoria for Scotland was appointed in March 2015 in fulfilment of the ICC report recommendation. The Inspector role will change when the Burial and Cremation (Scotland) Act 2016 comes into force (which may not be until around June 2017).

The Inspectors' current role is to:

- Ensure crematoria are operating in line with the principles set down by Lord Bonomy and in line with the new code of practice
- Report any criminal or potentially criminal activity to Police Scotland
- Visit every crematorium in Scotland at least once every year
- Deal with queries or complains from the public
- Provide an annual report to ministers on activities, but can also report to ministers on specific issues or concerns if needed

The Inspector of Crematoria Scotland will deal with complaints from the public against the service. It is vital that the Audit, Risk and Scrutiny Committee must be sighted on any complaints upheld by the Inspector in the same way it is sighted on complaints upheld by the Scottish Public Services Ombudsman.

MAIN ISSUES

1.0 The Working Practices at Hazlehead Crematorium

Findings of the National Cremation Investigation

I fully accept the conclusions reached in relation to the Aberdeen Crematorium. Within Appendix 1 I have listed all the conclusions pertaining to Aberdeen and have provided an update on the current situation relating to the Council's implementation of required responses.

In addition, Dame Elish's report contains a number of generic conclusions and recommendations and I have re-stated these in Appendix 2 providing an update on the implementation by the Council of responses to those issues within our local control.

I can also confirm that the chapters in the Investigation report relating to other crematoria have been reviewed and the conclusions within those chapters very much reflect the wording contained within the generic conclusions and recommendations. The analysis is available should members wish to see it.

Findings of the Infant Cremation Commission Report
The ICC report has 64 recommendations, all of which the Scottish Government has accepted. Of these, 33 are not for the Council specifically to action. To date 26 recommendations have been implemented and 7 recommendations are still to be completed. Of these 6 are awaiting changes to legislation and 1 is currently being progressed by the City Council and relates to a memorial. Appendix 3 and Appendix 4 provide a status update on all actions arising from the Commission's Report.

Findings of the Inspector of Crematoria Scotland
Following the publication of the report of the National Cremation Inspection, I requested the Inspector of Crematoria to undertake a full independent inspection of the Aberdeen Crematorium. On receipt of the report, I immediately shared it with all members and had it published on the Council's website. A full copy of the inspection report is included at Appendix 5 and Appendix 6 includes the details of management responses to the findings of the inspection.

2.0 Support and Response to Families affected

Of necessity a report such as this concentrates heavily on Council processes and how their management and delivery can be improved, but it must never be forgotten that at the heart of this matter are those families affected directly by the historic practices at Aberdeen Crematorium.

A dedicated phone line and online enquiry form was set up following the receipt of the anonymous letter allegations to assist families with concerns, enquiries and/or requests for information and documentation. Once the National Cremation Investigation was established the Council liaised closely with it, passing on contact details of concerned families (unless specifically asked not to do so). Since the publication of Dame Elish's report further enquiries have been received, logged and responses have been sent.

Wherever requested personal visits have been undertaken by service colleagues and I have now met with a number of affected families. I will continue to meet with any affected family that contacts me and asks

that I do so. By their very nature these discussions are highly personal to the individuals involved.

All families that have made contact with the Council will receive a copy of this report and the Council's decisions taken in relation to it.

In addition, the Council is also working closely with relevant groups and organisations in relation to the commissioning of an appropriate memorial.

3.0 Management actions within Aberdeen City Council

At the end of June 2016 I appointed Richard Penn, an experienced associate of SOLACE and an experienced Chief Executive of a number of major urban local authorities, including 10 years as Chief Executive of Bradford City Council (the fourth largest metropolitan council in England) to assist in looking at how operational and strategic responsibility for Hazlehead Crematorium had been managed. This was to cover a period of time including the period since the issue came into the public domain in December 2012 and was to inform how these matters might be addressed within Aberdeen City Council going forward. Mr Penn's input is of significant benefit and consideration is being given to what steps, if any, should flow from this.

The initial findings from Mr Penn's work will be tabled at the meeting as a confidential appendix to this report.

4.0 Aberdeen City Council's Governance Arrangements of the Crematorium

Amongst many of the failures and/weaknesses identified within the Infant Cremation Commission and the National Cremation investigation was the absence of an independent inspector of crematoria. The absence of this external independent source of assurance necessitated more reliance on the Council's other sources of independent assurance through its Chief Internal Auditor or through assurance provided by local management. It has taken both national reviews to highlight to the Council the historical absence of a source of external independent assurance.

The creation of the Inspector of Crematoria Scotland is a welcome development and I understand he will visit each crematorium across Scotland twice a year, with one of the visits being a full investigation. His annual inspection report will be submitted to the Communities, Housing and Infrastructure Committee. In addition, I have instructed the service that the findings from any audits undertaken by the industry body (FBCA) will also be submitted to committee.

It is important that the Council has a better understanding and sight of the range of Council services which are subject to an independent

external inspection regime and which services, if any, are not. Assurance maps are now regularly produced in other organisations in order to provide this overview of all external assurance and I would recommend that the Council direct that such a map be produced. This exercise would be developed within the remit of the Council's Governance Review and would identify, whether there are any services which are not subject to an external independent inspection. If gaps are identified, it would be appropriate for the Chief Internal Auditor to advise the Audit, Risk and Scrutiny Committee, whether such gaps can be addressed through his Internal Audit Workplan or whether it would be appropriate for management to provide assurance. It may be possible within the assurance map to identify where an industry code exists in relation to a specific service and how Council policies reflect the requirements of the industry's code. I would expect all external independent inspection reports to be submitted to the relevant service committee.

A strong assurance framework is based on a solid understanding of a service's risks, on an understanding of the controls in place to manage the risks and their appropriateness and a comprehensive understanding of the blend of assurances provided e.g. external independent inspection, independent internal auditing by the Chief Internal Auditor or management assurance. Members of the Audit, Risk and Scrutiny Committee will be aware that the corporate management team has been improving its risk registers to include the details of controls and assurance. It is important therefore that both the audit committee and the service committees actively challenge all sources of assurance provided and that opinions of different inspectors and auditors are cross tested as well as being triangulated with other information.

A proactive assurance framework would also use the emergence of a risk in another system to test local management to prove firstly whether the risk could materialise in the local system and secondly, if it could materialise that there is an adequacy of control and mitigation in place which control the impact of the risk. It is vital therefore that this approach becomes second nature within our governance approach as it allows us to evaluate regularly the appropriateness of our controls. Subject to Council agreeing to adopt a more proactive approach, I will instruct each Director to provide details regularly of significant risks emerging in other systems in order to enable local testing. I will also ensure that the ongoing review of the Council's system of risk management, which is part of the Governance Review, promotes a proactive approach to assurance in the future.

5.0 Organisational Culture within Aberdeen City

There are a number of references within the National Cremation Investigation report to the organisational culture within the Council.

There is a growing acceptance generally across organisations that strategies, policies and procedures alone will not guarantee an organisation's success but instead success will be determined by the nature of the culture within the organisation.

Shaping the organisational culture has been one of my priorities since taking up post. As a result, a significant cultural change programme is currently underway within the Council. I have articulated my hope for the culture through the Triple Aim statement of improving our customer's experience of the Council, improving our staff's experience of the Council and improving our use of resources. The triple aim give's equal importance to all three elements.

The core purpose of the programme is to improve the experiences for our customers and staff whilst ensuring that resources are increasingly focussed on desired outcomes. These aspirations are not mutually exclusive and the programme streams have significant linkages which will lead to an organisation with a much stronger customer focus provided by a more engaged workforce.

Within the refresh of the strategic corporate plan noted by council at its February 2016 meeting, the cultural triple aim was expressed within the organisational development section. Each Directorate was also required to set out its plans for improvement against the triple aim statements. In addition, the work being done, following the recommendation contained within the Best Value Audit undertaken by Audit Scotland, to realign the performance reporting to the Council's strategic plan is also being re-aligned to report against the three cultural aim statements.

The National Cremation Investigation Report recommends that Chief Executives and senior management must take full responsibility for setting a forward looking and proactive approach to the management of their businesses and duties. This should include responsibility for ensuring a caring and sensitive culture in their operation and a renewed focus on customer service and standards of care. The inclusion of improving our customer experience within the Council's cultural change programme is therefore key to addressing the customer service and standards of care issues raised within the Report.

The Improving Customer Experience Programme comprises four components:

1. Introducing a customer service framework
2. Improving access to quality services
3. Engaging our customers, and
4. Digital delivery

The focus of items 2, 3 and 4, above, ranges from improving the physical layout of our customer facilities; improving processes; giving

customers a greater ‘voice’ (actively listening to their feedback) and re-channelling services through digital delivery and improving accessibility and efficiency.

Item 1 seeks to establish customer service standards throughout the organisation. To this end, a customer service charter has been introduced which makes it clear that all employees are personally responsible for delivering an excellent customer experience. The charter stresses that Council staff are here to help, listen, answer to and be open with the organisation’s customers.

To help embed the focus on customer standards, all customer-facing staff will be trained to be more customer focussed and encouraged to empathise with customers and their specific needs and perspectives. Increasingly, staff will be multi-skilled to enable a more personalised service to be delivered.

A customer service recruitment framework will be introduced, incorporating a customer service recruitment toolkit. This will enable the Council to test potential customer-facing employees on their customer focus. When recruited, in keeping with the rest of the workforce, new employees will be expected to adhere to our four core organisational behaviours, one of which is to provide ‘customer focus’.

As stated, the content and focus of the improving staff experience programme assists with the delivery of improved customer focus and standards. For example, the view is taken that the more engaged our workforce is the better the quality of service will be delivered to our customers. A range of actions have been (or will be) implemented to provide for stronger employee engagement.

For example, we are placing an increasing emphasis on our senior staff being more visible to the workforce. Moreover, we require our managers to adopt management practices which ensure that staff are well informed, consulted and engaged in the wider organisation and a management style which strikes a balance between supporting and assisting staff and holding them to account for their performance. Equally, managers too are held to account for their performance and every manager has (or will have) objectives which test their progress in improving the staff and customer experience in their area. The importance of managers being receptive to feedback from their staff (and others) is being stressed (e.g. through 360 appraisals). This should assist with managers being more self-aware in relation to their management style and decision making (i.e. reducing the likelihood of subjective, non-evidence based decisions).

It is hoped that the greater visibility of managers and the adoption of an appropriate management style will create an organisational culture which is centred on trust. We want every one of our employees to feel confident to raise any issue of concern, including ‘whistleblowing’ if

there is cause to do so. To assist with this, all HR policies and procedures are being reviewed to make them staff friendly and fit for purpose (staff are contributing to this review process). In addition, through the Governance Review, work is underway to put in place a corporate policy framework that will provide oversight of all policies, their maintenance and accessibility to staff. In order to play my part in shaping the culture, I attend every corporate induction event where I meet all new staff joining the council and a significant part of my presentation is focused on describing the culture we seek to create and personally making myself known to all new starts. In addition, I've now participated in over 25 staff events, attended by approximately 1,200 staff where again, I'm discussing the culture within the organisation.

As part of the Improving Staff Experience programme, a greater focus is being given to personal development. Every employee is entitled to a yearly Performance, Review and Development meeting (our appraisal scheme) and this process enables an assessment of an employee's performance, both from a technical and behavioural perspective (although performance assessment is an ongoing process throughout the year). Customer focus (including customer empathy and standards) is tested as part of this review

6. IMPACT

It is difficult to overestimate the impact the subject matter of this report has had on those affected by the past practices at Hazlehead Crematorium. Work continues to provide, support, information and wherever possible reassurance to those who quite rightly seek answers from the Council.

It must also be acknowledged that these issues have had a profound effect on public trust and confidence in both the Crematorium and the Council more generally.

As I said in my statement to the Council in June, sadly it is impossible to undo what was done in the past. My commitment is to ensure that such practices do not occur in the future. Set out in paragraph 5 above is an overview of the cultural change activity I am driving across the Council which aims to change fundamentally the experience of working for, and being served by, the Council.

In general terms the present and future operation of Hazlehead Crematorium will be delivered within the context of this changing culture; in specific terms the operation of the Crematorium will meet and strive to exceed the requirements placed on it through the implementation of the recommendations made by the National Cremation Investigation, the Infant Cremation Commission and the Inspector of Crematoria Scotland.

7. MANAGEMENT OF RISK

The recommendations made in this report seek to put in place a far more robust infrastructure of performance management and assurance both specifically within the Crematorium itself and more generally across the Council.

Through this infrastructure the intention is to more timeously and more proactively identify the risks faced by the Council and to more effectively deploy mitigation measures to address them, ensuring that at all times elected members have the information required to allow them to hold management to account.

8. BACKGROUND PAPERS

Report of the Infant Cremation Commission June 2014
Aberdeen City Council Report to CH& I Committee Infant Cremation Commission Report (CH/14/079) 18 March 2015
Report of the National Cremation Investigation, The Rt Hon Dame Elish Angiolini DBE QC June 2016
Inspector of Crematoria Scotland Investigation report on Hazlehead Crematorium June 2016

9. REPORT AUTHOR DETAILS

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Appendix 1 Annotated NCI Conclusions for Aberdeen Crematoria with note of Actions to date.

Conclusion number	Conclusion/ Comments	ACC response (if applicable)
1	Like Mortonhall this was a section of the City Council working in almost complete isolation without any strategic direction, development or quality control of the service, so far as it related to babies, infants and non-viable foetuses. There was little knowledge by Senior Management of the service provided to the families of these babies. There was insufficient interest taken or leadership shown by management.	**Comment** - From 2010 until the appointment of the Performance and Development Manager in 2013, the Service Manager was visiting the Crematorium on a fortnightly basis. The Performance and Development Manager visits the Crematorium more frequently. The Crematorium was involved in the development of two Service Plans for Environmental Services one for 2011 and one in 2012 for 2013/14. In both plans Crematorium Services were identified for an "Operational Review" although in 2011 other works took priority; and in 2012 events at Mortonhall overtook events.
2	As with Mortonhall, much of what was learned by Cremator Operators at Aberdeen was received wisdom from more experienced peers. The extraordinary belief that there would be no recovered ashes from babies up to the age of eighteen months or two years was contradicted by what was known to be recovered in many other crematoria as well as in Aberdeen itself in earlier years.	**Comment** – accept the findings Revised procedures introduced on 25 November 2013 for still born, small infants and non-viable foetuses. To date these new procedures have recovered ashes from all cremations.
2	It is also clearly contradicted by the evidence of the Forensic Anthropologist, Dr Julie Roberts, who states that bones in cremated foetuses from as young as 17	**Comment** – accept the finding

	weeks' gestation can and do survive the cremation process. She stated in her report, *"My previous report prepared for Dame Elish provided evidence that the skeletal remains of foetuses as young as 17 weeks can and do survive the cremation process (City of Edinburgh Council, 2014). Taking that into consideration alongside the data presented in this report, it is inconceivable that there would be nothing left of new-born babies and infants aged up to two years following cremation. The 'no ashes' or 'no remains' policies at the Crematoria of concern must therefore be related to issues surrounding recovery processes, the ability to recognize burnt skeletal remains, and/or individual or corporate management decisions. The same applies to the reasoning that the remains of infants and adults could not be distinguished and separated in instances where they had been cremated together."*	ACC changed its cremation processes whilst listening and following guidance from the industry whilst engaged in the ICC. The result was recoverable ashes some five months prior to the published Mortonhall report.
3	Training was largely carried out in-house and there was no appetite to look beyond and seek best practice from other crematoria, professional organisations or manufacturers of equipment.	**Comment** – accept the findings. Crematoria staff have now carried out visits to other Crematoria, we were proactive in seeking ICC guidance, asking questions, comparing Forms, APSE benchmarking, FBCA guidance, management consulting group for best practice comparisons, checking out infant cremators, learning from recommendations from all reports, commissions and investigations. A facility has been developed within the YourHR system which will assist in the maintenance of training records and training requirements for cremator operators. In particular the system will flag any re-accreditation requirements for cremator operatives enabling management to assure

		themselves that appropriate action is being taken.
3	There was no evidence of any joint training with Funeral Directors or NHS midwives working in this area.	**Comment** – Accept the finding There was A practical demonstration of procedures took place on the 8/10/14, including information sheet for distributing to clients. Advised in meeting notes of the 20/2/14 that any changes of procedures would be advised by email. Further changes to procedures were advised by email, these emails can be seen on request. Through the development of formal terms of reference for the inter-agency Bereavement Services Group, it is intended that a cohesive and comprehensive training programme will be developed in partnership with NHS Grampian, Funeral Directors and Aberdeen Crematorium staff. The training package will inform all those involved at each stage of bereavement about what happens and the requirements on each person involved in informing and caring for those who are bereaved. A bespoke training programme will be developed with assistance from the Council's Organisational Development team.
3	The inter-agency Bereavement Services Group did not address the issues of	**Comment** – Accept the findings

	baby cremation until after the Mortonhall Investigation	This was discussed in detail at meeting of 20/2/14 and recorded in the meeting notes. Mortonhall Investigation was published 30/4/14 (2 months later). It is intended that the formal terms of reference for the inter-agency Bereavement Services Group will be developed. These terms of reference will cover matters such as joint training, communications and associated literature and changes in legislation and guidance.
3	It is incumbent on all those professional agencies involved in the cremation of these babies to ensure that they communicate effectively with each other and have appropriate joint training and joint understanding of their obligations to the parents of these babies	**Comment** – Accept the findings All professional agencies were immediately informed of the re-introduction of an infant tray in 25/11/13 and have been constantly kept updated in any change to our procedures. The NHS Agreement provides each parties obligation and we understand that this was of the one of the few in the country at the time. Examples of updates circulated can be provided on request. It is intended that the formal terms of reference for the inter-agency Bereavement Services Group will be developed. These terms of reference will cover matters such as joint training, communications and associated literature and changes in

		legislation and guidance.
3	This inertia allowed unacceptable practices to develop across all the relevant agencies in Aberdeen. The cremation of babies along with unknown adults is an unethical and abhorrent practice which will offend the sensibilities of the wider community and cause great distress to those whose babies were cremated there. It will also cause profound concern to the next of kin of unrelated adults who may have collected and continue to retain ashes of loved ones cremated at Aberdeen which also contain the ashes of a baby or one or even several nonviable foetuses.	**Comment** – Accept the findings Processes have been changed to ensure that all cremations are individual and that ashes are recovered from each individual cremation. The Council will handle sensitively any concerns raised by the next of kin of adults cremated at Hazlehead on a case by case basis.
4	The understanding that there were no ashes or that they could not be recovered was not explained and is inexplicable.	**Comment** – accept the findings
4	The nature of the processes and the expedient way this was done, without any recording to this effect, means that it is not possible to identify those adults and babies who were cremated with each other.	**Comment** – Accept the findings Cremators (Facultatieve Technologies) record each cremation. This is now audited by comparing the number cremated with the number of booked services to ensure they tally.
5	An additional practice carried out at Aberdeen was described to the Investigation. This involved raking adult ashes forward at the completion of a cremation and inserting into the same chamber an infant to be cremated while the adult ashes were still present. The entire contents of the chamber were then raked into the ash pan to cool. For obvious reasons this process was not recorded. It is	**Comment** – Accept the findings Processes have been changed to ensure that all cremations are individual and that ashes are recovered from each individual

	therefore not possible to identify those unrelated adults and babies to whom this happened.	cremation.
6	When obliged to consider this issue with the commencement of the Mortonhall Investigation and during the separate opportunity to explain their position to Lord Bonomy and his team the true picture at Aberdeen Crematorium was not disclosed. The Infant Cremation Commission was misled about the practices taking place.	**Comment** – Accept the findings The Infant Cremation Commission was informed about the anonymous letter by the (Acting) Chief Executive on 06/06/14.
7	It was clear from the interviews of staff in early 2015 that despite the passage of time since the Mortonhall Report, the report of the Infant Cremation Commission and extensive media coverage of the circumstances at Mortonhall Crematorium that staff had not yet been properly briefed or briefed at all to allow them to have an accurate understanding of the physiology of the bones of foetuses, stillborn babies and infants.	**Comment** - All staff were emailed on 08/05/14 (email can provided) following the publication of the Mortonhall Report to ensure that they read and fully understood the issues and recommendations in the report. This was followed with a team meeting specifically on the subject. When use of the tray was introduced in 25/11/13 all staff including the Performance and Development Manager were able to see first-hand the result of infant cremations and what the process did to the bones. All the staff were included and involved in developing the new process further to maximise the ashes recovered. Now that ashes have now been specifically defined this removes any confusion with

		regard to bones. ACC asked the NCI team to clarify how they define staff being 'properly briefed', and were advised that staff should read and understand Dr Roberts report.
		Additionally, they should have had a training session with management with appropriate pictures to discuss. A further training session was arranged in July 2016 to reinforce the crematorium teams current knowledge. This training through the FBCA includes training about the cremation of infants and is carried out at another Crematorium.
8	The most senior level of management at Aberdeen must provide strong leadership and now take full responsibility for the effective management of the crematorium. It must also ensure that immediate and appropriate training takes place and that effective and ethical practices are maintained. This relates not only to a change of working practices but to an assurance that the culture of the organisation and the knowledge and understanding is such as to prevent any future abuse of the trust of those families who have placed the remains of their loved ones in their care.	**Comment** – Accept the findings The CEO has asked the Head of Service to develop a suite of compliance measures which will be routinely reported to service committee to evidence continued compliance by the crematoria service as well as a set of performance measures with external benchmarks where available. For example, the crematorium manager should report to the service committee, in addition to the inspector of crematoria Scotland in the event that the service is unable to recover ashes following a cremation

		Bereavement customer care training was held in 04/09/14 and 14/01/15. All training verified as appropriate by three recent Audits (including FBCA and Inspector of Crematoria). There are now assurance audits checking cremations against bookings in place. Knowledge and understanding of processes by Senior Managers is now very comprehensive. A training matrix is currently being developed to ensure that all staff receive re-fresher training, particularly on infant cremation as part of normal operations, as appropriate. In addition, through the development of formal terms of reference for the inter-agency Bereavement Services Group, it is intended that a cohesive and comprehensive training programme will be developed in partnership with NHS Grampian, Funeral Directors and Aberdeen Crematorium staff. The training package will inform all those involved at each stage of bereavement about what happens and the requirements on each person involved in informing and caring for those who are bereaved. A bespoke training programme will be

		developed with assistance from the Council's Organisational Development team.
9.	It is of serious concern that some of the mothers of the babies referred to this Investigation were unable to give informed consent to the cremation of their child because of the persistent effects of sedating medication or strong pain relief. Some were recovering from surgery and all were suffering considerable grief. Steps should be taken to ensure that any form to be completed by any patient after a foetal loss, stillbirth or infant death is fully explained to the mother at a time when they are fully able to understand that to which they are consenting. Likewise, for those suffering the unexpected loss of an infant baby must be given adequate time and consideration to make a decision about the cremation of their child.	**Comment** – This action is mainly for NHS to implement. ACC have and will continue to work closely with the NHS to provide details of the current processes to assist them in ensuring that parents can make informed decisions at a time when they are able to fully understand what they are consenting to.
10	As with other crematoria there was a total absence of any local written instruction or guidance. This remained the case even in 2015 after an audit report of 2013 which highlighted the lack of written procedure. This meant that the actual practices employed in the crematoria were not documented and available for inspection by normal quality assurance procedures.	**Comment – Accept the findings** Written local procedures for all cremations including infant tray cremations were in place in Nov 2013 (example emails can be provided from 22, 26, 27 & 28/11/13 with Risk Assessments and procedure). These compliment the three volumes of FT Cremator Operator manuals and the FBCA Code of Practice and Training and Examination Scheme for Crematorium Technicians (TEST). All other procedures were then reviewed in a logical manner beginning with the most important which was the Application Forms and record keeping.

		All procedures were written down including how to set up the floral displays. These individual procedures were amalgamated into one “live” document in early 2015. The intention was for this document to be one of the best operational procedures in the country. A great deal of work went into this with all staff having the opportunity to contribute, review and agree so that they had ownership of the new and developing procedures. The NCI were advised that ACC were working on this single document. The hard work to ensure this document was the best it could be was verified by The Inspector of Crematoria stated in his recent inspection report that it is “a credit to the authors and is one of the most comprehensive and useful guidance and training aids seen by the Inspector at any of the other 28 crematoria in Scotland”. The Chief Executive has asked the Director of Corporate Governance to consider a mechanism for evidencing that staff have read and understood the organisational policies with which they must comply.

10	Had such written guidance been available it may have alerted Cremator Operators to the deviant nature of their practices.	**Comment** – Accept the findings These were historical practices but staff should still have been following the Code of Practice i.e. individual cremations.
11	By allowing the predicted outcome rather than the actual outcome to remain in the disposal column Aberdeen City Council created a situation where the inaccurate information was allowed to remain on the Register.	**Comment** – Accept the findings The Council understands that this was a historic issue throughout the country. The current actions on this matter are detailed in the following comment below.
11	Although the inaccuracy was identified no steps had been to correct the accuracy of the Register. This casual and careless approach to a statutory obligation is of considerable concern.	**Comment – Accept the findings** ACC have taken advice from our Legal team with regard to these discrepancies and the likelihood of records being inaccurate. The advice given is not to change a record based on likelihood or because an unofficial record (on the Daily Schedule) contradicts the record. The better approach in these sensitive circumstances, where absolute certainty may be lacking, would be to add a note to the relevant record as mentioned below. This should serve to provide the fullest picture possible.
		It has been decided that a note should be added alongside the record to show any

		discrepancies and this has been completed were discrepancies are known. It is believed that this is the correct course of action as we have received a number of enquiries from families asking for a copy of the records. We understand that this is a nationwide issue. ACC will seek advice from the Inspector of Crematoria for the best way forward on this matter. The CEO has instructed the SIRO to independently review the present public records arrangement and information governance arrangements within the crematoria to ensure they are appropriate.

Appendix 2 Annotated Generic Conclusions / Recommendations to the NCI Report

Conclusion number	Conclusion/ Comments	ACC response (if applicable)
1	The evidence discloses unethical and abhorrent practices at Aberdeen Crematorium over many years, including the cremation of foetuses and babies along with unrelated and unknown adults.	Comment – fully accept the conclusion and see list of actions noted in Appendix 1 for how these issues are being addressed
2	A criminal sanction should be created to prohibit the cremation of a nonviable foetus, stillborn baby or infant with an unrelated person unless there is express written consent from the next of kin of the baby. There must also be express written consent from the next of kin of the unrelated person or it must be compliant with the testamentary intention of the unrelated person.	**Comment** – Legislation required from Scottish Government.
3	The overall regulation of the funeral profession needs to be improved. Funeral Directors as well as Cremation Authorities should be licensed and subject to a statutory regime of regulation and inspection.	**Comment** – Legislation required from Scottish Government. Scotland's first Inspector of Crematoria was appointed by the Scottish Government and commenced in post in March 2015. The Inspector's duties will include undertaking an inspection visit to every crematorium in Scotland at least once a year. The Inspector of Crematoria will: • Ensure Cremation Authorities in Scotland are adhering to current legislation and best practice;

		• Respond to complaints or queries from the public about cremations; inspect cremation registers and other statutory documentation to ensure they are being completed and maintained appropriately; • Provide direction to crematoria managers and staff to ensure they are operating in line with the recommendations of the Infant Cremation Commission; and • Support the development of future primary legislation on burials and cremations.
4	The Scottish Government should exercise its powers under the Burial and Cremation (Scotland) Act 2016 to regulate the Funeral Directing profession.	**Comment** – Legislation required from Scottish Government relating to Funeral Directors.
5	An Inspectorate of the Funeral Business should be appointed incorporating the current role of the Inspector of Crematoria.	**Comment** – Legislation required from Scottish Government.
6	The Chief Executives and Senior Management of the Councils and organisations responsible for crematoria and funeral care in Scotland must take full responsibility for securing a forward looking and proactive approach to the management of their businesses and duties. This should include responsibility for ensuring a caring and sensitive culture in their operations and a renewed focus on customer service and standards of care. The parents of many of the families involved in this Investigation have been failed	**Comment** – Accept the recommendations Independent external inspection of the service will be undertaken by the Inspector of Crematoria annually and periodic audits undertaken by the FBCA. Reports from both these bodies will be submitted to committee

	by both crematoria and funeral care organisations over many decades.	for scrutiny. In addition, independent inspection will be undertaken by the Chief Internal Auditor as directed by the audit committee. The CEO has directed the Head of Service to develop a set of compliance measures as well as performance measures (with external benchmarks where available) and for both sets of measures to be reported to service committee. The CEO has directed each directorate as part of the cultural change programme with its focus on customer, to undertake its own baseline against the recently developed customer standards and for the service to develop its plans for improving its customer service. The CEO has directed the Director of Corporate Governance to the explore scope for co-location of the registrar service at the crematorium.
7	Minimum standards of training and joint training should be introduced for the cremation of foetuses, stillborn and infant babies. Chief Executives should take responsibility for ensuring all staff are trained and certified to those standards, which should be periodically re-assessed. Such staff should be given opportunities to develop best practice along with funeral professionals and NHS staff.	**Comment** – Accept the recommendation **<u>Training</u>** Crematoria staff have now carried out visits to other Crematoria, we were proactive in

		seeking ICC guidance, asking questions, comparing Forms, APSE benchmarking, FBCA guidance, management consulting group for best practice comparisons, checking out infant cremators, learning from recommendations from all reports, commissions and investigations. Joint working with Funeral Directors and NHS commenced with a practical demonstration of procedures 8/10/14, including information sheet for distributing to clients. Advised in meeting notes of the 20/2/14 that any changes of procedures would be advised by email. Further changes to procedures were advised by email, these emails can be seen on request. Bereavement customer care training was held in 04/09/14 and 14/01/15. All training verified as appropriate by three recent Audits (including FBCA and Inspector of Crematoria). There are now assurance audits checking cremations against bookings in place. Knowledge and understanding of processes by Senior Managers is now very comprehensive. Recently further training session were arranged in July 2016 to reinforce the crematorium teams current knowledge. This

		training through the FBCA includes training about the cremation of infants and is carried out at another Crematorium. A training matrix is currently being developed to ensure that all staff receive re-fresher training as part of normal operations, as appropriate. In addition, through the development of formal terms of reference for the inter-agency Bereavement Services Group, it is intended that a cohesive and comprehensive training programme will be developed in partnership with NHS Grampian, Funeral Directors and Aberdeen Crematorium staff. The training package will inform all those involved at each stage of bereavement about what happens and the requirements on each person involved in informing and caring for those who are bereaved. A bespoke training programme will be developed with assistance from the Council's Organisational Development team.
8	All midwifery students should be trained to deal with the care of parents of deceased babies. There is a particular need to ensure that parents are given time and space to make decisions about the disposal of their baby's remains, that mothers are fit to provide consent and that accurate information is provided about the options available for parents.	**Comment – Action for NHS.** ACC is committed to working with both NHS and Funeral Directors.

9.	It was clear that the quality of communication between NHS staff, crematoria staff and Funeral Directors also varied considerably across the country and was subject to confusion and disagreement between the organisations. While the Investigation was told that some crematoria would warn Funeral Directors that ashes could not be guaranteed, this had been understood by Funeral Directors that no ashes were available for foetuses or babies and parents had been advised as much. As with the findings in the Mortonhall Investigation Report, the whole process of communication with bereaved parents about cremation was generally unsatisfactory and muddled, with a small number of notable exceptions.	**Comment – Accept the findings; Action for NHS, Funeral Directors and Council.** ACC has joint working with Funeral Directors and NHS and this commenced with a practical demonstration of procedures 8/10/14, including information sheet for distributing to clients. Advised in meeting notes of the 20/2/14 that any changes of procedures would be advised by email. Further changes to procedures were advised by email, these emails can be seen on request. It is intended that the formal terms of reference for the inter-agency Bereavement Services Group will be developed. These terms of reference will cover matters such as joint training, communications and associated literature and changes in legislation and guidance.
10	Steps must be taken by all Chief Executives of health, crematoria and funeral organisations to ensure that all staff required to advise parents on cremation or to carry out such cremations are properly briefed. They must have an understanding about the survival of baby bones in cremation where proper care is taken. They must also have an understanding of the fundamental importance to families of having back any small remnant of their baby, including ashes from the baby's clothes, blanket, toy or coffin to help them grieve for their loss.	**Comment – Accept recommendation; Action for NHS, Funeral Directors and Council.** For ACC refer to Conclusion / Comment 7 above.

11	It is incumbent on all senior management in each of these three sectors to lead and secure adequate training, appropriate working practices and a culture of care and sensitivity. Given what is disclosed in this Report, systems must be in place to ensure those services are delivered consistently and are subject to regulation and inspection.	**Comment – Accept recommendation; Action for NHS, Funeral Directors and Council**. For ACC refer to Conclusion / Comment 7 above.
12	The practice of inserting the disposal outcome of the remains of the baby on the Statutory Register of Cremations before the actual cremation had taken place was widespread. In short, what appears to be a record was a prediction and not a record at all. This rendered many records wholly unreliable and meaningless as a statutory record of the actual outcome of the cremation. There was significant evidence that in many cases across the country the outcome recorded was in fact only the instruction for the disposal of ashes and that this was not updated with the actual outcome. As at Mortonhall, prior to the computerised systems being introduced, most crematoria did not record in manual registers that there were 'no remains' even though they stated this to be the case. Most often the words 'dispersed in the Garden of Rest or Remembrance' would appear. This casual and careless approach to a statutory obligation is of considerable concern. Steps now need to be taken to rectify these inaccuracies and to ensure this obligation is treated with the solemnity it deserves. The statutory requirement to maintain such records implicitly contains a duty to do so conscientiously and truthfully.	**Comment – Accept the findings;** ACC have taken advice from our Legal team with regard to these discrepancies and the likelihood of records being inaccurate. The advice given is not to change a record based on likelihood or because an unofficial record (on the Daily Schedule) contradicts the record. It has been decided that note should be added alongside the record to show any discrepancies and this has been completed were discrepancies are known. It is believed that this is the correct course of action as we have received a number of enquiries from families asking for a copy of the records. We understand that this is a nationwide issue. ACC will seek advice from the Inspector of Crematoria for the best way forward on this matter.

13	Evidence was discovered of Funeral Directors and crematoria holding on to baby ashes for many years on their premises without advising parents until the intervention of this Investigation. Crematoria and Funeral Directors must be vigilant to secure the return of ashes to parents or next of kin where the parents or next of kin have applied for the return of ashes. Ashes should also be offered where any of the circumstances described in this report may apply to parents who may be unaware that the ashes are still being held either at the crematorium or at the Funeral Director's premises.	**Comment – Action for Funeral Directors and Council.** No evidence found in relation to this being a practice within Aberdeen. ACC have a process which manages the return of ashes, or other authorised requirements from the bereaved family or appropriate applicant.
14	Many parents relied wholly on the advice given by NHS staff and accepted in good faith the advice that there would be no ashes to be recovered from the cremation of their baby. This misleading information deprived many parents in Scotland of the opportunity to recover the ashes of their babies. Such advice and guidance to parents needs to be accurate and set out in different formats to take into account the impact of grief on the ability of the parents to absorb information given on one occasion. Most importantly, parents must also be given the time and space to make their decision.	**Comment** – **This action is mainly for NHS to implement.** ACC have and will continue to work closely with the NHS to provide details of the current processes to assist them in ensuring that parents can make informed decisions at a time when they are able to fully understand what they are consenting too.
15	This Report identifies incidences where babies have been cremated with an unknown, unrelated adult and/or their ashes have been disposed of without the knowledge of parents. Steps should be taken by the Chief Executives of organisations responsible for such crematoria to consult affected parents about an appropriate memorial.	**Comment** – **Action for CEO's.** The Council has commenced discussions with several organisations about facilitating consultations with affected parents about an appropriate memorial. The Council will be contacting those parents affected who are known to it with further details.

Appendix 3
summary action plan of the 7 outstanding ICC Recommendations that ACC has responsibility to address and implement:-

ICC Recommendation	ACC Action	Target Date
19, 22, 23, Statutory Application Forms	Await statutory forms and legislation As legislation and statutory forms may take some time to implement, we have update our current application forms as per ICC Recommendations where possible.	Await statutory forms and legislation
33 Medical certificate for all non-viable babies	Await legislation. Already procedure for single at ACC but not for shared cremations.	Awaiting legislation
35 Additional entries required to Cremation Register from future legislation	ACC has implemented but awaits legislation to finalise	Awaiting legislation
41 Notice issued confirming the disposal of cremated remains	Awaiting clarification from legislation. ACC has added a request notice to current application for cremation forms for non-viable babies.	Awaiting legislation
55 Where invited to do so by affected parents, local councils should facilitate discussion for plans for local memorials	Commence discussions with affected parents on their wishes for an appropriate local memorial.	On going

Appendix 4

This following table shows each individual recommendation along with the Scottish Governments response, timescale and ACC's response.

Recommendation	Government Response	Timescale	**ACC Response**
1 In legislating, devising policy, drafting information and guidance documents, and making arrangements for and conducting baby cremations, the baby and the interests of the family should be the central focus of attention. Parents and families should be given time and space to reach the correct decision for them. Arrangements should be in place at each hospital for ongoing contact with parents, particularly mothers, where that contact is necessary. **(11.34)**	Accepted. The Government endorses recommendation 1 as a fundamental principle of practice in this area.	All organisations involved in infant cremation, or in supporting bereaved parents, should adopt this principle immediately. All hospitals dealing with bereaved parents should ensure arrangements are in place to support on-going contact with parents where necessary. This Recommendation will be monitored by the National Committee proposed at Recommendation 57.	Complete. Accepted and principle adopted
2 The FBCA in the course of their "critical friend" visits to crematoria and the ICCM in their self-assessment questionnaire should address specifically the conduct of baby cremations and recovery of ashes. **(5.6)**	This is primarily for the FBCA and ICCM, but the Scottish Government supports this recommendation. FBCA and ICCM will be expected to amend practice in this way. Both FBCA and ICCM were represented on the Commission and have committed to taking forward recommendations.	The National Committee proposed at Recommendation 57 will have oversight of this recommendation. Both organisations will be expected to confirm when training programmes will be updated to the National Committee and this will be included within the National Committee Action Plan.	Not for ACC to action. But will support additional checking mechanisms
3 The "ashes" which the Cremation Authority is obliged to give into the charge of the person who applied for the cremation if he so desires should be	Accepted. Legislation will be amended to reflect this definition. Government will consider whether	If this amendment can be made to the 1935 Regulations using existing powers this will be done by April 2015 at the latest.	Complete. Accepted and principle adopted.

defined in legislation as "all that is left in the cremator at the end of the cremation process and following the removal of any metal". That should not preclude the applicant from consenting in advance to the removal of metals, such as coffin nails and artificial joints, and their separate disposal, including as part of a metal recycling scheme. **(7.21)**	or not existing powers can be used to amend the 1935 Regulations, but that is not likely to be possible in relation to non-viable foetuses (which are not currently regulated for the purposes of cremation), and so would only be a partial response.	If primary legislation is required the new Burials and Cremations Bill will set out the necessary provisions. A consultation on the bill will be published by the end of 2014. (Even if the 1935 Regulations can be updated immediately, that will be a temporary arrangement until the new Burials and Cremations Bill replaces the 1935 Regulations.)	
4 Cremation Authorities should review their practices immediately to ensure that, in dealing with the "ashes" following cremation, they proceed on the basis that the "ashes" are as defined in the foregoing recommendation. **(7.21)**	This is for Cremation Authorities and the ICCM and FBCA, but Scottish Government supports the recommendation.	Cremation Authorities should proceed on this basis immediately – it is not necessary to await legislation. The National Committee proposed at Recommendation 57 will monitor practices, and this approach will also be included in the Code of Practice in recommendation 61.	Complete
5 The Scottish Government should inform their counterparts in England and Wales and Northern Ireland about the changes in legislation in Scotland to enable them to consider clarification of the definition of "ashes" in identical terms. **(7.23)**	Accepted. Scottish Ministers will write to counterparts in the three UK Governments reflecting this point, and the work of the Commission more generally.	Scottish Ministers will write to counterparts by the end of June 2014.	Not for ACC to action.
6 All Cremation Authorities at whose crematoria ashes are not always recovered should liaise with a crematorium or crematoria where ashes are recovered more regularly to share their experiences and information about their respective practices in order to identify changes in practice that should be introduced immediately with a view to increasing the prospects of recovering ashes. **(8.13)**	This is for Cremation Authorities but Scottish Government supports the recommendation and expects all Cremation Authorities to take immediate steps to ensure practices are adopted to increase the potential for ashes to be recovered.	The implementation of this recommendation will be monitored by the National Committee proposed in Recommendation 57. Cremation Authorities will be expected to report at the first meeting of the National Committee on their progress towards implementation of this recommendation.	Complete

7 The Cremation Authorities which have rejected the use of trays for baby cremations on health and safety grounds should urgently consider, in light of the experience of others, the introduction of a local protocol to allow trays to be used in a way that will expose no one to undue risk. **(8.14)**	This is for Cremation Authorities but Scottish Government supports the recommendation. And expects all Cremation Authorities not currently using baby trays to look at this as a matter of urgency.	The implementation of this recommendation will be monitored by the National Committee proposed in Recommendation 57. The use of baby trays will be included in the Code of Practice proposed in Recommendation 61. Cremation Authorities will be expected to report at the first meeting of the National Committee on their progress towards implementation of this Recommendation.	Complete
8 As an urgent interim measure, the ICCM and the Federation of Burial and Cremation Authorities (FBCA) should form a joint working group, which should also include two lay persons nominated by the Scottish Government and a representative of Facultatieve Industries Ltd, to consider the various practices and techniques currently employed in baby and infant cremation in full-scale cremators with a view to identifying those practices which best promote the prospect of recovery of ashes inclusive of baby remains and compiling guidance for cremator operators. The working group should identify aspects of the cremation process which could conceivably be changed or improved and into which research ought to be commissioned by the Scottish Government. The working group's endeavours may be assisted by the fact that the majority of cremators in use in Scotland are produced by the same manufacturer, Facultatieve Technologies Ltd. **(8.36)**	Recommendations 8, 9 and 10 are for ICCM and FBCA but Scottish Government supports the recommendation. The Scottish Government will support the establishment of such a working group, and will provide any assistance necessary to ICCM and the FBCA to take this work forward. The Scottish Government will work with affected parents to identify two lay members for this group.	The Working Group will be established as a priority over the summer of 2014. In due course the Working Group will become a sub-group of the National Committee recommended in recommendation 57, once that Committee is established.	Complete for single cremations. Cremation Practice Guidance provided on 19/11/14 and ACC following this guidance.

9 Following completion of its work in **8** above, that working group should also consider the operating systems and other features of the cremators in use in Scotland and the practices currently employed with a view to identifying those aspects of the cremation process which could conceivably be changed or improved and into which research ought to be commissioned by the Scottish Government. That should include the practice of cremating babies at the end of the working day and overnight with the cremator operating and monitoring equipment switched off in a way that will cause no material environmental damage and satisfies SEPA that it should be permitted, with a view to increasing the prospects of recovering ashes. **(8.36 and 8.39)**	As above.	As above.	Not for ACC to action.
10 That working group should consider and advise whether, in light of experience in England and Ireland, and having regard to their efficiency in recovering ashes and the costs of installation and operation, the Scottish Government should commission research into the design and development of small-scale cremators. **(8.40)**	As above.	As above.	Not for ACC to action.
11 Each Cremation Authority should publish a policy statement, which should include a commitment to the sensitive treatment of the baby throughout and to respecting the wishes and needs of parents and families, and also set out the Authority's policy on ashes. To ensure clarity and consistency the ICCM and the FBCA should form a joint working group to develop a	This is for Cremation Authorities and the ICCM and FBCA, but Scottish Government supports the recommendation and expects Cremation Authorities to respond to this recommendation as a priority, based on advice from ICCM and FBCA.	The Scottish Government can see no reason why such policy statements cannot be published swiftly. Cremation Authorities will be expected to have appropriate policy statement in place by the end of August 2014. Cremation Authorities will report progress	Complete. Policy Statement approved at CH&I Committee on 18/03/15.

model policy statement reflecting best practice and allowing for local variation as appropriate. **(8.44)**	The Scottish Government will support any joint discussions between ICCM and FBCA that may be necessary.	against this recommendation to the first meeting of the National Committee. The subject of policy statements will be included in the Codes of Practice in recommendations 29 and 61.	
12 Funeral directors and healthcare staff should include appropriate extracts from the Cremation Authority policy in information and guidance material given to families. **(8.45)**	Accepted. Funeral directors and the NHS should ensure the policy statements of relevant Cremation Authorities are included within information and guidance as soon as possible.	The NHS and Funeral Directors should ensure materials are updated as soon as policies are published by Cremation Authorities. The implementation of this recommendation will be monitored by the National Committee proposed in Recommendation 57, and the first meeting of the Committee will consider progress against the implementation of this recommendation.	Complete. Policy Statement has been sent to NHS & Funeral Directors since approval CH&I Committee on 18/03/15.
13 The cremation of non-viable babies should be the subject of legislative regulation. **(9.4)**	Accepted. Legislation will be amended to reflect this recommendation.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Not for ACC to action. ACC will review subject to legislative changes
14 Appropriate forms of application for cremation should be prescribed for each of three categories of cremation of babies and infants: (a) stillborn baby; (b) shared cremation of non-viable babies; and (c) individual cremation of a non-viable baby. **(9.7, 9.23, 9.40, 9.42 and 9.44)**	Accepted. Legislation will be amended to reflect this recommendation and separate statutory forms will be prescribed.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Not for ACC to action. – await statutory forms. ACC have added as many of the recommendations as possible to our current Application Forms.

15 On each form of application for cremation there should be a clear warning, in terms appropriate to that form, that ashes may not be recovered, with provision for the applicant to acknowledge having read that warning. In the case of (b) shared cremations the warning should also state that any ashes recovered will either be scattered or interred, and specify which, at the crematorium. **(9.10, 9.24, 9.40, 9.44)**	Accepted. Legislation will be amended to reflect this recommendation.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Complete, added to our current Application for Cremation Forms although statutory form to be produced.
16 In the context of their introduction of a new death certification process, the Scottish Government should review the currently prescribed content of cremation application Form A to ensure that only essential questions are incorporated into the new prescribed forms for (a) and (c). **(9.18, 9.24 and 9.44)**	Accepted. Form A will be reviewed as part of the implementation of the Certification of Death (Scotland) Act 2011.	Implementation of the new death certification process is planned for April 2015.	Not for ACC to action. ACC will adopt forms when they become available
17 All forms of application prescribed should be designed by the Scottish Government with simplicity and clarity in mind, and all Cremation Authorities, Health Boards and other healthcare providers should be required to use the forms so prescribed and designed. **(9.14 and 9.16)**	Accepted. Forms will be designed on this basis.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Not for ACC to action. ACC will adopt forms when they become available
18 The forms prescribed for (a) and (c) should contain a question requiring the applicant to specify how the ashes should be dealt with following the cremation. The options available should include retention for a defined period pending a final decision and also later extending the period of	Accepted. This provision will be included when legislation is updated.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Complete, added to our current Application for Cremation Forms although statutory form to be produced.

retention. **(9.10, 9.24 and 9.44)**			
19 There should be provision in forms for (a) and (c), or on a separate form, for the applicant to authorise a representative, such as the Funeral Director, to collect the ashes. Where the Funeral Director is the person authorised, the form should also provide for the consent of the applicant to the Funeral Director returning the ashes to the crematorium in the event that the applicant does not collect them from the Funeral Director or give the Funeral Director instructions as to their disposal within a defined period. **(9.11)**	Accepted. This provision will be included when legislation is updated.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	**ACC to Action.** Awaiting statutory forms
20 There should be a specific legislative provision that the cremation should not be authorised to proceed if the application does not contain a clear direction as to how the ashes should be dealt with. **(9.12)**	Accepted. This provision will be included when legislation is updated.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Complete, ACC have implemented this recommendation although this will be a specific legislative provision.
21 Where ashes are left in the care of the crematorium on the basis that they will be collected, or to await further instructions within a defined period, the Cremation Authority may not scatter or inter them unless 14 days' notice of their intention to do has been given to the applicant. **(9.13)**	Accepted. This provision will be included when legislation is updated.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Complete, although this is also to be included in legislation
22 The forms prescribed for (a) and (c) should be completed and signed by the applicant personally, and the applicant's signature should be witnessed by a person who is not a member of the applicant's	Accepted. This provision will be included when legislation is updated.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	**ACC to Action.** Awaiting statutory forms and legislation

family and has no part in the arrangements for the cremation. (**9.9, 9.10, 9.21 and 9.44)**			
23 It should be provided in legislation that those entitled to apply for cremation are: (i) in the case of (a) and (c) the nearest relative as defined by section 50 of the Human Tissue (Scotland) Act 2006; and (ii) in the case of (b) a person authorised by the Medical Director of a Health Board or other healthcare provider, and that an application presented by a different person should be accepted only on cause shown, which should be recorded in the register referred to below. **(9.19, 9.20 and 9.42)**	Accepted. This provision will be included when legislation is updated.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	**ACC to Action.** Awaiting legislation
24 Senior Cremation Authority staff should be responsible for the scrutiny of all cremation application forms to satisfy themselves that the applicant is entitled to make the application as mother, nearest relative or on cause shown. There should be legislative provision that, if the Cremation Authority is not satisfied of the applicant's entitlement to apply, then authority for the cremation to proceed may be refused. **(9.20)**	Accepted. This provision will be included when legislation is updated.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Complete, Procedure in place and further legislation will be implemented.
25 Legislative provisions similar to those in Regulation 20 of the 2008 Regulations (England and Wales) should be introduced requiring appropriate certification of a stillbirth. **(9.22)**	Accepted. Legislation will be updated to reflect this.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Not for ACC to action. ACC will implement the legislation
26 The duty of Cremation Authorities as to the	Accepted. Legislation will be	The recommendation proposes amendments	Not for ACC to

handling of ashes set out in Regulation 17 of the 1935Regulations should be extended to apply to stillborn and non-viable babies. **(9.25)**	updated in this way.	to existing secondary legislation. If possible the Government will make these amendments by the end of 2014/15. If not the Burials and Cremations Bill will address this point.	action. ACC will implement the legislation.
27 The provisions of Regulations 13 and 15A of the 1935 Regulations should be amended to apply to stillborn children. **(9.26)**	Accepted. Legislation will be amended as recommended.	The recommendation proposes amendments to existing secondary legislation. If possible the Government will make these amendments by the end of 2014/15. If not the new Burials and Cremations Bill will address this point.	Not for ACC to action. ACC will implement the legislation.
28 NHS Scotland should review the provision of the facility of hospital-arranged cremation throughout Scotland with a view to making consistent provision in all Health Boards. **(9.32)**	Accepted. The Scottish Government endorses this recommendation and will work with Health Boards to ensure this is implemented.	Given that these arrangements may depend on contractual arrangements, Health Boards will be expected to have consistent provision in place by the end of April 2015. The National Committee proposed in Recommendation 57 will provide oversight on progress against this recommendation, and will consider this at the first meeting of Committee.	Not for ACC to action. ACC will assist NHS when required
29 The Scottish Government should establish a working group comprising representatives of Health Boards, Funeral Directors, Cremation Authorities and miscarriage and child bereavement support organisations to consider evolving practices in the arrangement and conduct of shared cremations and to draw up a code of practice setting down minimum standards for shared cremations. **(9.35)**	Accepted. A working group will be established to consider these issues.	The National Committee proposed in Recommendation 57 will take on this action. This code of practice could be incorporated into overarching Code of Practice proposed at Recommendation 61 below.	Not for ACC to action. ACC to consider involvement on this group

30 The 2012 CMO and CNO Guidance on sensitive disposal should be reviewed and consideration should be given to revising it to take account of the comments made in Section 9. **(9.36 to 9.39)**	Accepted. The CMO/CNO Guidance will be updated.	A new CMO/CNO letter was issued in summer 2014, which will an interim guidance while the work of the National Committee is in progress.	Complete.
31 Annex C to the CMO and CNO Guidance should be revised to: (i) set out specifically the options for disposal explained to the mother above the space for her signature; (ii) state that ashes may not be recovered following cremation, and that any which are recovered will be scattered or buried at the crematorium; and (iii) state specifically that the standard procedure to be followed where the mother declines to discuss disposal is cremation along with others. **(9.40 and 9.41)**	As above.	As above.	Complete.
32 The form of application for (b) should state that each mother has authorised the hospital to arrange a shared cremation, and that such authorisation is held in hospital records. **(9.40)**	Accepted. This approach will be included in the updated form.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Complete for ACC. This is mainly an NHS requirement.
33 Each application for cremation of a non-viable baby should be accompanied by a medical certificate that the pregnancy loss occurred before 24 weeks and showed no signs of life. **(9.42)**	Accepted. This requirement will be included in legislation.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	**ACC to Action** Await legislation. Already procedure for single at ACC but not for shared cremations.
34 Cremation Authorities, Funeral Directors and Health Boards should review the contractual arrangements in place for shared cremations in light	Accepted. The Scottish Government supports this recommendation. Such	Cremation Authorities, Funeral Directors and Health Boards should be taking steps immediately to ensure arrangements are	Complete. Contract with NHS signed on 16/07/15.

of ICCM guidance contained in Section 6 to satisfy themselves that the respective responsibilities of the parties are so defined as to ensure that such cremations are carried out in a dignified and sensitive manner. **(9.48)**	cremations should be carried out in accordance with the code of practice which will be developed as per Recommendation 29 above.	dignified and sensitive. Arrangements can be further reviewed/updated once the code of practice as proposed in Recommendation 29 is produced.	
35 Each Cremation Authority should be required by legislation to record the cremation of each deceased baby, stillborn baby and non-viable baby carried out by the Cremation Authority in a register or registers comprising prescribed columns, every one of which must be completed, including in particular, if the ashes were scattered or buried, the date and their location and, if collected, the date and by whom. **(10.4 and 10.5)**	Accepted. This requirement will be set down in legislation.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	**ACC to Action** ACC has implemented but awaits legislation to finalise
36 The Cremation Register should be a public document and the Scottish Government should make legislative provision to that effect, subject to any restrictions necessary in the interest of privacy and to comply with data protection requirements. **(10.6)**	Accepted.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Not for ACC to action ACC to make provision subject to legislation
37 Each Health Board and other healthcare providers should maintain a register of authorisations in which the crematorium at which the baby was cremated is recorded in a way that will ensure traceability of the link between the baby and the ashes. **(10.8)**	Accepted. This does not need to be a legislative requirement – although we will consider including a provision in new legislation – and the NHS should put in place arrangements for such registers immediately.	If this is enshrined in legislation this would be via the Burials and Cremations Bill, to be introduced in 2015. However Health Boards needs not wait for that and can established registers immediately. The National Committee proposed in Recommendation 57 can provide oversight of this work to ensure a consistent approach,	Not for ACC to action

		and this issue will be included in the Code of Practice proposed at Recommendation 61.	
38 Since responsibility for preserving important records relating to hospital arranged cremations lies with the hospital or other healthcare provider, a working group comprising Health Board representatives and a representative from the private healthcare sector, chaired by a Scottish Government official, should be appointed by the Scottish Government to review hospital record-keeping practice in all hospitals and other healthcare providers in relation to documents relevant to baby and infant cremations with a view to identifying best practice to be applied across Scotland. **(10.9)**	Not shown in Scottish Government's Summary of Recommendations?	Not shown in Scottish Government's Summary of Recommendations?	Not for ACC to action
39 The registers kept by Cremation Authorities, Health Boards and other healthcare providers should be preserved indefinitely. All forms of application, certificates and other official documents relating to a cremation should be preserved for a minimum of 50 years. **(10.10 and 10.11)**	Accepted. Although the recommendation does not explicitly state that these requirements should be statutory, it may be appropriate to make this a legislative requirement. If so primary legislation would be the appropriate mechanism.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	Complete. Arrangements in place to keep for 50 years. Currently 17 years Application Forms in store. Future data storage systems to be investigated.
40 The Scottish Government should form a working group drawn from Cremation Authorities and providers of software to crematoria to review the available facilities for electronic processing and storage of cremation	Accepted.	This working group can proceed as a sub-group of the National Committee proposed in Recommendation 57. Rather than specifying a specific end-date for	Not for ACC to action

documents and records, to consider and recommend appropriate improvements to achieve the objects of the recommendations of this Commission, and to consider what additional features and facilities the software manufacturers should be invited to develop, all with a view to ensuring that the systems in use by Cremation Authorities are as efficient and secure as possible. The working group should also consider and advise on the appropriate requirements for back-up systems. Having regard to the importance of keeping records secure, the working group should also consider and advise whether additional security measures are necessary and what back-up storage systems should be provided. **(10.12)**		this work the Government would ask the National Committee to consider establishing this working group on an on-going basis given the likelihood that IT systems will continue to evolve.	
41 In the case of deceased and stillborn babies, on completion of the entry by recording the ashes location or collection and the date thereof, the Cremation Authority Registrar should be required to send a notice to the applicant confirming which occurred and, if scattered or interred, where that was, along with an extract of the full register entry. In the case of the individual cremation of a non-viable baby the Registrar should issue such a notice and extract on request and the form of application should provide for such a request to be made. **(10.13)**	Accepted. Although not explicitly stated within the recommendation this will be best be secured via a legislative requirement.	This will require primary legislation, and will be part of a new Burials and Cremations Bill. We will publish a consultation on this new bill by the end of 2014.	**ACC to Action** Awaiting clarification from legislation. ACC has added a request notice to current application for cremation forms for non-viable babies.
42 The ICCM and FBCA should review their respective technical training programmes in accordance with the requirements identified in Section 11. **(11.12 to**	This is for ICCM and FBCA but Scottish Government supports the recommendation.	The National Committee proposed at Recommendation 57 will have oversight of this recommendation. Both organisations will be expected confirm when training	Not for ACC to action

11.16)		programmes will be updated to the National Committee and this will be included with the National Committee Action Plan detailed below.	
43 The FBCA should review all published guidance documents to provide clear and fully informed guidance on the prospects of ashes being recovered based on knowledge of skeletal maturity rather than gestational age alone. **(11.14)**	This is for the FBCA but Scottish Government supports this recommendation.	The FBCA will be expected to update all published guidance documents which are in use in Scotland as a priority. The FBCA will be asked to confirm to the National Committee which materials will be updated. The issue of Guidance documents will be addressed in the Code of Practice in recommendation 61.	Not for ACC to action ACC to review procedures subject to future guidance
44 The ICCM and FBCA should each introduce into their respective technical training programmes provision requiring the trainee technician and his mentor to attend and undertake, in the course of the training period and at a crematorium identified by the Institute or the Association as excelling in the conduct of baby and infant cremations, a full day of training in the conduct of baby and infant cremation on two separate occasions. The trainee should be required to satisfy the examiner of his knowledge and understanding of the methods and techniques of the conduct of baby and infant cremations that enhance the prospects of recovering ashes. **(11.16)**	This is for the ICCM/FBCA but Scottish Government supports this recommendation.	The National Committee proposed at Recommendation 57 will have oversight of this recommendation. Both organisations will be expected confirm when training programmes will be updated to the National Committee and this will be included with the National Committee Action Plan detailed below. The issue of training will be included in the Code of Practice at Recommendation 61.	Not for ACC to action. To be incorporated into ACC in-house training. Review refresher training for staff
45 The ICCM should revise their management training scheme to include an element dealing with baby and infant cremation and to make that a compulsory part of study for the certificate in	This is for the ICCM but the Scottish Government supports this recommendation.	The National Committee proposed at Recommendation 57 will have oversight of this recommendation. The ICCM will be expected confirm when training programmes	Not for ACC to action. Need to check standards and

cremation management. **(11.18)**		will be updated to the National Committee and this will be included with the National Committee Action Plan detailed below.	qualifications from both FBCA and ICCM
46 The person with direct management responsibility for the operation of a crematorium should hold either a qualification in crematorium management or the FBCA certificate of competence to operate cremators or the ICCM intermediate certificate for crematorium technical operations. **(11.19)**	Accepted. This will be included in the Code of Practice in recommendation 61.	There may be value in making this a regulatory requirement and the Scottish Government will give this further consideration in preparing the Burials and Cremation Bill. Meantime Cremation Authorities will be expected to ensure those with direct management responsibility have appropriate qualifications.	Complete - Senior Staff hold qualifications and future staff will be trained and fully qualified.
47 The FBCA should develop and introduce a training programme for continuing professional development. **(11.20)**	This is for FBCA but the Scottish Government supports this recommendation.	The National Committee proposed at Recommendation 57 will have oversight of this recommendation. The FBCA will be expected confirm when training programmes will be updated to the National Committee and this will be included with the National Committee Action Plan detailed below.	Not for ACC to action To review training of staff once FBCA have developed programme
48 Mothers of non-viable babies and families of stillborn babies and very young deceased babies considering cremation should be advised where there is a possibility that ashes will not be recovered and reminded of the availability of the option of burial. **(11.24 and 11.34)**	Accepted. This should be part of the Code of Practice proposed in Recommendation 61.	The National Committee proposed at Recommendation 57 will take forward the work to develop the new Code of Practice in recommendation 61	Complete. Advice provided in the updated application for cremation forms and Funeral Directors have been informed that they require to advise clients
49 All providers of training programmes for Funeral	Accepted. This is primarily for	The National Committee proposed at	Not for ACC to

Directors should review them in the light of any legislative changes affecting the cremation of non-viable and stillborn babies and associated administrative procedures. **(11.26)**	Funeral Directors but Scottish Government supports this recommendation.	Recommendation 57 will have oversight of both of these recommendation and representatives of Funeral Directors in Scotland be expected confirm progress to the National Committee.	action
50 All providers of training programmes for Funeral Directors should devise modules designed to give Funeral Directors an understanding of the cremation process, the effect it has and the prospects of recovering ashes in baby and infant cremations. **(11.26)**	Accepted. As above, this is primarily for Funeral Directors but the Scottish Government supports this recommendation.	These actions will be reflected in the National Committee Action Plan detailed below.	Not for ACC to action Although we have shown Funeral Directors our new processes to dispel any perceived continuing bad practice. Suggest annual refresher.
51 Each Health Board, as part of continuously improving the quality of the service, should identify staff who will have responsibility for communicating with families about arrangements for disposal and liaising with Funeral Directors and crematoria and, as part of their continuous professional development, arrange for their further education and training in the necessary skills, including developing their communication skills, improving their understanding of the roles and responsibilities of colleagues, and providing an appreciation of the capabilities of modern cremation equipment and contemporary cremation practice and the effect of cremation on babies and infants. **(11.35)**	Accepted. The Scottish Government will work with NHS Scotland and the relevant Royal Colleges to ensure appropriate training is available and undertaken.	The National Committee proposed at Recommendation 57 will have oversight of this recommendation and representatives of NHS Scotland will confirm when training arrangements are in place. This will be reflected in the National Committee Action Plan detailed below. This recommendation will also be addressed in the Code of Practice in recommendation 61.	Not for ACC to action specifically although NHS Grampian representative has been shown our new processes

52 Health Boards should support staff in initiating the formation of local multi-disciplinary working groups comprising all with a role in dealing with the fate of the baby from hospital to crematorium to exchange information, knowledge, understanding, practice and experience, as well as promoting joint training programmes, with the aim of ensuring that all involved are familiar with the facilities available and practices followed locally. **(11.36)**	Accepted. This is primarily for Health Boards but the Scottish Government supports such an approach and would expect all Health Boards and other organisations to establish local multidisciplinary groups.	The formation of such groups will be overseen by the National Committee proposed at Recommendation 57, but work towards the establishment of such groups can progress immediately. The operation of such groups should be seen as good practice and will be included in the Code of Practice proposed at Recommendation 61.	Not for ACC to action specifically although ACC will support and assist NHS with local practices
53 Health Boards, organisations providing advice, support and guidance to grieving families such as SANDS UK and the Miscarriage Association, Funeral Directors, the ICCM and FBCA, and any other body providing advice, support and guidance to grieving parents and families should review all publications dealing with cremation that are likely to be distributed to, or seen by, the public to ensure that they include accurate information that is expressed clearly and consistently, including in particular information about the prospects of recovering ashes, and that they contain a reminder of the availability of the option of burial. **(11.37)**	Accepted. This is for the relevant organisations to take forward but the Scottish Government supports the recommendation. It is important that consistent and accurate information is provided to bereaved families.	Organisations should begin updating materials as a priority in light of the findings of the Infant Cremation Commission, and the National Committee proposed at Recommendation 57 will oversee this. Regular review of guidance and publications will be included in the Code of Practice proposed at Recommendation 61.	Complete. Application for Cremation Forms updated, information sheets on infant cremations available, and policy statement has been approved, web pages have been reviewed and updated.
54 The Scottish Government should establish a working group comprising a representative from each Health Board and chaired by a Scottish Government official to review all guidance documents and information leaflets in use over all	Accepted.	This work will be taken forward by the National Committee proposed at Recommendation 57, either within the Committee itself or via a subgroup established for this purpose. This will be	Not for ACC to action

Health Boards and private healthcare providers, including those compiled by, or in conjunction with, bodies such as SANDS and the Miscarriage Association, relating to management of pregnancy loss and infant bereavement and arranging disposal, with a view to ensuring consistency in that guidance and information, and endeavouring to reduce the proliferation of different documents in use. **(11.38)**		reflected in the National Committee Action Plan detailed below.	
55 Where invited to do so by affected parents, local councils / authorities should facilitate discussion for plans for local memorials. **(12.7)**	This is for Local Authorities but Scottish Government supports the recommendation and expects all local authorities to support requests for local memorials.	No specific timescale – this is a matter for local authorities. But where there is an appetite for a local memorial this should be prioritised.	**ACC to Action** Commence discussions with affected parents on their wishes for an appropriate local memorial.
56 The Scottish Government should form a working group, to include representatives of affected parents and bereavement support groups to consider whether there should be a national memorial dedicated to the babies whose ashes were mishandled or mismanaged and, if so, the form that it should take. **(12.8)**	Accepted. This group will be established as a subgroup of the National Committee proposed at Recommendation 57. The Scottish Government will support the development and maintenance of any national memorial.	This work will be included within the National Committee Action Plan as detailed below. The Government will establish such a group before the end of 2014.	Not for ACC to action
57 The Scottish Government should establish a National Committee with responsibility for baby and infant cremations. **(13.4)**	Accepted.	The National Committee will be established and will hold its first meeting no later than autumn 2014. The National Committee will be asked to	Not for ACC to action

		produce an Action Plan to set out how it will take forward the various recommendations made by the Infant Cremation Commission. That report will provide timescales for all actions and for reporting to Ministers.	
58 The National Committee should be chaired by a senior Scottish Government official. Its membership should be drawn from authorities, organisations, professions and other bodies with a role in baby and infant cremation, and should include representation from groups or organisations representing affected parents and providing bereavement support. **(13.5)**	Accepted.	The National Committee will be established and will hold its first meeting no later than autumn 2014. The National Committee will be asked to produce an Action Plan to set out how it will take forward the various recommendations made by the Infant Cremation Commission. That report will provide timescales for all actions and for reporting to Ministers. First report expected to be no later than 12 months from the first meeting of the National Committee.	Not for ACC to action
59 The National Committee should have power to establish working groups of its membership, with co-opted members where appropriate, to consider specific recommendations from this report. Each of the working groups recommended above would be sub-groups of the National Committee. It would be open to the National Committee to assign to one working groups the tasks assigned in more than one recommendation, for example recommendations relating to technical matters and cremation technology could be dealt with by a professional sub-group reporting back to the full Committee. The National Committee should also have the power to	Accepted. Responses elsewhere in this table identify where particular recommendations can be taken forward via specific subgroups.	The FBCA will be expected to update all published guidance documents which are in use in Scotland as a priority. The FBCA will be asked to confirm to the National Committee which materials will be updated. The issue of Guidance documents will be addressed in the Code of Practice in recommendation 61.	Not for ACC to action

establish working groups to consider other issues identified by the National Committee and to report back to the National Committee. **(13.6)**			
60 The National Committee should report to Scottish Ministers annually on progress against the recommendations made by this Commission. That annual report should be published on the Scottish Government website. **(13.7)**	Accepted. In producing its Action Plan the National Committee will identify when its first report will be provided to Ministers	The National Committee proposed at Recommendation 57 will have oversight of this recommendation. Both organisations will be expected confirm when training programmes will be updated to the National Committee and this will be included with the National Committee Action Plan detailed below. The issue of training will be included in the Code of Practice at Recommendation 61.	Not for ACC to action
61 The National Committee should, as a priority, develop a national Code of Practice for baby and infant cremation. Such a Code, which should be informed by the recommendations of this Commission, should set down the minimum requirements for organisations to adhere to when supporting bereaved parents and families through the baby and infant cremation process, and seek to identify best practice to be followed by all bodies involved in baby and infant cremation. The Code of Practice should include general principles and guidance as well as specific technical and operational guidance for Cremation Authorities, Health Boards and Funeral Directors, with a view to achieving consistently high standards of practice among all with a role in baby and infant cremation. **(13.8)**	Accepted. An overarching Code of Practice for all organisations involved in infant and baby cremation will be a welcome development. The Code of Practice should be the first priority for the National Committee. The Code of Practice can also take account of issues of training, good practice and Recommendation 29 relating to a code of practice for shared cremations.	The National Committee will identify timescales for the development of a Code of Practice within its Action Plan.	Not for ACC to action ACC to implement agreed Code of Practice

62 The Code of Practice should be a live document that is not only responsive to developments, but also instrumental in promoting improvements, in practice, technology, policy and legislation. The National Committee should therefore continue to monitor developments in all aspects of activity related to baby and infant cremation and review the Code annually to ensure that it reflects contemporary standards and best practice. **(13.9)**	Accepted.	The National Committee will review the Code of Practice on an annual basis.	Not for ACC to action ACC to promote developments and actively share and spread best practice.
63 Scottish Ministers should appoint an independent Inspector to monitor working practices and standards at crematoria, provide feedback to Cremation Authorities on how they are performing and to report to the Scottish Ministers as required. The independent Inspector should have authority to investigate complaints from the public about working practices and standards at crematoria, to adjudicate upon these complaints and report findings to the Scottish Ministers. The role of the Inspector should be extended to the funeral industry in respect of which there is no current provision for inspection. **(13.10 and 13.11)**	Accepted. The Scottish Government welcomes the suggestion of independent Inspector for crematoria and recognises that this function could extend beyond those issues relating only to infant cremation. Some inspection powers already exist within the 1935 Cremation Regulations and consideration will be given to whether or not these are sufficient to enable an Inspector to be appointed during 2014.	If an Inspector of crematoria can be appointed during 2014 under existing powers this will be done. But the Burials and Cremations Bill, will set out provisions to put an inspector of crematoria and the funeral industry on a firm footing. We will publish a consultation on this Bill by the end of 2014. No powers exist for an Inspector of the funeral industry and that will require primary legislation.	Not for ACC to action
64 The Scottish Ministers should keep the cremation and funeral industries under review and should consider whether further regulation of either is required. **(13.13)**	Accepted. The Scottish Government will consider further the benefits of additional regulation of the cremation and funeral industries, and may consult on this ahead of the	This Recommendation will be kept under review by the Scottish Government.	Not for ACC to action To review subject to further regulation

	Burials and Cremation Bill.		

Appendix 5

Inspector of Crematoria Scotland
Robert Swanson QPM

Email: Robert.swanson@scotland.gsi.gov.uk

Inspection of Crematoria

Name and Address of Crematorium: Aberdeen Crematorium Skene Road Aberdeen	
Name of Cremation Authority: Aberdeen City Council	**Date of Inspection:** Thursday 30th June 2016
Undertaken by: Robert Swanson QPM Inspector of Crematoria Scotland	**In the presence of:** Graham Keith Performance and Development Manager Angus Beacom Crematorium Manager

1. Operational Hours / Time Between services
Opening Hours: Monday to Friday – 0830hrs to1630hrs Saturday – 0830hrs to 1600hrs

Time between services: 40 mins (to be increased to 45mins) with option of booking extended period.

2. Staffing levels and structure

Staff certificated to carry out infant cremations:
2 members of staff qualified to carry out infant cremations with a further 4 undergoing training.

Training programme (brief overview)
Staff at Aberdeen Crematorium have ready access to hard copy and computer held guidance and legislative documents, and receive local and in-house training on all relevant duties. The Cremation Authority is a member of the FBCA and staff undertake qualification training at the FBCA Centre of Excellence in South Lanarkshire. Individual membership of the ICCM is available to all staff.

3. Office Management

Administration Procedure:
The majority of the administration and record keeping is carried out by Bereavement Services at the Council Headquarters, and is recorded on the BACAS computer system. Senior staff at the crematorium thereafter access BACAS and print the relevant documentation. There are regular mail runs between the Headquarters and the Crematorium and further communication by fax.
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 and in compliance with the crematorium Operational Procedures. A number of in-built safeguards were noted with much emphasis placed on ensuring the process minimised the risk of human error.

Computer System:
BACAS

4. Total Number of Cremations Carried Out

Breakdown by category	**2014:**	**2015:**
Adult:	2540	2718
Baby / Infant (under 1 year)	10	5
Infant / Child (1-16 years)	2	3
Stillbirth:	11	6
Pregnancy Loss **Individual:** **Shared:**	 156 1427	 135 1566
Body Parts:	3	5
Anatomical Body Parts:	0	0

5. Cremation / Identity Card Process

The process and all related documentation examined and demonstrated by staff, from the point of arrival of the coffin, throughout all stages, including cooling, cremulation, storage, dispersal of the ashes, subsequent updating of computer records, and storage of documentation.
All were found to be of a good standard with noted attention to detail, and with a number of checks carried out to minimise the risk of error resulting in the mislabelling of ashes, or non-compliance of the applicant's instruction.

6. Recovery of Ashes

Instances where ashes were NOT recovered (2015)
Not applicable – all recovered.

7. Ashes Policy (retain / scatter / inter / storage)

Details of process:

The instructions to staff are clear and comprehensively documented in the Operational Procedures, and detail all the options available to the applicant. These are 'collected by the applicant, or by a nominated person or funeral director', 'retain at crematorium', 'scatter with no family in attendance, or scatter with family in attendance'. The applicant instructs as to which Garden of Remembrance (Hazlehead or Kaimhill) the ashes are to be scattered and may stipulate a particular area within. Provision is made allowing for a change by the applicant prior to disposal. Ashes awaiting disposal are stored in a secure room with clear identification and instruction labels affixed. A check of the disposal instructions on a dip sample of documentation was found to accurately reflect the disposal outcome.

8. Cremators
Number of cremators: 4
Make (s): all FT
Size (s): all large

9. Sample of Cremation Register	
Category: NVF (shared) **Cremation number:** 5759 (Box No. 29/16,34/16,35/16 and 36/16 – each containing 12 pregnancy loss) **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 6th May 2016, with the collective ashes scattered by crematorium staff in the Garden of Remembrance at Hazlehead (Section May) on13th May 2016.	**Category:** NVF (shared) **Cremation number:** 5620 (Box No. 50/15 and 54/15 both containing 12 pregnancy loss) **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 22nd June 2015, with the collective ashes scattered by crematorium staff in the Garden of remembrance at Hazlehead on 29th June 2015.
Category: NVF (Individual) **Cremation number:** 5757	**Category:** Adult **Cremation number:** 145546

Result: All documentation and records examined and found to be in order. Baby A was cremated on *u* May 2016, with the ashes collected by the nominated person on *w* May 2016.	**Result:** All documentation and records examined and found to be in order. The cremation was carried out on *x* March 2016, with the ashes collected by the applicant on *x* April 2016.
Category: NVF (Individual) **Cremation number:** 5762 **Result:** All documentation and records examined and found to be in order. Baby B was cremated on *x* May 2016, with the ashes collected by the applicant on *x* June 2016.	**Category:** Stillborn **Cremation number:** 145927 **Result:** All documentation and records examined and found to be in order. Baby C was cremated on *y* May 2016 with the ashes collected by the nominated person on *z* May 2016.

10. Use of Baby Tray
Number / Source: 2 x FT
When introduced: Re-introduced on 25th November 2013, with extended use introduced on 23rd July 2014 to include card coffins for pregnancy loss.

11. Pregnancy Loss Policy / Procedure
NHS / Shared: Aberdeen City Council (Cremation Authority) have a current contract (dated 14th September 2015) with NHS Grampian for regular (as and when required) cremation of pregnancy loss (up to and including 23 weeks and 6 days gestation) There is no stipulation on the number other than there is a maximum of 3 such cremations on any one day. All pregnancy loss delivered to the crematorium, which is by NHS (usually) or funeral director, is cremated on the same day. The collective ashes are scattered in the Garden of Remembrance at Hazlehead within seven days of the cremation.

All relevant documentation and records examined during the course of the Inspection was found to be in order.
Individual: The contract with NHS Grampian also includes individual cremation of pregnancy loss. In all other instances the policy and procedure carried out at the Crematorium does not differ from that of an infant.

12. Metal Extraction
Policy: Large metal parts are extracted before ashes are placed in the cremulator, smaller parts are extracted by magnet or hand before or after cremulation. Metal extracts are sensitively re-cycled in accordance with the Cremation Authority Policy, unless otherwise instructed by the applicant. The Operational Procedures Manual states that 'surplus money from this recycling scheme is donated to bereavement charities of the Council's choice'. It was observed during the course of the Inspection that a ceramic surgical ball joint was amongst the metal awaiting collection by the recycling company. This is commented on further in the overall assessment section of this report.
13. Code of Practice, Cremation Practice Guidance and Policy Statement (on website / displayed)
A check of the Cremation Authority website confirmed that the Policy Statement on Infant Cremations is publically available. The inspection confirmed that from observations and an examination of a number of documentation and computer records for the current and recent period that the Crematorium's procedures are fully in accordance with it. Staff have ready access to all relevant hard copy documentation and are required to sign acknowledgement when seen. A number of the key documents are prominently displayed within the crematorium.

14. General Observations

Buildings: All public and private areas visited during the course of the inspection were found to be well maintained, clean and tidy. It is believed there are plans to improve facilities with renovation to both chapels and the car park in the future.
Car park: Car parking is considerate adequate and there is overspill provision. When a large attendance is expected an extended service can be facilitated.
Grounds / Garden of Remembrance: Large and well maintained grounds, which at Hazlehead provide Gardens of Remembrance divided into twelve areas, one for each calendar month.
Access for the disabled: All public areas seen during the inspection had unrestricted access for the disabled, with both chapels being on ground level. Wheelchairs are provided if required.
Security: There are security and fire alarms throughout. Management stated there have been no issues regarding vandalism or theft.
Health and Safety: Risk assessments are carried out on all relevant duties. Protective equipment was seen (during the course of the inspection) to be used by the technicians. Crematorium staff receive additional training in respect of attendance by prison inmates.

15. Issues highlighted by staff
Matters discussed during the course of the inspection are incorporated in the overall assessment section, which follows.

16. Overall Assessment
This report has been compiled following a one day inspection carried out by the Inspector of Crematoria Scotland on Thursday 30th June 2016, at the request of the Chief Executive of Aberdeen City Council, following publication of the Report by the National Cremation Investigation, on 17th June 2016.

Whilst this report is in the same format used during inspections of all 29 Crematoria in Scotland, in this instance focus was given to examining current procedures and working practices in place at Aberdeen Crematorium to assess what changes have been implemented to ensure that there will be no repeat of the unethical and abhorrent practices described in the report by the Rt. Hon Dame Elish Angiolini.

The inspection found the operational procedures to be of a good standard with no evidence of current working practices which are comparable to those described in the Report of the National Cremation Investigation.

However, of most concern to the Inspector was being advised that a number of the five employees currently working at the Crematorium, who were in post during the period subject to the investigation, regard themselves as being 'the victims'.

Staff were clearly very apprehensive about what the future holds for them and intimated that a representative of their 'Union' was in attendance that day.

It is the opinion of the Inspector that if public confidence in the Cremation Authority and the Crematorium is to be restored, then the 'air needs to be cleared' with staff at the earliest opportunity.

It is beyond the remit of the Inspector to comment further on staffing issues.

A number of positive and good practice was observed, along with several other points worthy of consideration by the Cremation Authority. These, in no particular order, are listed below:

The Crematorium Operational Procedure document, which was first published in May 2015, has in the space of one year been updated on five occasions, with revised instruction added as a result of internal and external audits, and the National Committee on Infant Cremation Code of Practice 2015. The live document is a credit to the authors and is one of the most comprehensive and useful guidance and training aids seen by the Inspector at any of the other 28 crematoria in Scotland.

Good practice was observed during a demonstration of the cremulation of infant ashes. Staff have put in place a variation to the 'pestle and mortar' process by using 3 metal balls removed from a previous cremulator, producing a more effective and sensitive method of grinding. The Operational Procedure document has yet to be amended to reflect this practice.

Good Practice was observed in the procedure of recording proof of identity when ashes are being collected, and recording the means of

identification on the back of the ‘yellow card’.

Good Practice was seen in the handling of coffins at all stages, with two attendants always present.

Good Practice was noted in procedures for the removal and disposal of what is termed ‘fly ash’ from the cremators, before and after certain cremations.

Good Practice was observed as regards the storage and dispersal of ashes.

Good Practice was observed in the procedure of leaving the envelope containing the Certificate of Cremation unsealed allowing it to be examined alongside other documentation as a final check against the details on the ashes.

Other observations / considerations:

It was noted that in both the NHS contract on pregnancy loss, and in the Operational Procedure document, it refers to the ‘applicants wishes’, it should be made clear that it is an instruction not a wish.

As regards Option 2 (Page 21) on the use of an Infant Tray, the yellow card which follows the coffin throughout the cremation process should be inserted into the holder on the ‘cold cremator’ whenever the Tray is introduced. This will ensure that the cremator will be seen to be in use, and will not be inadvertently switched on whilst the infant ashes are cooling.

A surgical ceramic ball joint was seen amongst the metal extracts awaiting collection by the recycling company. This appears to be a noted recent change by a number of hospitals as it has also been seen in other crematoria. If these joints do not contain metal they would by definition be regarded as ashes, however as they appear to withstand cremulation intact, they cannot be scattered along with the ashes, and cannot be recycled as metal extracts. Until such time as guidance is given at national level, consideration should be given to seeking an instruction from the applicant prior to any decision on the disposal of any ceramic ball joints.

It was observed from the documentation flow and from discussion with staff, that during the cremation of shared pregnancy loss, the attendants carrying out the cremation are unaware of the number contained within each coffin. By way of example it was seen during a dip sample of documentation that during one cremation of pregnancy loss, each of the four coffins contained 12 pregnancy loss, whereas the attendant was only aware of the number of coffins (4) and not the pregnancy loss (48). Consideration should be given to providing those who are carrying out the cremation the total number of pregnancy loss rather than just the number of coffins.

It was seen that the yellow cards and computer entries recorded the receptacles containing the pregnancy loss as 'Boxes'. The Inspector considers that a more appropriate term should be used.

It was noted that current procedures does not facilitate attendance at any service for shared cremation by family members. There are a number of Crematoria who offer, via the NHS, this facility, and who have informed the Inspector that a number of families have attended. Consideration should be given to discussing this with NHS.

Whilst it is seen that Aberdeen City Council website provides a good deal of information on cremation, the Inspector considers that the Q and A section could contain more positive answers regarding the recovery of ashes in cases of stillbirth, Baby and NVFs.

It was noted that there was a delay in certain final information being input onto computer, which is probably due to there being distance between the office and crematorium. Whilst not seen as an issue, consideration should be given, in the interest of efficiency to co-locating the office within the crematorium.

In conclusion, in respect of current working practice within Aberdeen Crematorium, the inspection found no evidence of a continuation of the unethical and abhorrent practices as described in the Report of the National Cremation Investigation by Dame Elish Angiolini, dated 17th June 2016.

Signed: Robert Swanson QPM,
Inspector of Crematoria Scotland

Date: Thursday 7th July 2016

Appendix 6

Commentary of Inspector of Crematoria inspection report
Recommendations are given in bold and answers to these, with other comments, are given in the ACC progress column.

Area	Commentary	Inspector Observations/ Recommendations	ACC Progress

1. *Operational Hours/ Time between services*	• Opening hours outlined	• No recommendations	
2. *Staffing levels & structure*	• Currently two members of staff who are trained to carry out infant cremations, four staff members currently undergoing training • Training programme: o Staff have access to soft and hard copy guidance and legislative documents o Receive local and in house training on all relevant duties o Crematorium is member of the FBCA and individual membership of ICCM is available to all staff	• No recommendations	• Three staff are qualified for infant cremations and a further three who are undergoing training of which two are awaiting a date for examination. It is planned to train a further two staff to carry out infant cremations by the end of this year.
3. *Office management*	• Majority of administration and record keeping done at Marischal College, recorded on the BACAS system. Regular runs between MC and the crematorium. • Whole administration procedure and process was examined	• Administration procedures and processes were found to be of a good standard and in compliance with the crematorium Operational Procedures. • Noted the in-built safeguards to ensure that the process minimised the risk of human error • **The Inspector suggests that a more appropriate term is used to record the receptacles that contain pregnancy loss. Term 'boxes' is currently in use** • **Inspected noted the delay in some final information being inputted and suggests consideration the co-location of office and crematorium**	• To date communication with other Scottish Crematoria shows that some refer to the receptacle as a box while others simply refer to a number and do not refer to the receptacle as any form of container. A consistent approach is to be adopted by Aberdeen City Council Bereavement Services. Further

		to speed up process. However it is also noted that this isn't an issue.	advice is being sought prior to formulising an appropriate term. • Consideration is being given to the practicality of co-locating Bereavement Services within the crematorium at Hazlehead. A business case will be developed for consideration by CMT.
4. Total number of cremations carried out	• No comment	• No recommendations	
5. Cremation/Identity Card Process	• Inspector witnessed the process and all related documentation examined and demonstrated by staff from when coffin arrived and all subsequent stages. Including the updating of computer records and document storage	• All found to be of a good standard and it is noted in the Inspectors report the attention to detail given by staff. Notes the checks that they carry out to minimise risk of error in the mislabelling of ashes or non-compliance with instructions given. • Good practice observed by Inspector in the procedure of the recording proof of identity when ashes are being collected and recording the means of identification on the back of the 'yellow card' • Good practice noted in the procedure of leaving the envelope that contains the Certificate of Cremation unsealed	

		to allow a final check of the documentation against the details of the ashes	
6. Recovery of ashes	• Not applicable as all ashes recovered	• Good practice observed when witnessing a demonstration of cremulation of infant ashes. A variation of the 'pestle and mortar' process was adapted to produce a more effective and sensitive method of grinding. But the Operational Procedure document had not been amended to reflect this. • Good practice observed regarding the storage and dispersal of ashes	• The infant cremulation practice has proven to be an effective means of reducing the recovered remains to a fine granular consistency. This practice is currently being included in the Operation Procedures.
7. Ashes policy	• Instructions to staff are clear and comprehensively covered in Operational Procedures and detail all the options available to applicant. Application can choose which Garden of Remembrance to choose and what area with provisions made for a change of mind prior to the disposal	• A dip sample of documentation was found to accurately reflect the disposal outcome • Good practice in relation to the procedures of the removal and disposal of 'fly ash' from the cremators, before and after certain cremations	
8. Cremators	• No commentary – just statistics	• No recommendations	
9. Sample of cremation register	• Range of records sampled, including adult, stillborn, shared and individual NVF cremations	• All sample records examined were found to be in order. Ashes disposed or collected as instructed by applicants.	
10. Use of baby tray	• Introduced November 2013 with extended use introduced in July 2014 to include card coffins for NVFs.	• **Suggestion that Option 2* on the use of the Infant Tray, the yellow card which accompanies the coffin throughout the process should be inserted into the holder on the cold**	• Option 2 has never been required however, Operational Procedures are currently being

		cremator whenever the tray is introduced therefore ensuring that the cremator is seen to be in use and will not be turned on whilst the ashes are cooling.	updated to clarify this part of the process
11. Pregnancy loss policy / procedure	• ACC has a contract with NHS Grampian for regular shared cremation of NVFs – includes no stipulation of the number, only that there are no more than three a day. Collective ashes usually scattered within seven days of cremation • Individual cremations also covered under contract with NHS, policies and procedures are the same as those of infant cremations.	• All relevant documentation that was examined was found to be in order by the Inspector. • **Noted that both the NHS contract and the Operational Procedure document refer to the 'applicants wishes' , this should be changed to 'applicants instructions' and made clear that this is an instruction not a wish** • **Observed that attendants who carry out the cremation of shared NVFs are unaware of the number of NVFs that are contained within each coffin (i.e. four coffins, not that each coffin contains 12 NVFs, therefore there are a total of 48 NVFs contained). Suggests that consideration is given to providing staff with the total number of NVFs**	• Operational Procedures are currently being updated to refer to 'applicants instructions' instead of 'applicants wishes' • The paperwork submitted to Bereavement Services, in respect of the cremation, details the contents of the coffin. Consideration is being given to how the numbers of NVFs in each coffin received from NHS is included in the relevant documentation to inform cremation staff. It is uncertain what benefit could be gained by informing the cremating technician of the contents of the coffin.

12. Metal extraction	• Metal extracts are sensitively re-cycled in accordance with the Cremation Authority policy unless it is otherwise requested by applicant. • Operational Procedures Manual states that any surplus money from recycling scheme is donated to a bereavement charity of ACC's choice. • Observed that a ceramic surgical ball joint was amongst metal awaiting collection for recycling	• **A ceramic ball joint was amongst the metal extracts awaiting cremation; this has been seen in a number of crematoria. Until guidance is given at national level, consideration should be given getting instruction from applicants regarding this issue prior to disposal**	• Ceramic joints are now separated and are being accumulated with the intention of being cremulated in the old cremulator which is capable of cremulating more resilient materials. To date there have only been two ceramic ball joints. The relevant documentation is currently being reviewed to determine the most appropriate method of getting instruction from the applicants in regard to the disposal of ceramic ball joints.
13. Code of practice, Cremation practice guidance and policy statement (on website / displayed)	• Policy statement on Infant Cremations is publically available • Staff have access to all relevant hard copy documentation and required to sign acknowledgement when seen • Number of key documents are obviously displayed within the crematorium	• Confirmed from observation and examination that a number of documentation and computer records (from the current/recent period) are in accordance with Crematorium's procedures • Crematorium Operation Procedure document is a 'credit to the authors and is one of the most comprehensive and useful guidance and training aids seen by the Inspector at any of the	• The Q&A's regarding stillbirth, baby and NVF cremation are currently being reviewed.

		other 28 crematoria in Scotland' • **Although the website provides lots of information about cremation, the Inspector suggests that there is more positive answers included in the Q&A regarding stillbirth, baby and NVF cremation**	
14. General Observations	• Buildings: Public and private areas were found to be well maintained. • Car park: considered adequate. • Grounds/Garden of Remembrance: large and well maintained. • Access for the disabled: unrestricted access to public areas. Wheelchairs available if required • Security: security and fire alarms throughout building. No issues with theft or vandalism • Health and Safety: Risk assessments are carried out for all relevant duties – including additional training when prison inmates attending. PPE is used by technicians.	• Good practice in handling coffins at all stages with two attendants always present	
15. Issues highlighted by staff	• Incorporated into overall assessment • Inspector was concerned that five employees who were in post during the period investigated in the NCI report regarded themselves as 'the victims'	• Inspectors opinion that the 'air needs to be cleared' in order for public confidence to be restored in the Crematorium and ACC	
16. Overall assessment	• Report has come after a one day inspection in June 2016 at request of Chief Executive. The focus was	• Report found that the operational procedures were of a good standard with no evidence of current working	• Currently there are two memorial services per year which are

	examining the current procedures and working practices in place at the crematoria to assess what changes have been implemented. • Number of positive and good practice was observed by the inspector – these have mostly been noted in the respective categories outlined above in the observation columns where applicable. • The inspector found no evidence of the working practices outlined in the NCI report	practices which are comparable to those described in the NCI report • **Inspector has noted that a service is not facilitated to allow family to attend a shared cremation. Other crematoria do this across Scotland, and he suggests it is considered**	facilitated by NHS Grampian. Parents are advised that an individual service can be held for their loss. Information is being sought from other Crematoria to ascertain "best practice" in this matter. Following which there will be discussions with NHS Grampian and other stakeholders with a view to increasing the number of memorial services held at the Crematoria.

* Option 1 – Infant Tray is removed from the cremator and placed on the trolley. A bespoke cover is placed over the tray to protect the recovered remains until the tray has cooled sufficiently to be handled. Option 2 - Infant Tray is removed from the cremator and placed in a cold cremator to protect the recovered remains until the tray has cooled sufficiently to be handled. Option 2 is used if the Crematoria is not working to capacity.

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