Inspector of Cremation Annual Report:

1 April 2019 - 31 March 2020

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Introduction

1. This report has been compiled by Robert Swanson, Inspector of Cremation for the purpose of providing Scottish Ministers with a resume of duties undertaken in the role during the period 1 April 2019 to 31 March 2020.

2. The Inspector was first appointed to the post (Inspector of Crematoria) in March 2015, as one of the 64 recommendations made in the Report of the Infant Commission, headed by Lord Bonomy which was published in June 2014.

3. The appointment was made under the Cremation (Scotland) Regulations 1935.

4. On 28th April 2016, the Burial and Cremation (Scotland) Act 2016, which repealed and replaced previous Cremation legislation, received Royal Assent, and granted Scottish Ministers powers to make Regulations.

5. On 4th April 2019, the Cremation (Scotland) Regulations 2019 came into force, introducing a number of significant changes affecting stakeholders (as detailed in last year's Annual Report).

6. On that date the Inspector was re-appointed under the new legislation, as Inspector of Cremation, with a broader remit extending to the whole cremation process.

7. The legislation has now been in force for over one year, and has been widely welcomed and accepted by all within the funeral industry.

8. During the course of the past year the Inspector has carried out an inspection of all 31 crematoria, with a brief resume of the findings as follows.

9. Physical visits to crematoria were suspended in March 2020 due to the COVID-19 pandemic. For the remainder of the period of this report, the Inspector continued to liaise remotely with staff and other stakeholders.

Findings from Visits and Inspections

10. There are currently 31 crematoria in Scotland, with planning applications pending for a number of new builds.

11. Of those, 14 are owned and operated by local authorities, with the remaining 17 under private ownership.

12. Since commencing in the role, the Inspector has carried out an inspection of all crematoria on an annual basis, with additional visits and contact throughout the year.

13. As well as dealing with general enquiries, a number of these visits related to complaints or other matters, as described elsewhere in this report.

14. The following incorporates the findings from the latest completed annual inspections which were carried out during 2019 and up to 10th March 2020.

15. There continues to be 100% recovery of ashes from all cremations carried out, that figure having been achieved for the past 5 years.

16. During 2019 a number of crematoria have undergone major upgrades to buildings with additional facilitates for staff and attendees, including the installation of audio/video equipment and provision for the streaming of services.

17. Staffing levels of those certificated to carry out cremations is currently being increased at a number of crematoria with ongoing training to assist in emergency situations such as the current pandemic.

18. Overall the number of staff certificated[1] (over 120) is regarded as being more than adequate.

19. The number of cremators in use remains around the same as last year (62), albeit there have been a number replaced.

20. There has been a noted increase over recent years in the number of cremation authorities that recycle metal extracts (with the consent of the applicant).

21. That figure has increased from 21 in 2018/19 to 25 this year.

22. Of the 6 who are not part of a recycle programme several have indicated their intention to consider joining.

23. The main benefits of the scheme, as described by operatives, are that all monies generated, which run into thousands of pounds at each crematoria, are donated to local charities, and recycling is considered to be more environmentally friendly by not having the metal extracts interred in the gardens.

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[1] By The Federation of Burial and Cremation Authorities (FBCA) or The Institute of Cemetery and Crematorium Management (ICCM)

24. Where applicable almost 100% of applicants give their authority to the cremation authority to recycle the metal extracts.

25. The number of crematoria that carry out shared cremation of pregnancy loss remains the same as last year, which is 12.

26. All crematoria carry out individual cremation of pregnancy loss.

27. Overall performance of the 31 crematoria was considered to be of a good standard, with crematoria adequately staffed and equipped to deal with any seasonal increase, or, as was found to be the case dealing with a pandemic.

Complaints / Enquiries

28. The following is a summarised resume of some of the varied enquiries or complaints reported to the Inspector during the period covered in this report, details of which have been anonymised.

29. Unless otherwise stated all are considered closed with enquiries completed.

30. As anticipated, introduction of the new application forms caused a number of initial enquiries from funeral directors, crematoria staff and members of the public.

31. The Inspector worked closely with the Scottish Government Burial and Cremation Team, who provided regular updates to all members of the funeral industry covering all of the issues raised.

32. Examples of other matters reported directly to the Inspector (prior to the pandemic) include the following:

Family Disputes

33. As was the case last year, a number of issues concerning family disputes were reported to the Inspector.

34. These included one instance where, after collection of the deceased's ashes, two parties sought possession.

35. There were several other enquiries concerning legal entitlement to ashes including a family dispute as to who was legally entitled to be executor, as one family member planned for a cremation and the other a burial.

36. The majority of disputes related to arrangements for cremation of the deceased who had died whilst co-habiting, but still married to another person and had children by the married partner.

37. Section 65 of the Burial and Cremation (Scotland) Act 2016 lists the hierarchy of who is entitled to make arrangements on the death of an adult, however, that is not always accepted without question.

38. Almost all of these cases have been resolved by the Inspector without the need for further action.

Formal Complaint – Dispersal of ashes

39. Crematorium staff failed to note that on the application form the applicant wished to be present when the ashes of their relative were scattered. Although not stating it on the form, the applicant had intended to scatter the ashes at the same location where another family member's ashes had been dispersed.

40. The crematorium duly scattered the ashes, however, being unaware of the intention to disperse them at a specific location, it resulted in them being scattered in a separate Garden of Remembrance to that of the applicant's relative.

41. The cremation authority has accepted full responsibility for the error and has amended working practice to reduce the risk of a recurrence.

Staff Self-Referral

42. This concerned an allegation made by a former employee against another staff member. As the allegation concerned the handling of ashes following a cremation, the staff member self-reported to the Inspector, who completed the enquiry. Minor irregularities in procedures were noted, which have been addressed by the cremation authority. No further action was deemed necessary.

Incident – Leaking Coffin

43. Following a service, the coffin was placed in the cold storage before being removed for cremation. It was then noted that the coffin had been leaking fluid which necessitated staff to use the spillage kit to clean the cold store and charging trolley.

44. After enquiry with the funeral director it was learned that standard procedures, which would have prevented such an occurrence, had not been followed.

45. The funeral director agreed to highlight the issue within their branches and gave an assurance that they would endeavour to ensure that there was no recurrence of such an issue.

Incident – Unacceptable quality standard of coffin

46. This concerned a cardboard coffin for direct cremation (unattended service) having been delivered to a crematorium, where it was seen to be of such poor and damaged condition that crematorium staff were unable to proceed with the cremation. The funeral director was contacted immediately and returned with a coffin of acceptable standard, allowing the cremation to proceed.

47. The Inspector spoke with the funeral director of the branch concerned who confirmed that they contacted their head office who intimated that they would no longer use the supplier of these coffins.

Incident – Battery found in ashes

48. Following a cremation, staff recovered a large battery and what appeared to be the remnants of a small motor attached, from within the ashes.

49. Enquiry with the funeral director concerned revealed that the presence of the items had gone unnoticed when the coffin was closed, and that after enquiry with the family they were able to confirm where the battery originated.

50. As the presence of a battery within a coffin can lead to an explosion during cremation, such items are forbidden.

51. The funeral director intimated they were unaware of the existence of the item, and accordingly would notify all their branches of the incident, and instruct all their funeral directors to ensure detailed checks of the contents of the coffin are carried out on all occasions prior to final closure.

Whistleblower Allegation

52. Confidential information was received by the Inspector relative to matters relating to funeral plans. The information was forwarded to, and dealt with by the relevant authorities.

Stillbirth Deaths Abroad

53. During the course of the year the Inspector was informed by the Death Certification Review Service (DCRS) of stillbirths abroad, repatriated to Scotland. As the DCRS have no remit for stillbirths abroad, the Inspector completed the enquiries allowing for the funerals to proceed.

54. The Scottish Government Burial and Cremation Team are addressing procedural issues for dealing with such (future) bereavements.

Pregnancy Loss – family presenting at crematoria

55. Over the course of the last year there have been a number of occasions where family members have presented themselves at crematoria offices, in possession of pregnancy loss seeking guidance on disposal procedures.

56. Assistance and advice was provided in all cases.

57. After obtaining more detail the Inspector liaised with the Scottish Government Burial and Cremation Team who agreed to address the matter further with appropriate stakeholders.

Micro Pacemakers

58. It was learned that on two occasions mortuary staff and funeral directors were unable to locate pacemakers, said by family members to be present in the deceased. It was subsequently found to be of a type that unlike most pacemakers that are placed in the chest with leads running to the heart, micro pacemakers are implanted directly into the patient's heart, via a vein in the leg.

59. As pacemakers are deemed a hazard and must be removed before cremation, guidance has been sought on whether or not micro pacemakers which are a fraction of the size of standard ones, are also deemed a hazard.

60. The information provided by the manufacturers of these devices is that they can be left in place and are safe to cremate. The Inspector is unable to provide definitive advice on whether or not a given implant is safe to cremate, or verify statements made by manufacturers.

Exhumation Enquiries

61. Over the course of the year the Inspector received a number of varied enquiries relating to exhumation. These included ashes to be exhumed following expiry of a lease, ashes to be placed within the buried coffin of a relative, body parts and retained tissue to be re-united with deceased who had been buried, ashes unrecoverable on exhumation due to a degradable casket. Legislation concerning exhumation is under review at this time.

Change of Instruction – breakdown in communication

62. This concerned a breakdown in communication whereby the funeral director omitted to inform crematorium staff of a change of instruction given by the applicant in respect of whether ashes were to be collected or scattered.

63. The funeral director concerned admitted responsibility for the error and gave an assurance that steps would be taken to minimise the risk of a recurrence.

Funeral director ceased trading

64. Assistance was provided to the cremation authority and Police Scotland following discovery of uncollected ashes from the vacant premises of the funeral director. Enquiries are still ongoing.

65. Overall, the number of complaints made directly to the Inspector concerning crematoria, particularly in connection with handling of ashes has decreased significantly since his appointment in 2015.

Covid-19 Response

66. On commencement of lockdown, the Scottish Government restricted attendance at a funeral to close family members only. Only in circumstances where no family members were in attendance, could friends attend, and that remained in place for the remainder of this reporting period.

67. Cremation authorities set their own upper limit on attendance (by close or immediate family) depending on a number of local factors.

68. That figure varied quite considerably between crematoria, with an overall average (of the 31 crematoria in Scotland) being around 15.

Conclusion

69. There is no doubt that the past year has been a most challenging one for cremation authorities and all their staff.

70. Throughout the period of this report staff worked closely with funeral directors in respect of the major changes brought about by introduction of the new legislation, and whilst there were initial teething matters, these were soon ironed out and everything has gone relatively smoothly, with no outstanding major issues or differences of opinion.

71. As noted earlier, the number of complaints made directly to the Inspector concerning actions by crematorium staff or cremation authorities has reduced significantly over the past five years, with the majority of the examples provided being more of a general nature across the funeral industry.

72. It should be noted that a number of these issues highlighted would have been referred to the Inspector of Funeral Directors, however that post is currently vacant.

73. The pandemic necessitated changes to working practice that had never before been encountered by current operatives, and indeed by almost all others within the funeral industry.

74. Announcement of a lockdown in the UK did not however come as a complete surprise, as operatives were fully aware of what was happening elsewhere in the world.

75. As the UK appeared to be behind a number of other European countries in respect of Covid-19 cases, cremation authorities had time to prepare and familiarise themselves with contingency plans.

76. In conclusion, the Inspector considers that crematoria staff and all others within the funeral industry should be applauded for their commitment, dedication and professionalism during this unique period.

77. In closing the Inspector would like to record his appreciation for the assistance and co-operation afforded to him by the cremation authorities, crematoria staff, funeral directors and other stakeholders during the period of this report.

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