Complaint concerning the identification of ashes following the cremations of [REDACTED] and [REDACTED] on [REDACTED] August 2018 at Kirkcaldy Crematorium.

Introduction

This report has been compiled by HM Inspector of Crematoria Scotland for the purpose of providing the Minister for Public Health with details of the complaint and the outcome of the resultant enquiry undertaken by the Inspector.

It further provides for consideration of dissemination to other parties deemed to have a legitimate reason for seeking access to the information contained within.

The report concludes with a number of recommendations for consideration by the Cremation Authority, and for considered action by the Inspector of Funeral Directors in respect of the respective funeral directors involved.

Nature of the Complaint

This report concerns complaints made by [REDACTED], son-in-law of the now deceased [REDACTED], and [REDACTED], daughter of the deceased [REDACTED], relative to what they considered to be either receipt of the wrong ashes, or the mislabelling of the respective caskets containing the ashes of the said [REDACTED] and [REDACTED], following their cremations on [REDACTED] August 2018 at Kirkcaldy Crematorium.

Summary of Events

On [REDACTED] August 2018, there were a total of [REDACTED] funerals carried out at Kirkcaldy Crematorium.

The [REDACTED] of that day, was the funeral of [REDACTED] at [REDACTED], and [REDACTED] at [REDACTED].

These services were carried out at the scheduled times, and in accordance with the instructions of the applicants, the ashes for each were prepared for collection by the respective funeral directors.

On [REDACTED] August 2018, the funeral director representing the family of [REDACTED], called at Kirkcaldy Crematorium and collected the cardboard casket marked as containing the ashes of the late [REDACTED].
The family were informed of this by the funeral director, and arrangements made for them to be collected by the family from the local Branch in [REDACTED] on [REDACTED] August 2018.

On [REDACTED] August 2018 the funeral director representing the family of [REDACTED] called at Kirkcaldy Crematorium and collected the cardboard casket marked as containing the ashes of the late [REDACTED].

On [REDACTED] August 2018, the family collected the casket from the funeral directors in [REDACTED].

Both families retained the respective caskets unopened for a period of time, being unable to take the final step of carrying out their loved ones final wishes with dispersal.

On [REDACTED] 2018, a family member of [REDACTED], opened the green cardboard casket bearing the identity label ‘Cremated Remains of the Late [REDACTED]’ only to discover it contained a polythene bag with ashes labelled ‘Cremated Remains of the Late [REDACTED]’.

This, in the words of the family ‘devastated our entire family and raised the obvious questions of where were the correct remains of [REDACTED] and what had gone wrong that allowed this to occur. It was heart wrenching to know that we have retained someone else’s loved one for so long without their knowledge yet at the same time believing we had possession of our own loved one. That particular evening events promoted lack of sleep and phases of anxiety not knowing what had happened to [REDACTED] remains, were they scattered?, were they buried?, would we ever get them back?.

Fortunately, [REDACTED] son-in-law, [REDACTED], an [REDACTED], made contact with the funeral director who dealt with the funeral of [REDACTED], and eventually spoke directly with [REDACTED], daughter of the late [REDACTED],

He established that like the [REDACTED] family, the [REDACTED] family had not previously opened the green casket, and on doing so at that time, discovered the casket to contain a polythene bag with ashes labelled ; The Remains of the Late [REDACTED]’.

Understandably [REDACTED] was upset and angry at the discovery.

On [REDACTED] September 2018, [REDACTED] travelled to the home of the [REDACTED] family, where it was agreed that they would exchange the ashes and for the respective families to retain them pending an investigation, in order to confirm or otherwise whether they now held the correct ashes.

On behalf of the [REDACTED] family [REDACTED] thereafter lodged a formal complaint with the Chief Executive of Fife Council (Cremation Authority for Kirkcaldy Crematorium), the Inspector of Crematoria and Inspector of Funeral Directors.

It is understood that [REDACTED] also communicated with Fife Council.

Summary of Investigation

On [REDACTED] October 2018 HM Inspector of Crematoria Scotland was made aware of the complaint, and made arrangements to meet [REDACTED] at his home on [REDACTED] October 2018.

The Inspector also made contact with management at Kirkcaldy Crematorium and arranged to attend at the Crematorium on [REDACTED] October 2018.

At [REDACTED] that date ([REDACTED] October) the Inspector called at Kirkcaldy Crematorium where he met with [REDACTED], Lead Officer and Acting Manager, and [REDACTED], Senior Manager, Fife Council.

Copies were obtained of documentation relative to both cremations.

It was learned that [REDACTED] was currently on sick leave (since [REDACTED] 2018) and that the technician, [REDACTED], who carried out both the cremations referred to in the complaint, was currently on holiday, due to return on [REDACTED] 2018.

In their absence the Inspector spoke to the two technicians on duty ([REDACTED] 2018) and was given a demonstration of what is normal working practice in respect of the handling of ashes.

Arrangement was made for the Inspector to return to the Crematorium at a later date when the technician [REDACTED] had returned to work.

The Inspector thereafter made contact with [REDACTED] and both of the funeral directors involved, with arrangements made for meetings with all.

On [REDACTED] October 2018, the Inspector called at Kirkcaldy Crematorium, by prior arrangement, and in the presence of [REDACTED] interviewed [REDACTED] within the Crematory.

[REDACTED] was made aware of the nature of the enquiry, however as [REDACTED] had returned from leave the day before, [REDACTED] was already aware of the ongoing enquiries both by the Inspector and Fife Council.

[REDACTED] apologised profusely for causing distress to both families and confirmed from documentation that [REDACTED] was the technician who had carried out both cremations and was responsible for the handling of the ashes within the Crematorium. As to be expected, [REDACTED] had no specific recollection of these two cremations.

[REDACTED] thereafter talked the Inspector through normal procedures and demonstrated the cremation process from start to finish, as referred to below.

Cremation Process

As stated earlier, on [REDACTED] August 2018, there were a total of [REDACTED] funerals carried out at Kirkcaldy Crematorium, with the cremations of [REDACTED] and [REDACTED] being the [REDACTED] of the day.

The cremation of [REDACTED] was carried out immediately following the scheduled service at [REDACTED], with records showing the coffin to have been placed in cremator number [REDACTED].

The cremation time is recorded as 85 minutes, after which the remains were moved to the cooling section, where they remained overnight.

This is normal practice at most Crematoria [REDACTED]

The cremation of [REDACTED] was carried out immediately following the scheduled service at [REDACTED], with records showing the coffin to have been placed in cremator number [REDACTED].

The cremation time is recorded as 84 minutes, after which the remains were moved to the cooling section, where they remained overnight.

There are a total of three cremators at Kirkcaldy Crematorium, however only two are regularly in use at the same time.

The Crematorium carries out on average around 2000 adult cremations per year and 600 infant and pregnancy loss cremations.

For there to have been [REDACTED] cremations on [REDACTED] August 2018, would be considered to be fewer than the daily average.

As is normal procedure in advance of the funerals, usually the day before, admin staff prepare the documentation required for use by the technicians who carry out the cremation.

That documentation is conveyed by hand from the Admin Office (situated at the entrance to the grounds) to the Crematorium, and includes two identical sheets of A4 size card with self-adhesive cremation cards (identity labels) each containing details of the cremations scheduled for that day. The technician cuts the individual labels from one of the A4 cards, leaving it still affixed to the card, and leaves the other A4 card untouched at that stage.

The purpose of there being two labels for each is that one accompanies the coffin throughout the different stages and is displayed on the holder outside the cremator, cooling box and cremulator in that order, whilst the other is subsequently affixed to the outside of the casket which contain the ashes.

After the remains have been cremulated an empty polythene bag is placed inside the cardboard casket (as was the case in both the cremations subject of this report) and

the ashes are placed within the bag, it is then sealed with the identity label which accompanied the coffin and remains throughout the process.

The identity label from the second A4 card is peeled from the card and placed on the outside of the casket.

The technician cannot recall whether [REDACTED] placed that label on the outside of the respective casket before or after the ashes were placed within.

Irrespective, [REDACTED] is adamant that the inner bag containing the ashes and sealed with the identity label which accompanied the coffin and remains throughout the process, are the correct ashes for both, and that [REDACTED] must have applied the wrong identity labels to the outside of the caskets.

The information on these labels includes the name and age of the deceased, details of the funeral director, and the dispersal instructions ie to be collected.

As a safeguard to highlight to the technicians the disposal instruction the procedure at Kirkcaldy Crematorium is to mark the different instructions by colour code ie Green is Take Away (to be collected), Red is Scatter with no family present, and Orange is scatter with family present.

This ashes are thereafter stored in the designated location according to the colour code.

Further documentation includes the daily sheet showing details of the cremations, with the times of service, and a Certificate of Cremation for each of the cremations.

The Certificates, which include the name, age, address, date of death and cremation number are contained in clearly marked individual envelopes.

The certificates are placed with (but not inside) the respective caskets awaiting collection.

The technician is not certain but believes [REDACTED] would have prepared the two empty caskets the night before, ie before going off duty on the day of the cremations.

[REDACTED] accepts that [REDACTED] should not have prepared the two caskets together at the same location, and put the reason down to [REDACTED] liking to be prepared for [REDACTED] duties the following morning.

The area where [REDACTED] carried out that process is in close proximity to the two cremulators.

It is believed that the ashes from both cremations subject of this report were cremulated about the same time, one in each of the cremulators.

The process of cremulation only takes a few minutes to complete.

Collection of ashes by Funeral Directors

On [REDACTED] August 2018, the casket bearing the identity label [REDACTED] and Certificate of Cremation, were collected from the Crematorium by [REDACTED], of [REDACTED].

Both the technician and funeral director confirm that neither checked the identity label on the bag containing the ashes but just checked the name on the Certificate against the name on the outside of the casket, then signed the collection slip and record book.

[REDACTED] recalled that, as is normal practice, he did open the casket and place the envelope containing the Certificate inside, but didn't see the label inside. His reason for doing that is to keep the certificate and casket together during transportation and storage.

These ashes were thereafter transferred to their branch in [REDACTED], where they were collected on [REDACTED] August 2018 by [REDACTED], husband of the late [REDACTED].

The Funeral Director ([REDACTED]) who handed over the casket and certificate confirmed that he did not open the casket to examine the identity label on the ashes within, but accepted the identification as being correct, based on the details on the Certificate and identity label on the outside of the casket being the same.

On [REDACTED] August 2018 the casket bearing the identity label [REDACTED] and Certificate of Cremation were collected from the Crematorium, by [REDACTED].

Both the technician and funeral director confirm that neither checked the identity label on the bag containing the ashes but just checked the name on the Certificate against the name on the outside of the casket, then signed the collection slip and record book.

The funeral director could not recall, but claims she always opens the casket and places the certificate inside. She accepts that she clearly could not have seen or examined the identity label affixed to the ashes.

On [REDACTED] August 2018, the [REDACTED] family collected these ashes from the Funeral Directors in [REDACTED].

Again, there were no checks carried out on the contents of the casket, and it was assumed based upon the Certificate of Cremation and identity label on the outside of the casket that it contained the ashes of the Late [REDACTED].

Findings and Conclusion

Due to their being no corroboration to the actions of the technician and with no forensic opportunities to confirm beyond doubt that the ashes have been correctly labelled, the Inspector can only base his findings on the balance of probability.

The working practice and procedures in place at Kirkcaldy Crematorium in respect of their handling of ashes has never before been subject of a complaint to the Inspector of Crematoria since he took office in March 2015.

Fife Council however who also operate Dunfermline Crematorium have been subject of a similar complaint in 2015 regarding their handling of ashes at that Crematorium.

A full enquiry was conducted at that time by both the Inspector of Crematoria and Fife Council and working procedures were changed.

Both crematoria are managed by the same staff.

With regards to the complaint subject of this report, both families having already suffered the grief of losing a loved one endured a further avoidable period of anxiety and uncertainty on realising that they had either received the wrong ashes or the caskets containing the ashes had been wrongly labelled.

The investigation carried out by the Inspector established that on the balance of probability both families had indeed received the wrong ashes from their respective funeral directors, but fortunately due to the actions of [REDACTED], son-in-law of the late [REDACTED], both sets of ashes were exchanged then retained and not dispersed pending the outcome of the investigation.

In addition to the technician having either placed the correctly labelled ashes into the wrong casket, or wrongly labelling the casket after the ashes had been inserted, there were a number of other failings and missed opportunities which could and should have detected the discrepancies, and prevented both families from such an ordeal.

These all relate to the lack of checking and cross checking of the identity labels on the outside of the caskets with the label on the ashes within, and the Certificate of Cremation.

As described earlier, this could and should have been carried out, firstly when the ashes were collected from the Crematorium, secondly whilst in the care of the funeral directors, and thirdly before they were handed to the respective families.

The Inspector has been given an assurance by the Cremation Authority and both of the funeral directors involved, that these checks will be carried out with immediate effect on every occasion in the future.

This report concludes with a list of recommendations which the Inspector of Crematoria considers, if implemented, will minimise the risk of their being a recurrence.

As the Inspector of Crematoria is only in a position to monitor actions at Crematoria, this report has been made available to the Inspector of Funeral Directors to address issues relating to the respective funeral directors concerned.

On [REDACTED] October 2018 the Inspector attended a pre-arranged meeting with members of the [REDACTED] family in [REDACTED], and made them aware of the findings of the enquiry.

They were most understanding and accepted the apology and explanation given by the technician [REDACTED].

They expressed a degree of surprise that so much responsibility should be placed on the technician, often working alone.

They intimated that they will now proceed with making arrangements for interment.

Arrangements have been made for the Inspector to meet with members of the [REDACTED] family on [REDACTED] October 2018 to make them aware of the findings of the investigation.

A meeting has also been arranged with their MSP [REDACTED] (at her request) on [REDACTED] October 2018.

Recommendations

1 The Cremation Authority review staffing levels at Kirkcaldy Crematoria, as the investigation revealed there are a number of occasions when only one technician is responsible for carrying out cremations, cremulations, and handling of ashes, and can be called upon to assist with other duties such as the collection of ashes, the scattering of ashes, or assistance in providing a shoulder positioned entrance of the coffin to the chapel.

2. The Cremation Authority need to be mindful of SEPA Regulations as regards the monitoring of cremations.

3. The Cremation Authority review their Bereavement Services Cremation Process Instructions and in particular consider in Step 7 including more detailed procedures as regards requirement for cross checking of identification prior to collection of, or other dispersal of ashes.

4. The Cremation Authority consider placing the Certificate of Cremation inside the casket containing the ashes, thus ensuring that in order to check details on the Certificate the casket would need to be opened which would reveal sight of the identity label on the ashes. That would still require a cross check of the identity label on the outside of the casket which could be carried out prior to closing the casket. There is also a need to ensure that the name on the envelope matches the Certificate contained within.

5. The Cremation Authority consider transferring the responsibility for the collection of ashes away from the technicians within the crematory to staff within the admin office. All ashes to be collected by funeral directors or family could be conveyed and temporarily stored within the admin office.

6. The Cremation Authority review working practice in the crematory to ensure that there is no recurrence of more than one casket being prepared together at the same location.

7. The Inspector of Funeral Directors should note the failings of the funeral directors as described in this report and take whatever action is deemed appropriate.

Respectfully submitted

Robert Swanson QPM
HM Inspector of Crematoria Scotland
23rd October 2018

From: Robert Swanson <[REDACTED]>
Sent: 28 May 2015 12:34
To: [REDACTED]
Subject: Report concerning Complaint by [REDACTED]

[REDACTED],

Please find enclosed, to be forwarded to whoever you consider most appropriate, my report into the complaint concerning the ashes of [REDACTED].
Should you require anything further please do not hesitate to get in touch.

Kindest Regards
Bert

From: Swanson R (Robert) <[REDACTED]>
Sent: 23 October 2018 15:19
To: [REDACTED]
Cc: [REDACTED]
Subject: Complaint - Kirkcaldy Crematorium

Hi [REDACTED] and Team,

Please find enclosed report regarding a complaint concerning the identification of ashes following two cremations at Kirkcaldy Crematorium.

[REDACTED] - You will note at the end that I have a meeting with the local (Fife) MSP next week regarding this, so you may wish to ensure it has been forwarded to the Minister before that.

[REDACTED] – let me know if you require anything further regarding funeral directors involved.

Kind Regards

Bert

Complaint concerning the ashes of the late [REDACTED] who was cremated at Dunfermline Crematorium on [REDACTED] February 2015

Purpose

This report has been compiled by HM Inspector of Crematoria for Scotland for the purpose of providing the Minister for Public Health with details of the complaint and the outcome of the resultant enquiry undertaken by the Inspector.

It further provides for consideration of dissemination to Mr Steve Grimmond, Chief Executive of Fife Council (Cremation Authority) and any other parties deemed to have a legitimate reason for seeking access to the information contained within.

The report concludes with a number of recommendations for consideration by the Cremation Authority.

Introduction

The report concerns a complaint made by [REDACTED], daughter of the now deceased [REDACTED], relative to what she considered to be either the wrong ashes having been given to her following the cremation of her mother at Dunfermline Crematorium on [REDACTED] February 2015, or the wrong label (cremation card) having been affixed to the polythene bag which contained the ashes of her mother.

[REDACTED] intimated that she believed that Fife Council were conveniently saying that the ashes she received were those of her late mother, and that it was a mix up of labels, but to [REDACTED] mind that did not add up, and there remained a lot of unanswered questions which cast doubt on their version of events.

Notification to Inspector of Crematoria

On [REDACTED] April 2015 HM Inspector of Crematoria for Scotland was contacted by a member of the Scottish Government National Cremation Investigation Team and made aware that they had on that date received a call from [REDACTED] regarding her concerns, as described above, and that she was seeking an Independent enquiry into the circumstances.

On receipt of the information the Inspector of Crematoria contacted [REDACTED]and arranged to visit her at her home the following day.

At [REDACTED] the following day ([REDACTED]April 2015) the Inspector called on [REDACTED], where in the presence of her husband, she provided the following information relating to the cremation and subsequent events concerning the ashes of her mother.

Circumstances as Reported

The funeral for [REDACTED], [REDACTED], was scheduled for, and took place at [REDACTED] on [REDACTED] February 2015, at Dunfermline Crematorium, Fife.

The resultant ashes, which are the subject of the complaint, were collected and signed for, by the Funeral Directors, [REDACTED], on [REDACTED]February 2015, where at the request of [REDACTED]they were retained pending their collection at a later date.

On [REDACTED]April 2015, the ashes were given to [REDACTED] who intended to have been scattered at a chosen location (local hill) which was much loved by the deceased.

A number of close relatives had travelled from various locations in Scotland, including Shetland, to be present at the scattering.

To the horror of [REDACTED], and all present, when the outer box, which was labelled as [REDACTED] was opened and the inner polythene bag, which contained the ashes was removed, it was seen that the label stapled to the bag, bore details of another woman, by the name of [REDACTED].

Note: Appendix 'A' to this report is a copy of a photograph showing the two labels as described above.

The [REDACTED] were contacted immediately and uplifted the ashes. They later advised [REDACTED]that they contacted Dunfermline Crematorium that afternoon ([REDACTED]April 2015) however were advised that as the Funeral Directors who dealt with the funeral of [REDACTED] ([REDACTED]) were closed, nothing could be done at that time.

At 1010hrs the following day ([REDACTED]April 2015) [REDACTED]was contacted by [REDACTED] and was advised that 'the ashes of her mother had been found at the Crematorium'.

The box containing the ashes, now bearing the same details ([REDACTED]) on the two labels and certificate of cremation, were returned into the care of [REDACTED], to be retained pending collection by [REDACTED]at a later date.

During late afternoon, that date ([REDACTED] 2015) the [REDACTED], telephoned [REDACTED], and intimated that due to staff absentees she could not start an investigation until the following Monday [REDACTED] 2015).

Not satisfied that the matter was going to be dealt with timeously, [REDACTED], contacted Mr Steve Grimmond, Chief Executive, Fife Council, and was advised that the matter would be looked into as a matter of urgency.

Initial enquiry was carried out by [REDACTED]on [REDACTED]April 2015, however she was advised by [REDACTED] that [REDACTED] did not consider this to be independent and asked that she ([REDACTED]) did not make further contact with her ([REDACTED]).

On [REDACTED] April 2015, [REDACTED] concluded her enquiries, and on that date sent an email to [REDACTED] in which she apologised on behalf of herself and Bereavement Services for 'an inexcusable lapse in our procedure'. She intimated there was no intention to cover any mistakes in what she described as being down to 'human error and lack of care'.

She included by way of attachment, a copy of her report.

Note: Appendix 'B' to this report is a copy of [REDACTED] ***Report as referred to above.***

[REDACTED] was far from satisfied with the content of the Report, which she considered to raise even more questions, resulting in even more confusion and distress. In pursuit of an independent investigation she contacted her MSP, and subsequently the Scottish Government National Cremation Investigation Team.

Enquiry conducted by Inspector of Crematoria

The following is a resume of the extent of the investigation undertaken, from which the findings and recommendations which follow have been sourced:

- Personal visits to [REDACTED] and her husband on two occasions, in addition to several phone calls and correspondence by email.
- Meeting with [REDACTED], at Dunfermline Crematorium, with additional communication by telephone and email.
- Two visits to Dunfermline Crematorium to interview staff and obtain a demonstration of working practices in respect of relevant matters.
- Discussion with [REDACTED].
- Discussion with [REDACTED].
- Discussion with [REDACTED]
- Obtained copy of photographs showing the labels in situ on the outer box and inner polythene bag which contained the ashes which had been given to [REDACTED].
- Examination of electronic copies of communication held by [REDACTED], in respect of correspondence with a number of those referred to throughout this report.
- Examined and obtained copy of Fife Council Guidance Notes on the Cremation Process, held at Dunfermline Crematorium.
- Examination of computer records relating to the cremation of [REDACTED]and [REDACTED].
- Examination of coverage provided by CCTV installed at Dunfermline Crematorium.
- Examination of the relevant qualifications of the Technician at Dunfermline Crematorium, who carried out the cremations of both [REDACTED]and [REDACTED].

Findings

On [REDACTED] February 2015 there were a total of [REDACTED] cremations carried out at Dunfermline Crematorium.

Preparation Stage

As was normal procedure, the day before the funerals, admin staff prepared Cremation Certificates and Cremation Cards for each, with two cards for each deceased, and forwarded them to the technicians in the Crematorium.

The cremation cards were printed on A4 size card, with each sheet containing details of all the [REDACTED] cremations for that day, clearly showing the time of the service, allowing the technicians to place them in time order for the day.

The technician separated the cards (using a scissors) into individual ones, and repeated the exercise with the second sheet, thereafter marrying the cards and placing them along with the Cremation Certificate, all held together with a paper clip, into the time order box situated beside the cremulators at the end of the process, with the first cremation of the day to the front and subsequent cremations immediately behind.

This resulted in the cremation certificate and cards prepared for [REDACTED] to be the last in the time order box, immediately preceded by those for [REDACTED].

Note*: **Both cremation cards referred to throughout this report are identical, and to avoid any confusion, they have for the purposes of this report been described as first and second card, purely to differentiate*.**

It was at the 'cutting into individual cards' stage that the technician concerned, [REDACTED], believes [REDACTED] made the mistake when picking up the second cards for [REDACTED] and [REDACTED], and pairing them with the first card i.e [REDACTED] placed the 2nd card for [REDACTED] along with the 1st card for [REDACTED], and the 2nd card for [REDACTED] along with the 1st card for [REDACTED].

When viewed in the time order box (prior to commencement of the cremation) this meant that when looking at documentation for the [REDACTED] cremation of the day, [REDACTED], the technician would see the 1st card, with the details for [REDACTED] thereon to the front, the 2nd card, which [REDACTED] wouldn't see at that time, was the wrong card with the details of [REDACTED] thereon, and the certificate to the rear, with the correct details for [REDACTED] thereon.

In respect of the [REDACTED] cremation of the day, [REDACTED], the technician would see the 1st card, to the front, with the details for [REDACTED] thereon, the 2nd card, which [REDACTED] wouldn't see at that time, was the wrong card with the details of [REDACTED] thereon, and the certificate, to the rear, with the correct details of [REDACTED] thereon.

Cremation Stage

In advance of the service for [REDACTED] which took place at [REDACTED], the name plate on the coffin was checked against the cremation list for the day, to ensure spelling of the name was correct.

This was found to be in order, and immediately following the service the coffin was presented to the technician for cremation.

At that stage, the first card was removed from the time order box and placed in the holder on Cremator number 2, into which the coffin was placed (charged). Computer records show the time the coffin was charged as being [REDACTED].

This occurred some seven minutes before the service for [REDACTED] began.

The first card thereafter followed the ashes throughout the remainder of the process.

When the cremation was complete the ashes were placed into the cooling box (underneath the cremator) with the first card placed in the card holder on the box.

The ashes remained in the cooling box overnight.

The service for [REDACTED]took place at [REDACTED] ([REDACTED] February 2015). The name plate on the coffin was checked against the cremation list for the day and found to be correct. Immediately following the service the coffin was placed (charged) in Cremator number 1. Computer records show this to have occurred at [REDACTED].

At that stage the first card was removed from the time order box and placed in the card holder on Cremator Number 1.

When the cremation was complete the ashes were placed into the cooling box with the first card placed in the card holder on the box.

The ashes remained in the cooling box overnight.

[REDACTED] **February 2015**

There being no cremations on [REDACTED] February 2015, the Technician ([REDACTED]) was alone that morning when [REDACTED] completed the final stages of the process in respect of the ashes for [REDACTED] and [REDACTED].

[REDACTED] states [REDACTED] first removed the cooling box with the ashes of [REDACTED] which [REDACTED] brought through to the room housing the Cremulator. [REDACTED] removed the first card from the cooling box and placed it in the card holder on the Cremulator, and after any metal had been removed and the ashes cremulated, in accordance with the instructions on the first card, [REDACTED] placed the ashes in the plastic urn, which had been provided by the Funeral Directors ([REDACTED]) in advance of the funeral.

[REDACTED] then removed the first card from the card holder and returned it to its original position in front of the second label, which [REDACTED] claims not to have read, with the cremation certificate to the back. [REDACTED] then placed an elastic band around the cards and certificate affixing all three documents to the outside of the plastic urn.

[REDACTED] then removed the cooling box with the ashes of [REDACTED] which [REDACTED] brought through to the room housing the Cremulator. [REDACTED] removed the first card from the cooling box and placed it in the card holder on the Cremulator, and after any metal had been removed and the ashes cremulated, [REDACTED] placed the ashes into a polythene bag, placed the certificate of cremation into the box in which the ashes were to be placed, affixed the 1st card to the outside of the box, and stapled the second card, which [REDACTED] states [REDACTED] did not read, onto the polythene bag containing the ashes, and thereafter placed the ashes inside the box.

The effect of these actions meant that the first card (label) on the outside of the green cremation box displayed the details of [REDACTED], whilst, as was later established, the second card which was stapled to the polythene bag containing the ashes was in the name of [REDACTED]. The certificate of cremation was in the name of [REDACTED].

Following completion of the cremation process for both, the technician placed the plastic urn and the green cremation box into storage for collection by the respective funeral directors.

Collection of the Ashes

On [REDACTED]February 2015, the funeral directors acting for the family of the late [REDACTED] ([REDACTED]) uplifted the green cremation box from Dunfermline Crematorium after having signed for, but not examined the contents.

Details were thereafter entered onto the BACAS computer system at the Crematorium.

On [REDACTED] March 2015, the funeral directors acting for the family of the late [REDACTED] ([REDACTED]) uplifted the Plastic Urn from Dunfermline Crematorium after having signed for, but not examined the documentation beyond the outermost cremation card.

Details were thereafter entered onto the BACAS computer system at the Crematorium.

Missed Opportunities

Between the date of the cremation of both [REDACTED]and [REDACTED] and the date when the ashes were given to [REDACTED] there were a number of missed opportunities to identify that a mistake had been made.

The most obvious of these are listed below:

1. On the [REDACTED] morning ([REDACTED]February 2015) the technician should have observed when [REDACTED] commenced finalisation of the cremation process in respect of [REDACTED]that the name on the cremation card facing [REDACTED], (which was within the time order box), was [REDACTED], and NOT [REDACTED].

2. On the [REDACTED] morning ([REDACTED] February 2015) the technician should have observed when he commenced finalisation of the cremation process in respect of [REDACTED]that the name on the cremation card facing him, (which was within the time order box, was [REDACTED]) and NOT [REDACTED].

3. On [REDACTED] February 2015, when the Funeral Directors, [REDACTED] called at the Crematorium to collect the ashes of [REDACTED], despite having to sign for them, neither the Funeral Director nor the Crematorium staff examined the contents or documentation within the green cremation box.

4. On [REDACTED] March 2015, when the Funeral Directors, [REDACTED] called at the Crematorium to collect the ashes of [REDACTED], neither the Funeral Director nor the Crematorium staff checked all the documentation affixed to the outside of the Plastic Urn.

5. The Funeral Directors, [REDACTED], have intimated that as only the certificate of cremation was required by them in respect of the ashes of [REDACTED], they discarded the two cremation cards without examining the information thereon.

6. When the Funeral Directors, [REDACTED] prepared and delivered the ashes to [REDACTED], they failed to examine the contents of the green cremation box or the documentation within.

Conclusion

The cremation process in place at Dunfermline Crematorium has, according to staff, never before been subject to any investigation of a similar nature.

The technician ([REDACTED]) who carried out the cremations of both [REDACTED]and [REDACTED] is highly experienced and qualified, with over [REDACTED] years' service.

[REDACTED] has co-operated fully with the enquiry, and accepts full responsibility for [REDACTED] actions which [REDACTED] claims was down to a mix up with labels (cremation cards), as described earlier in this report.

The fact however that [REDACTED] acted on [REDACTED] own on the morning following the cremations, when [REDACTED] finalised the process for the cremations of [REDACTED] and [REDACTED], is the period most questioned by [REDACTED] on the possibility of the wrong ashes being given to her.

There is no corroboration to the actions of [REDACTED] on the [REDACTED] morning ([REDACTED] February 2015) and whilst there is good quality CCTV within and around the Crematorium, it was found to be on a monthly loop and therefore not available given the period between cremation and the investigation. In any case, the CCTV coverage would have been of limited benefit as it did not provide coverage of the area around the cremulator.

There is no disputing the fact that the cremation cards, or labels as they are referred to by some, were mixed up, at some stage of the process, that most likely to have been either at the outset, as stated by the technician, or at the final stage on the [REDACTED] morning, when the ashes were cremulated.

It is known that the cremation of [REDACTED] commenced at a time when the service for [REDACTED] was about to commence. There is no reason to doubt that anything other than the correct cremation card for [REDACTED] was placed on the cremator at that time, and throughout the rest of the process on that day.

It follows that as the cremation of [REDACTED] was the [REDACTED] cremation that day there is no reason to doubt that anything other than the correct cremation card was placed on the cremator at that time, and throughout the rest of the process that day.

That then leaves the following day, when the ashes for both were removed from the respective cooling boxes and brought into the room housing the cremulator.

The technician has given a clear account, as described earlier, of what occurred on that day during the final process, and when asked, was adamant that [REDACTED] carried out [REDACTED] duties as normal, processing each of the ashes independently.

It is worthy of note that the ashes of [REDACTED], as per the cremation card which accompanied the coffin, and ashes throughout, was to be placed into a plastic urn, whereas the ashes for [REDACTED] was to be placed in a polythene bag.

As part of the investigation a copy of photographs taken by the funeral directors[REDACTED], and forwarded to [REDACTED], showing the cremation cards (labels) in situ, is appended to this report.

The extent of the investigation undertaken by the Inspector is described earlier in this report, and whilst all have co-operated fully, there are, as can be seen, a number of comments, which have been attributed to others, which have not been confirmed.

One such comment is from [REDACTED] who intimated that she was told by the [REDACTED] that her mother's ashes had been found in the crematorium on [REDACTED] April 2015. This is disputed by staff at the Crematorium, as they claim the ashes concerned were the correct ashes and only the label, or cremation card, attached was wrong.

The funeral directors also intimated to [REDACTED] that when they contacted Dunfermline Crematorium on the afternoon of [REDACTED] April 2015 that nothing could be done that day, as the other funeral directors involved ([REDACTED]) were closed.

It is unclear to the author of this report as to why, if accurate, these comments were made to [REDACTED], particularly at such an emotional time for her, other than perhaps in an attempt to deflect responsibility from the Funeral Directors, and claim that the only party to blame, was Dunfermline Crematorium.

Irrespective of their motives, the action, or rather lack of, taken by Fife Bereavement Services has also come in for criticism from [REDACTED].

Given the seriousness of the incident, the very least that would have been expected was a personal visit to [REDACTED] within hours of the discovery.

She should also have been given direction as to how to initiate an Independent Enquiry.

As will have been noted, [REDACTED] was understandably very frustrated at what appeared to be a lack of action into trying to establish what exactly happened, and confirmation as to whether or not she had been given the ashes of her mother.

Much of what has been included in this report, could, and should have been provided to [REDACTED] at a much earlier time.

[REDACTED] questioned much of what was contained in the report by [REDACTED].

These have since been addressed by the Inspector of Crematoria and are incorporated in the content of this report.

One procedural mistake made in the report by [REDACTED], concerns the ashes of [REDACTED], in which it is stated that as no bag is used (ashes placed in plastic urn) the second label (cremation card) was discarded and not affixed to the urn.

That was not the case, as confirmed by both the Cremation Technician and the Funeral Director.

The only occasion the second label (cremation card) is discarded at the Crematorium is when the ashes are to be retained and dispersed by staff. On these occasions the second card is discarded at the preparation stage.

In conclusion, it should be said that in every death there has to be trust in the procedures implemented from the point of death to committal.

Trust that the body in the coffin is the person whose name appears on the closed coffin lid.

Trust that staff are adequately trained to carry out their duties with dignity, respect and professionalism.

Trust that there are procedures in place to eliminate the risk of error.

Trust that when there are failings there is a robust procedure to investigate.

Trust that lessons learned are acted upon to safeguard a repeat occurrence.

In this particular case the trust which [REDACTED] had in both Dunfermline Crematorium and the [REDACTED] to carry out what should have been a straight forward and routine cremation has been eroded, and she is left with lifetime trauma and memories of what she saw when she went to scatter the ashes of her beloved mother.

She has intimated that she now intends to scatter the ashes whenever she can arrange a suitable date with her brother in [REDACTED], albeit she remains unconvinced that the ashes are those of her mother, [REDACTED].

Opinion

It is the opinion of the Inspector of Crematoria that on balance of probability the ashes subject of this enquiry are those of [REDACTED], and that the explanation given by the Crematorium Technician as to how the mistake was made is the most likely explanation.

Regrettably, the Inspector of Crematoria is unable to provide [REDACTED] with the 100% certainty that she should have, that the ashes she is to scatter are those of her late mother.

Recommendations

1. That the Cremation Authority commission a review of the process in place at Dunfermline Crematorium in respect of Cremation Cards, and in particular to address the practice of multiple details being included on cremation cards which are then cut and divided into individual cards.

2. That the Cremation Authority implement formal procedures to be adopted at Dunfermline Crematorium in respect of cross checking of the various processes, including procedures when ashes are being uplifted by funeral directors or other persons.

3. That the Cremation Authority consider measures to ensure that where practicable there is a secondary source to corroborate the actions of a technician when acting alone.

4. That the Cremation Authority update the Cremation Process Guidance Notes at Dunfermline Crematorium to incorporate any revised procedures.

5. That the Cremation Authority consider informing the family of the late [REDACTED] of the nature of this complaint, and its outcome.

6. That the Cremation Authority consider the need for any corrective training of staff in light of the findings of this complaint.

7. That the Cremation Authority ensure that the proposals for rectification recommended in the report by [REDACTED] (Appendix 'B' to this Report) are implemented.

Appendicies

Appendix 'A' - Photograph of cremation cards in situ

Appendix 'B' – Copy of Report by [REDACTED]

Appendix ‘A’

[REDACTED]

Appendix 'B'

FIFE COUNCIL – BEREAVEMENT SERVICES
DUNFERMLINE CREMATORIUM

Report of Incident Regarding Ashes

The late [REDACTED]
Funeral Service [REDACTED] **February 2015,** [REDACTED]

Background:
The funeral of the late [REDACTED] took place on [REDACTED] February 2015 at [REDACTED] at Dunfermline Crematorium with an instruction that the resultant ashes were to be collected from the Crematorium by the funeral director, [REDACTED].

[REDACTED] collected the ashes of the late [REDACTED] on [REDACTED] February 2015.

The family of [REDACTED] collected her ashes from [REDACTED] on the afternoon of [REDACTED] April 2015 where it was discovered that the labelling on the bag containing the ashes for the deceased did not match the labelling on the container in which the bag was held.

The ashes were returned to Dunfermline Crematorium by [REDACTED] on the morning of [REDACTED] April 2015 and the correct label was attached to the internal bag containing the ashes which were then collected by [REDACTED].

[REDACTED] was notified of the situation which had arisen on [REDACTED] April 2015 however due to being absent from work was unable to contact the applicant for the cremation, [REDACTED] until late afternoon. There being nobody else available in a senior position within Bereavement Services who was able to make contact.

[REDACTED] made contact with Mr Steve Grimmond, Chief Executive, Fife Council on [REDACTED] April 2015 and it was agreed that an investigation would be undertaken as soon as possible in week beginning [REDACTED] April 2015.

Due to staffing issues the initial enquiry had to be carried out by [REDACTED] on [REDACTED] April 2015 however [REDACTED] intimated via the [REDACTED] that she was unhappy that any such investigation would be independent and therefore transparent. It was agreed that [REDACTED] would visit the crematorium on

[REDACTED] April 2015 and the crematorium technician would explain and show [REDACTED] the process in place and where the error had occurred.

PROCESS IN PLACE:

For each cremation the relevant paperwork is prepared. This amongst other things includes in particular where ashes are to be removed from the crematorium; a certificate of cremation and 2 labels containing information on the date/time of funeral, deceased details, funeral director and what is to happen to the ashes.

Where the ashes are to be collected one label is attached to the relevant certificate of cremation and is filed in time order for that day's services.

When the coffin is ready to go through the cremation process the second label is slotted into a cardholder that is present on all the parts of equipment used in the cremation process and follows that cremation through the whole process up to and including the process of preparing the ashes.

Once the ashes are ready, the label is attached to the green cremation box, the certificate of cremation is placed in the bottom of the box, the cremation bag is inserted inside the box and the ashes are put into the bag. The bag is then fastened with the second label which was filed with the certificate of cremation. Only one set of ashes is prepared at a time.

When the ashes are collected there is a slip that requires to be signed by the person collecting the ashes and also a book detailing the cremation number, name of deceased, date collected and by whom.

Process Non-Conformity:

The process was discussed with the crematorium technician involved to identify how the non-conformance occurred.

The ashes from the service for the late [REDACTED] on [REDACTED] February at [REDACTED] were also to be collected from the crematorium. The technician believes that [REDACTED] has mixed the labels that were attached to the certificates of cremation for [REDACTED] and [REDACTED] during the initial filing process.

The ashes for [REDACTED] were to be collected from the crematorium in a plastic urn. In this situation the label that follows the coffin through the cremation process is fastened to the outside of the urn along with the certificate of cremation. No bag is used as the ashes are put straight into the urn and there is no requirement for the other label which is discarded. Therefore the correct label and certificate of cremation were received by the funeral director, [REDACTED] which they have confirmed. The cremation process and the preparation of the ashes for the late [REDACTED] would also take place before those of the late [REDACTED].

The crematorium technician is sure due to the initial cremation process, timing of the cremations and subsequent ashes preparation that the ashes of [REDACTED] could not have been mixed up with those of [REDACTED].

No double checks were carried out however during the preparation of the ashes of [REDACTED] or when they were collected so that the use of the incorrect label was not picked up by the crematorium staff or funeral directors.

Proposal for Rectification

Fife Council Bereavement Services holds a Certificate of Registration through BSI for their quality management system under ISO 9001:2008.

Through the requirements of that registration we are audited both internally on a regular basis and also externally twice a year by BSI.

This break in process will be logged as a major non-conformance and as such will require an audit to be carried out internally by our Performance Management Team Leader. The outcome of that audit will be to ensure that appropriate practices are put in place to ensure wherever possible that such a situation does not reoccur. This audit will then be raised with and investigated by BSI during their external audit, the next of which is due in May 2015.

The proposal to amend our process to ensure that this situation does not happen again would be to introduce a double check sheet to be signed off when the ashes are prepared by the crematorium technician and also a further signed double check by the Funeral Director when the ashes are being uplifted from the crematorium.

[REDACTED]