Section Six: Conclusions and Recommendations
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This extensive and complex Investigation commenced at the end of April 2013. The number of cases referred to the Investigation has grown considerably from 130 babies at its commencement to 253 babies at its conclusion. I am immensely grateful to a small team who have provided outstanding support to me in this harrowing and difficult Investigation, namely Claire Soper, Claire Duchart and Sean Griffin, on secondment from the Council, and to the lawyers Professor Peter Lyons and John Watt who provided invaluable assistance in interviewing witnesses and next of kin.

The main concern of parents involved in this Investigation is this; that having been told before or following the cremation of their baby or babies that there would be or were no ashes, there had in fact been ashes which had been interred or scattered at a part of Mortonhall Crematorium. They wished to know, so far as possible, what in fact happened at Mortonhall even if any remains of their baby could not now be located.

The findings of this Investigation are very much more complex and less certain for many parents than this original expression of concern by parents anticipates. For many the pain of their recently renewed grief and uncertainty will be compounded by the conclusions of this Report.

Following consideration of many hundreds of documents, 162 witness interviews, meetings with expert consultants and attendance at several crematoria in the United Kingdom the following conclusions and recommendations are made to the City of Edinburgh Council:

OVERVIEW

The extent to which practices in the cremation of foetuses, stillborn and neonatal babies at the Mortonhall Crematoria have failed to reflect the changes over the years in social attitudes and the corresponding need for greater care, sensitivity and transparency is partly a product of an inward-looking and isolated managerial approach at the operational level. That situation was allowed to persist because of an absence of meaningful supervision or leadership from senior management on this matter.

Staff employed there for many years largely adopted practices and beliefs formed and fixed over several decades. They worked for many years under the direction and supervision of the same Superintendent who also preserved such opinions. She was a manager with a lively concern for efficiency and cleanliness but an apparent aversion to change. The Bereavement Services Manager did little
to add value to the quality of the processes for these foetal, stillborn and neonatal baby cremations and acquiesced in procedures, working practices and record keeping that were known to be unreliable.

The Superintendent was, in turn, also influenced greatly by the received wisdom from her own supervisors over many years and she followed the general advice proffered by the Federation of Burial and Cremation Authorities (FBCA) in its publications, namely, that there may be no ashes when foetuses, stillborn or neonatal babies were cremated. Her own, apparent, belief was even firmer than this.

Over many years the local team of operators at Mortonhall was left to get on with things by the various senior management layers in the Council, with little evidence of any proactive, innovative or interventionist behaviours. The apparent belief at Mortonhall that the bones of foetuses and even stillborn and neonatal babies could not survive the cremation process continued, despite the exposure of the Superintendent and other staff to evidence and information to the contrary.

There was, additionally, a longstanding and wholesale failure to comply with the local authority’s duty to keep accurate records of the cremation of stillborn and neonatal babies.

An absence of any evidence of proactive and challenging leadership or meaningful supervision of the crematorium from any level of senior management over many years allowed the impression to form for these managers and others of a very well run crematorium under the experienced and expert management of the Bereavement Services Manager.

The Crematorium was considered by the senior managers and the Council as a model of excellence in the context of the wider range of Council activities. The reality was very different so far as it related to the cremation of foetuses, stillborn and neonatal babies.

The evidence in this Investigation discloses a comprehensive and long-term failure to provide an acceptable service to some of society’s most vulnerable next of kin.

It is recommended that the City of Edinburgh Council review the manner in which the Crematorium is managed in the future, ensuring greater understanding by senior managers of the processes and procedures at the operational level and significantly greater engagement in improving training and best practice.

There should also be robust systems of audit and inspection to ensure safe working practices that achieve best practice in providing quality of service to next of kin. Such audits should be part of a system for ensuring greater accountability and transparency in determining whether the Crematorium is fulfilling its statutory obligations.
Most importantly, senior management must lead and support the Crematorium in continuing a change of culture and attitude towards the quality of service to next of kin in this sensitive aspect of cremation practice; a change started by just one junior member of staff who was prepared to challenge what had become the norm.

1. THE ROSENDALE REPORT

The remit for this Investigation asked me to review the recommendations of an initial fact-finding investigation by a senior officer of the Council, Mike Rosendale. Mr. Rosendale’s investigation started on the 10 December 2012 and was reported on the 11 January 2013. His initial findings were presented to the Transport and Environment Committee of the Council on 15 January 2013 and are at Annex A to this Report.

Given the very short timescale of the initial investigation and his recognition of the need for an independent person to carry out a fuller investigation, I consider the Rosendale Report contains useful information. Mr. Rosendale’s limited investigation assisted my own enquiries and his report makes important recommendations with which I concur.

The original examination of Records commissioned by Mr. Rosendale was, however, of more limited value given the large number of additional records made available or recovered from the Council as this Investigation proceeded. The discovery that the law does not permit the formal registration of non-viable foetuses in the statutory Register of Cremations also explained the absence of statutory records for non-viable foetuses.

Accordingly, a Forensic Accountant was engaged by the Investigation to assist examination of both the records made available at the start of the enquiry and those records subsequently discovered through this Investigation.

2. THE PROCESS OF CREMATION

The successful recovery of ashes from infant and foetal cremations depends on whether conditions in a cremator can be modified to enable such an outcome and the methods of recovery refined to achieve the gentle treatment of the resulting ashes.

There is clear evidence of different, ad hoc, modifications of working practices that permit the consistent recovery of remains following cremation of foetuses as young as 17 weeks gestation in adult cremators. There are also other examples of specially designed foetal or infant cremators that allow the successful recovery of cremated remains.
It is recommended that the City of Edinburgh Council asks the Scottish Government to instruct comprehensive national research to ascertain the most effective, practical and safest practices for the future that will provide greater assurance to next of kin that the ashes of their child will be recovered.

The cremation of non-viable foetuses should also be regulated by legislation and any new financial obligations of crematoria recognized in the financial memorandum to the legislation.

3. CHANGES IN CREMATION EQUIPMENT

Ideally, the cremation process should destroy combustible organic components of the body and retain inorganic parts. The usual conditions for cremation of adults are not suitable for infant cremations, and it is a matter of establishing whether there can be suitable conditions created, having regard to all the factors which affect the outcome. The essential characteristic of infant cremation must be a gentle process.

There has been little development attention paid by the industry to how full-size cremators operate with infant cremations and, if there are to be consistent successful infant cremations, (i.e. with recoverable remains), changes are necessary.

The introduction of solid hearth cremators in the early 1990s assists the recovery of more adult remains but the higher temperatures created in the primary chamber with these cremators, along with robust air jets to accelerate combustion, make unsuitable conditions for the optimum recovery of delicate foetal or infant cremated remains.

The reintroduction in 2011 at Mortonhall of the use of a metal tray to contain infant ashes during the overnight cremation in adult, double-ended cremators has resulted in the consistent recovery of remains in all but two cases there. These cremations are carried out at the end of the working day when the cremator has been switched off and the coffin is left in the residual heat of the cremator overnight.

Such a procedure is, however, contrary to the terms of the permit authorising cremation at Mortonhall. The condition of the remains cannot be monitored if the process is not being observed carefully as at Seafield and Warriston Crematoria.

During the Investigation it was also evident that the quality of the remains recovered using this process was not as good as the remains recovered at Seafield and Warriston.
The work done over many years at Seafield Crematorium in Edinburgh demonstrates that it is practicable to modify cremation conditions sufficiently to achieve retrievable remains in single-ended adult cremators during the working day. Dr. Chamberlain, the expert combustion engineer, suggests that for such procedures to become accepted throughout the industry, they must be established on a number of cremator types and cremation authorities and be acceptable to cremation authorities.

Foetal remains cremators have also been introduced in England since the 1990s when hospitals started sending non-viable foetuses for cremation rather than disposing of the foetuses as clinical waste. There are currently none in use in Scotland.

The Investigation found mixed views from cremation industry professionals on the subject of infant cremators. Those few crematoria still using them were very pleased with the results. Other crematoria are consistently returning remains to parents using a tray and an adult cremator and considered they did not need an infant cremator.

The very small size of the door opening of the foetal remains cremator precludes crematoria from using the infant cremator for many stillborn or neonatal babies. For some crematoria the purchase and use of an infant cremator was not considered by them to be commercially viable.

The nature and type of equipment in use at the Crematorium can have some influence on the degree of success in achieving remains but as the expert Dr. Chamberlain explains in his report, the degree of care and attention paid to the process is what marks out those who are consistently successful in recovering ashes from those who are not. Whether by use of a foetal cremator or modified practices in an adult cremator, or a combination of both, there is a need for detailed, authoritative professional guidance on how best to maximise the recovery of ashes from the cremation of babies.

It is recommended that the Scottish Government should commission research to identify best practice in achieving remains in the cremation of foetuses, stillborn babies and neonatal babies. This research should also examine the most effective equipment. Dr. Chamberlain suggests a new methodology could be readily developed that may be more cost effective for some crematoria.

Unless a crematorium can demonstrate their competence in achieving remains and show consistent evidence of the sensitive treatment of next of kin in such cases it is recommended they should not be permitted to continue the cremation of these babies.

Until such time, it may be that centres of excellence in this most difficult and sensitive final act of care should be identified to parents and the funding for such cremations withdrawn from those crematoria that do not provide an adequate service to next of kin.
4. IDENTIFICATION OF REMAINS FOLLOWING CREMATION

Once complete combustion of the organic component of the bone has occurred, the amount of DNA present is much reduced if not lost completely. Standard DNA analysis techniques (for example, STR analysis of nuclear or mitochondrial DNA analysis) used to obtain DNA profiles from unburnt or charred remains have had very limited success when applied to calcined bone. Therefore positive identification of the deceased following complete cremation is generally not possible.

5. THE LAW

The legal framework governing the cremation of foetuses and infants in Scotland is peppered with gaps, ambiguity and uncertainty. The effect of a number of provisions in law were and continue to be unknown or uncertain to those professionals providing a service to the next of kin whose babies are to be cremated at Mortonhall Crematorium.

THE APPLICATION FOR CREMATION

The Cremation (Scotland) Regulations 1935 regulate the provision of crematoria in Scotland. These Regulations have been amended on a number of occasions.

An Application for Cremation must be made in writing (reg. 7). The application must be made by an executor, or the nearest relative of the deceased unless a satisfactory reason is given as to why it is made by someone else (reg. 7(2)). The cremation of the body of any neonatal infant (a baby who has lived and died within 28 days of birth) would require to comply with these provisions.

Although the Regulations suggest that Applications for Cremations will usually be made by the executor, or the nearest relative, of the deceased, in practice the application is often by made by another person, such as the Funeral Director or a person from the hospital involved in the care of the deceased. Such applications by Funeral Directors or hospitals are routinely accepted at Mortonhall and elsewhere.

Interviews conducted during this Investigation with Funeral Directors and parents and examination of the completed application forms for many of the cases makes it clear that important aspects of the legal significance of this form have not been appreciated by anyone.

The results over the many years during which this practice of third party completion of the form at Mortonhall took place has meant that many parents had no idea such a form was being completed by the Funeral Director nor what the legal consequences were for them of agreeing that the hospital would arrange the cremation.
In cases where the parents had signed the form many were also unaware of how the Funeral Director had completed the second non-statutory page of the form about the disposal of any ashes. For many others, the subject of ashes had not been raised with them by the Funeral Director.

It would appear to be implicit in Regulation 17 that the Crematorium ought to ask the person making the application whether they would wish to be given the ashes. Since applications were often made by the Funeral Director or a hospital by professionals who understood that there would be no ashes following cremation at Mortonhall, the subject of ashes was often not raised with parents and the section on the appropriate disposal of ashes was simply left blank. Mortonhall staff accepted these forms with the section on disposal left blank.

If the person who applied for the cremation (Applicant) does not state in the form what the disposal should be, Regulation 17 has the effect that, even if the Applicant does not wish to be given the ashes, their wishes regarding the method of disposal must nevertheless be sought and respected.

Regulation 17 continues that “in the absence of any such arrangement they shall be decently interred in a burial ground or in land adjoining the crematorium reserved for the burial of ashes or shall be scattered thereon”. This means that it is only in circumstances where the person who applied for the cremation (i) does not wish to be given the ashes, and (ii) does not come to an arrangement with the crematorium about the means of disposal, that the crematorium is entitled to decide how to dispose of the ashes.

The Regulation also stipulates that the options available are that the ashes "be decently interred... or shall be scattered."

If the Application for Cremation has been made by a Funeral Director or a hospital, the person whose wishes should be sought and respected in law in relation to the disposal of the ashes is not a relative of the deceased, but rather the Funeral Director or hospital. Such a situation in law, had it been understood by the professionals, could in many cases deprive parents of any opportunity either to receive the ashes or to decide how they are to be treated. As the relatives had not applied for the cremation, they would have no statutory entitlement to choose the means of disposal. This position in law was clearly not explained to parents nor understood by the professionals.

It is recommended that the City of Edinburgh Council take urgent steps to revise the Application form for cremation to make it absolutely clear to all what the consequences of an application by another for their baby’s cremation may imply.

The Form should be simplified and a bold explanation about the prospects of recovering ashes at Mortonhall should also be printed on the front page of the form until such time as equipment, training and working practices are improved.
It is also recommended that anyone guiding the parents through the application process should be fully trained on the subject and capable of providing accurate and understandable verbal and written advice.

A clear and well understood protocol about the responsibilities of each of the professionals for guiding grieving parents through this process should underpin the training on this important advice. This protocol should be developed as a matter of urgency and approved by all agencies involved in dealing with parents in this last act of care.

It is recommended that the City of Edinburgh Council make representations to the Scottish Government to review and clarify the Regulations to ensure that parents cannot be deprived of their legal rights through the obscurity of the drafting of the regulations and/or a lack of understanding by the professionals. I have made Lord Bonomy and the Infant Cremation Commission aware of these issues.

It is also recommended that the City of Edinburgh Council make representations to the Scottish Government to consider making the section of the Form A which relates to the instructions for the disposal of ashes a statutory part of the Form.

In England and Wales, regulation 30 makes similar provision regarding the disposal of ashes. One difference in England and Wales is that the regulation states that the ashes must be given to the person who applied for the cremation “or a person nominated for that purpose by the Applicant”. Although this would allow a Funeral Director to state that the ashes are to be given to the relatives of the deceased, it would not completely address the difficulties outlined above.

STILLBORN BABIES

Regulation 16 of the 1935 Regulations makes specific provision for the cremation of the remains of a stillborn child.

The Regulations do not expressly state that a formal application is to be made to the crematorium for the cremation of the remains of a stillborn child. Regulation 16 makes no mention of an application and the forms set out in the Schedule to the Regulations do not include a specific form of application for the cremation of the remains of a stillborn child. An application might be made using the Form A, however the wording of that form is not ideally suited for use in the case of a stillborn child.

This situation might be contrasted with the position in England and Wales where the 2008 Regulations make specific provision for an application to be made and include an “Application for Cremation of stillborn baby” amongst the statutory forms.
The term “stillborn” is not defined in the 1935 Regulations. However, it is defined in the Registration of Births, Deaths and Marriages (Scotland) Act 1965. The definition in the 1965 Act would probably apply to the 1935 Regulations. For the avoidance of doubt, it would be more satisfactory if the term was defined in the Cremation Regulations and provision made for a form to be made available that deals with the specific circumstances of stillbirth.

Any ashes obtained following the cremation of the body of a stillborn child would fall to be treated in accordance with regulation 17 of the 1935 Regulations.

It is recommended that the City of Edinburgh Council make representations to the Scottish Government for legislative clarification of the position of stillborn babies to be made as soon as possible. This matter has been drawn to the attention of Lord Bonomy.

Similarly, the Cremation (Scotland) Amendment Regulations 2003 amended the 1935 Regulations to make provision for the cremation of body parts (reg. 15A). The term “body parts” is defined as meaning “any organs and tissue removed from a deceased person during the course of a post-mortem examination”.

This definition does not seem to include tissue removed from the body of a stillborn child. In England and Wales, the 2008 Regulations define “body parts” as meaning “material which consists of, or includes, human cells from ... (b) a stillborn child”. Consideration should be given to amending the definition in the Scottish Regulations (and regulation 15A) along these lines.

These observations have also been passed to Lord Bonomy’s Commission for consideration of legislative amendment.

**FOETAL REMAINS (NON VIABLE FOETUSES)**

The category of foetal remains includes all foetuses following cases of pregnancy loss before 24 weeks gestation.

The disposal of foetal remains is not dealt with in any Act of Parliament or Regulations. If the pregnancy has not progressed to 24 weeks gestation, the 1935 Regulations have no application. Similarly, the 2008 Regulations in England and Wales make no provision for foetal remains.

Because there is no applicable Act of Parliament or Regulations, the disposal of foetal remains has been dealt with according to policies and codes of practice issued by various bodies.

In September 2009, the Human Tissue Authority (“HTA”) published guidance on disposal of human tissue after pregnancy loss in a Code of Practice. However,
that Code of Practice is of limited application in Scotland. The disposal of foetal remains in Scotland would not usually be covered by the Code of Practice.

Given the confusion demonstrated by the evidence obtained during this Investigation, there is a clear need to make appropriate and specific legislative provision for the cremation of non-viable foetuses. Likewise, statutory forms should be modified to take into account the special circumstances of the cremation of non-viable foetuses and stillborn babies.

6. DISPOSAL OF CREMATED REMAINS

Regulation 17 provides that:

“In the absence of any such arrangement they shall be decently interred in a burial ground or in land adjoining the crematorium reserved for the burial of ashes or shall be scattered thereon.”

The burial of any ashes from the cremation of a stillborn or infant baby in the land adjacent to the Garden of Remembrance at Mortonhall (shown at Annex I of this Report) would not fulfill this obligation.

It is recommended that immediate steps are taken, in consultation with the next of kin of babies cremated at Mortonhall and where ashes were not returned to parents, to address the condition of this land and to ensure it conforms to the statutory requirements of decency.

7. STATUTORY USE OF THE TERM “ASHES”

The 1935 Regulations do not define the meaning of the term “ashes”. Concern about the confusion created for those involved in the cremation of human remains was communicated to the Scottish Office in 1988 but no action was taken. Similarly, the issue was raised during the deliberations of the Scottish Burial and Cremation Review Group chaired by Sheriff Robert Brodie between 2005 and 2007.

The Review Group did not recommend legislative provision as it was considered that national guidance could deal adequately with the issue. Such guidance was issued to Health Boards in 2012 by the Chief Medical and Nursing Officers but the information about the availability of ashes following the cremation of non-viable foetuses contained in that document was not based on any scientific or clinical research. Instead, it repeated the misconceived belief within certain parts of the cremation profession that there are no ashes following the cremation of foetal remains because of the absence of formed bone.
8. NEONATAL INFANTS

Cremation of neonatal infants (new born babies who die within 28 days of delivery) in Scotland is governed by regulation 17 of the 1935 Regulations. The term “ashes” is not defined in the Cremation Act 1902 Act or the 1935 Regulations. The definition of the term does not appear to have been considered in any court case.

There are two possible interpretations. The first (“the narrow interpretation”) is that it concerns the remains of the body itself and does not extend to the remains of any associated item such as the coffin or any item cremated with the body. The second (“the broad interpretation”) is that it encompasses all that remains following the cremation (other than items which could not, on any view, be regarded as “ashes” such as the remains of the coffin’s metal fixtures) regardless of whether that substance is comprised of the remains of the body itself.

I agree with the broad interpretation of the term. The general purpose of the Regulations is to provide a practical scheme for the regulation of crematoria. The particular purpose of regulation 17 is to direct the disposition or interment of the “ashes” which follow “the burning of any human remains”. An interpretation of “ashes” that implied that a distinction fell to be drawn between those parts of the residue which are derived from the body of the deceased and those which derive from the container would be divorced from reality and the symbolic function of ashes as a focal point for the grief of the bereaved.

It follows that the word “ashes”, as it is used in Regulation 17, should be interpreted as referring to the residue (other than things, such as metal coffin fixtures, which on no sensible view would fall to be regarded as “ashes”) left after the cremation of the remains of a deceased person without seeking to distinguish between residue which derives from the remains of the deceased and residue which derives from the container or other things cremated with the body.

The purely technical and physiological definition adopted by the FBCA was used by its members as a reason to ignore the profound needs of the bereaved for a focal point for their grief. No parent interviewed by me said they would only wish the ashes of their baby returned to them if it could be shown to contain only the bones of their child. What was important to parents was transparency and honesty.

As Dr. Julie Roberts has stated in her report for this Investigation, in some cases only an expert would be able to identify the presence of tiny bones and even if those bones have been broken up in the raking process, there is still inorganic bone residue which will have survived the cremation process.

Parents confirmed that even if there were no actual bones from the baby they would still have wished to be given the ashes from the coffin, baby blanket and toy that were close to the baby during the cremation and which formed part of the baby’s last resting place. Recognition of this need is responded to by South West Middlesex Crematorium where a ceramic pebble is also placed with the
It is recommended that the City of Edinburgh Council make strong representations to the Scottish Government to have the term “ashes” defined in legislation to remove any continuing confusion and that the broader interpretation should be preferred in the meantime. Lord Bonomy’s Infant Cremation Commission will make further recommendations about this fundamental matter.

9. STILLBORN CHILDREN

There is serious doubt as to whether or not Regulation 17 applies to ashes that may be left after the cremation of the remains of a stillborn child. The question is whether or not a “stillborn child” is a “deceased person” for the purposes of Regulation 17; and the answer to this question is far from clear.

However, on balance and having regard, in particular, to the provisions in regulation 18, a “stillborn child” probably does fall to be regarded as a “deceased person” for the purposes of Regulation 17. It would, though, be highly desirable that the Regulations should be amended to clarify this important and ambiguous point.

10. NON-VIABLE FOETUSES

There is no specific provision in the legislation for foetal remains nor for the ashes of foetal remains. If the pregnancy has not progressed to 24 weeks gestation, the provisions in the 1935 Regulations, including Regulation 17, have no application. There is therefore no requirement in law for any record to be kept of the cremation of non-viable foetuses nor for the return of ashes to the next of kin.

It is recommended that the City of Edinburgh Council make strong representations to the Scottish Government to address this situation and to ensure proper, accountable and transparent regulation of the cremation of non-viable foetuses.

11. ENVIRONMENTAL PROVISIONS

The Mortonhall Permit

In terms of the Pollution Prevention and Control (Scotland) Regulations 2000, The City of Edinburgh Council was, on 31 March 2006, granted a permit to operate a crematorium installation at Mortonhall Crematorium. The
Crematorium has been operating overnight cremations of foetuses and babies under the residual heat from the adult cremations and under conditions that are incompatible with the terms of the permit.

**Overnight Cremation**

During the course of the Investigation, the longstanding practice of cremating babies at Mortonhall at the end of the working day when the cremation equipment had been switched off was explained by staff there. The coffin containing the baby would be placed on the lip of the cremator at the door and allowed to cremate slowly overnight as the temperature slowly decreased with the air jets off, preventing the turbulence that takes place when the cremator is switched on.

If there are any emissions released from the overnight cremation, there would be no monitoring of these emissions since the computer controlled monitoring equipment is switched off.

**Potential Breaches of the Permit Conditions**

If the overnight process is designed to maximise the opportunities to recover remains, it may bring with it potential breaches of the Permit.

In light of these potential problems SEPA (Scottish Environmental Protection Agency) were contacted and interviewed about this particular issue. SEPA have responded as follows:

"Any cremation of the remains of a foetus, stillborn or neonatal baby should, in accordance with Process Guidance Note 5/2 (12), take place in a small-scale cremator. Where this is not available, it is permissible under the permit to cremate the remains in a full size cremator if all the permit conditions are complied with.

If any cremation of a foetus, stillborn child or neonatal baby takes place in Edinburgh overnight, the permit does not allow the secondary chamber or the monitoring equipment to be switched off as per the conditions of the permit. It is necessary for the temperature in the secondary combustion chamber to be monitored to ensure it remains above 800/850 degrees. The crematorium would need to be manned to ensure the conditions of the permit are complied with.

However, given the very small size of the remains of a foetus, stillborn or neonatal baby, and the subsequent negligible environmental impact, SEPA may consider varying the permit to allow the cremation of these remains to occur without some of the requirements for an adult cremation. For example, it may be possible to switch off the burners during the cremation to assist in achieving remains. Other requirements such as maintaining oxygen levels and continuous monitoring for certain parameters may also be discounted. However maintaining the temperature above 800/850 degrees in the secondary combustion chamber throughout the
cremation would still be required. Until such time as the permit is varied to include these revised derogations, all conditions should be complied with. If changes are sought to the permit, the operator should contact SEPA in the first instance.”

If the City of Edinburgh Council wishes to continue the practice of overnight cremation, steps must be taken to ensure compliance with the terms of its Permit or for the Permit to be modified by SEPA.

12. HEALTH AND SAFETY AT WORK ISSUES

As with environmental issues, what can be achieved safely in the Crematorium is also regulated by law. For health and safety at work purposes, the operations at Mortonhall Crematorium are covered by the provisions of the Health and Safety at Work etc. Act 1974. Sections 2(1) and 2(2) deal with duties which employers have to their employees to ensure, so far as reasonably practicable, their health, safety and welfare at work.

If staff are not properly trained, deployed and certain of their own personal safety in carrying out their duties there will be little to motivate them to carry out practices which seem objectively hazardous to any reasonable observer.

The City of Edinburgh Council has clear, statutory obligations to its employees at Mortonhall Crematorium by virtue of the 1974 Act.

According to George Bell, the Bereavement Services Manager, a metal tray was used routinely at Mortonhall to contain infant coffins and remains during the cremation process until the early 1980s. Again according to George Bell, an operator was burned in the early 1980s while handling the tray and the practice was discontinued on his instructions because of his concern for staff safety. There are no records or other information as to when this happened or how.

Other members of staff who commenced employment in the early 1990s recollect the tray being in use then and withdrawn by Mr. Bell for safety reasons. There is therefore some conflict in the evidence of the employees about when this procedure was halted.

Whenever this happened, it would suggest that the system of work employed might have been unsafe. The Council, had it wished to continue use of the tray, would have an obligation to ensure, so far as reasonably practicable, that a safe system of work was in place to avoid the risk of injury to employees. That might have been achieved by ensuring that systems in place were fit for purpose and properly monitored or by putting different systems in place.

There are no records to say whether a risk assessment was carried out at any stage about the safe handling of the tray or whether any efforts were made to find a safer working system that could achieve the same objective.
Mr. Bell has said that the use of the tray was discontinued after a risk assessment was carried out along with a health and safety officer from the Council. The cremation of babies and foetuses continued, without a tray, until it was reintroduced at some time after May 2011 on the instructions of the new Bereavement Services Manager, Charlie Holt.

Since then ashes have been recovered in all but two cremations of babies. On 26 September 2013, a general risk assessment on infant cremation using a tray was produced following communication of my concerns to the Management team there. During the Investigation a number of former and current members of staff expressed misgivings about the safety of the procedures then in place. A new safety protocol has now been produced.

Given the very significant improvement in the prospects of achieving the recovery of ashes when a tray is deployed, the failure to investigate fully a safe alternative system of work at the time of its withdrawal, and ever since, is remarkable. The new safety protocol is straightforward and uncomplicated.

A tray was being used safely at Seafield and elsewhere in the UK for many years. It is therefore also of concern that the abandonment of this method of recovering ashes was not accompanied by any active investigation to determine how Mortonhall Crematorium might be able to continue to provide ashes from foetuses and babies.

The explanation may arise, in part, from the belief on the part of both Mrs. Grannum and Mr. Bell that there were no bones to be recovered from such cremations and as such any ashes were not proper remains. A more proactive focus on the quality of service to parents could have allowed ashes to be recovered safely for the benefit of next of kin. Instead, the parents of so many of these babies have been denied that opportunity at Mortonhall over many years.

13. ARE THERE ASHES FOLLOWING THE CREMATION OF FOETUSES AND BABIES?

There is overwhelming evidence that foetal bones do survive cremation, at least from 17 weeks gestation.

It is recommended that the City of Edinburgh Council takes urgent steps to communicate the evidence obtained from this Investigation to the Scottish Government, to the NHS, the FBCA, ICCM, Funeral Directors’ Associations and crematoria staff at Mortonhall. This information has also been passed to Lord Bonomy for its wider implications for the Infant Cremation Commission.

Detailed study of this issue should have been carried out many years ago and instead there has been a somewhat casual reliance on received wisdom from those engaged in practice, a reliance also followed in good faith by the Scottish Government and many medical and midwifery practitioners.
Despite the very successful recovery of ashes from the cremated remains of foetuses, stillborn and neonatal infants at the crematoria at Seafield and Warriston over many years, there had been no approach by any other crematoria or professional organisation to test or learn from what was happening there. This is inexplicable.

As far back as 2004 the Medical Referee at Hull Crematorium, Dr. James Dunlop, also published an article describing the modified process of cremation carried out at Hull Crematorium, a process very similar to that carried out at Seafield and Warriston Crematoria. He confirmed that bony cremated remains could be recovered if particular care was taken and certain modifications of practice introduced.

There can be little doubt that there has been inertia over many years on the part of senior management at Mortonhall in their continuing failure to investigate why their close neighbours at Seafield and Warriston were claiming to be successful at recovering remains when Mortonhall’s operational management claimed to be unable to provide a reliable service of recovery of ashes.

Commercial sensitivities could have been readily overcome by a formal representation to FBCA or ICCM or by the intervention of more senior levels of management. Likewise, it is surprising that the professional organisations did not carry out a study of what was happening there to ensure continuous improvement and best practice elsewhere.

The service provided for the cremation of babies at Seafield and Warriston is exemplary. The culture of care and attention in each of these crematoria is aimed at achieving the gentle and modified practice of cremation of babies.

The practices there should be considered urgently by the City of Edinburgh Council and by all others involved in this most sensitive aspect of their duties.

Most importantly, it is not simply the cremation process at Seafield that demonstrates best practice. The culture of utmost care and attention to the needs of parents is evident in all aspects of the service. Jane Darby, the Superintendent there, should be praised for the difficult and sensitive work she carries out with evident compassion and skill.

It is recommended that the City of Edinburgh Council urge the FBCA, ICCM and other associations representing Crematoria or their staff to instigate an immediate review of policy and practice underpinned by a greater understanding than that survival of foetal bones depends on gestational age alone. As Dr Roberts concludes in her report, there are clearly more factors involved, the key factors being methods of both cremation and recovery of remains.

Senior Management at the City of Edinburgh Council should also conduct an immediate review of the policies and practices affecting those foetuses and
infants to be cremated at Mortonhall. This review should ensure adequate training is now provided to all staff to allow a full understanding of these issues rather than relying on the informal system of received wisdom that has misinformed countless staff over many years.

14. GOVERNMENT POLICY AND GUIDANCE

It is recommended that the Scottish Government should make clear by legislative provision the obligations and rights relating to the burial and cremation of non-viable foetuses and stillborn babies. Such legislation is necessary to ensure that the misunderstandings and lack of adequate service to next of kin is not fostered by an absence of clarity in the law or of any law at all. Legislation should set out clearly the obligations of the professionals and make explicit definitions of terminology that are currently open to widespread confusion and uncertainty.

Similarly, where Government guidance is given about the subject of ashes, the guidance should be informed by scientific or medical expert evidence or research. Such experience, with notable exceptions, has lacked evidence of motivation, innovation or a sustained determination to improve the quality of service to vulnerable next of kin in the provision of this sensitive, specialised but unprofitable area of crematorium business.

It is recommended that the City of Edinburgh Council make strong representations for these changes to be made in order to assist the Council in the discharge of its duties and responsibilities.

15. HEALTHBOARD GUIDANCE AND PRACTICE

Those NHS Lothian employees who are, or will be, in the position of providing advice and guidance to parents on the last act of care should be fully trained and aware of the basis for their advice and the legal implications for next of kin of the advice they provide.

There is an urgent need to develop clear and simplified policy and guidance based on better researched material for staff. Staff need to have the opportunity to be properly trained in dealing with the difficult circumstances of such a loss and of the limitations of parents' ability to make quick decisions when they may be in a state of profound shock and grief.

The presentation of such guidance to parents needs to be set out in different formats to take into account the impact of the grief on their ability to absorb information given on one occasion. Most importantly, parents must be given the time and space to make their decision, a decision that was far from what they were expecting from life at that time and a decision
for mothers who may be in a state of physical pain, grief and exhaustion when asked to make such decisions.

NHS Lothian are currently reviewing guidance for staff and parents and attempting to simplify and improve the way information is presented and conveyed to parents.

Many fine policies are however produced but not implemented. As mentioned above, the introduction of mandatory training for midwives on this highly sensitive issue should be considered. The introduction of formal joint training with those other professionals dealing with these losses should also be used to enhance understanding of the processes and procedures, while improving knowledge of the other's obligations and constraints.

These recommendations should be discussed and addressed by the City of Edinburgh Council with NHS Lothian and with those Funeral Directors providing the service to parents and to Mortonhall. The Infant Cremation Commission will consider the wider, national implications.

16. PROFESSIONAL ORGANISATIONS

The guidance, training, seminars and publications made by the Federation of Cremation Authorities (FBCA) and the Institute of Cemetery and Cremation Management (ICCM) have immense significance for professional development and improvement of the quality of service for the bereaved at Mortonhall and elsewhere.

The differences in approach by each of these organisations to certain core issues has not helped the development of best practice in the sensitive, challenging but unprofitable service for the cremation of non-viable foetuses, stillborn and neonatal babies.

The absence over many years of any formal training modules by either organisation on best practice in the cremation of such babies is telling. Likewise, discussion among professionals in their publications is very sparse with just two articles made available to the Investigation. There was no evidence of any sponsored research or literature reviews on the matter. Instead, cremator operators relied on the received wisdom of their managers or peers.

There was evidence of some very professional and caring working practices in other crematoria, including at Seafield and Warriston in Edinburgh.

It is recommended that the City of Edinburgh Council ask the FBCA and ICCM jointly to review and set up interim guidance on best practice in the cremation processes and working practices involved in the cremation of these babies and to establish formal and consistent training of staff in safe
and effective practices. These interim measures should be put in place until appropriate research has been completed to inform longer term practices and equipment needs.

Given the evidence obtained during this Investigation about the lack of understanding of how the cremation process affects the remains of foetuses, stillborn and neonatal babies and concerns about the safety and lawfulness of the manner in which current guidance has been interpreted at Mortonhall, both the ICCM and FBCA may now wish to develop specialist training programmes on the subject of infant cremation. This should be a compulsory component of training for all members of both professional organisations.

17. COMMUNICATION

It was clear from the information provided to the Investigation by NHS staff that many staff were not well informed about the basis of the advice they gave to parents and that much of that advice was simply gleaned from predecessors or colleagues. Even written guidance was inaccurate and misleading in some respects. NHS staff often had to provide advice under great pressure from other duties and some midwifery staff did not appreciate that there was written guidance for staff to the effect that parents should be given ample time to consider the options.

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 at Mortonhall. Where there had been contact between the parents and the Funeral Director about the Application for Cremation (Form A), parents received similar advice from the Funeral Director but usually only in circumstances where the parent raised the issue.

Funeral Directors, having been advised that there would be no ashes from Mortonhall very often failed to complete the section of the Form A dealing with the instructions for the desired means of disposing of any ashes following the cremation. This section was simply left blank.

No one appeared to appreciate nor advise parents of the legal implications of agreeing to the hospital taking over the arrangements for the funeral. The Investigation found no evidence of anyone communicating to parents that by permitting the hospital to organise the cremation, they were making the Applicant for the funeral the Funeral Director.

The parents were inadvertently induced in many cases to hand over their right to give instructions for disposal of any ashes. It is unlikely that the hospitals or the Funeral Directors recognised the legal consequences of the Applicant being the Funeral Director. This highlights the lack of any meaningful joint training about this very sensitive matter.
Some parents said that the subject of ashes was not raised by anyone until they made enquiry with the Crematorium after the cremation had taken place. With one exception, parents had no recollection of being told about the options of cremation at the private Seafield or Warriston Crematoria should they have wished to obtain ashes. The written guidance at Simpson's Maternity Hospital wrongly suggested that parents may need to pay for these costs themselves. In fact the services there were free to parents.

The completion of the Application for Cremation is the most important aspect of communication of the instructions of the parents. Many parents had never seen the form. Others, who had opted out of the hospital arranged cremation, told the Investigation they had signed the form but that it had been completed by the Funeral Director.

Like the hospital staff, some Funeral Directors believed there would be no remains from the cremation of a non-viable, stillborn or neonatal baby at Mortonhall and so it was considered there was no need to raise the issue with parents. Where parents were not present at the Funeral Director's premises they were completely unaware that the Funeral Director was completing and signing the form as Applicant from information provided by the hospital over the telephone or from a hospital form, without any reference to ashes or the wishes of parents.

In those cases where the parents arranged the cremation for themselves they told the Investigation that the Funeral Director advised them that there would be no ashes. The Instructions for Funeral Directors issued by the Federation of Burial and Cremation Authorities (FBCA) in 2006 stated that:

“In cases where bereaved parents desire the cremation of an infant or foetal remains, they should be warned that there are occasions when no tangible remains are left after the cremation process has been completed. This is due to the cartilaginous nature of the bone structure.

If the warning is not given the parents may have been denied the choice of earth burial and thereby subjected to understandable distress.”

Funeral Directors should warn parents of infant or foetal babies that there are occasions when no tangible remains are left after the cremation process.

Funeral Directors also understood that there were no remains in such cases at Mortonhall. A number of parents received no such warning. One Funeral Director explained that unless the parents raised the issue of ashes she would not mention the subject of ashes to parents.

In short, the whole process of communication about cremation for bereaved parents in this Investigation with both NHS staff and Funeral Directors was generally unsatisfactory and muddled. It inadvertently deprived many
vulnerable parents of their legal rights and of the opportunity to make informed decisions over a reasonable period of time.

It is clear that in some cases the question of ashes was not addressed with parents by any of the professional bodies and where it was addressed, it was based on the received wisdom that "you don't get ashes from babies." While Mortonhall was the source of this understanding by NHS Staff there were inadequate steps taken by the NHS to address fully the options of Seafield or Warriston Crematoria where ashes could be recovered for parents.

There is no evidence of this received wisdom being challenged by anyone other than parents of the babies and two cremator operators at Mortonhall, Paul Jackson and Hazel Strachan. This changed when the new manager Charlie Holt took over in May 2011. The long history of the failure to challenge this presumption is all the more surprising when two other crematoria in Edinburgh, Seafield and Warriston, were recovering ashes from foetuses and babies and returning them to parents.

There was a general lack of rigour in communication methods used among the agencies concerned. A reliance on verbal communication was not backed up consistently by printed confirmation. This was particularly evident between the Funeral Directors and the crematorium staff.

Throughout this Investigation it became clear that different terms are used which cause confusion. For example, in the context of disposal of ashes the words “disperse”; “inter”; “strew” and “scatter” mean different things to different people. Most parents interviewed believed that the word “disperse” meant “scatter” whereas at Mortonhall “disperse” is used to mean “inter.” It would be helpful for a consistent glossary of terms to be produced among the agencies to ensure a common understanding.

It is recommended that important communication of these matters should be carried out on a more formal basis.

Changes have already been made since the Investigation began and new forms and information booklets are being introduced by the NHS with more explicit advice about choices for parents in the final act of care. The application form, Form A, has also had some minor adjustments and is now completed by the spiritual and pastoral care team at the hospital with parents present rather than by Funeral Directors.

It is recommended that all parents should be advised of the importance of this form and they, or their executors should, where possible, see and sign it, even if the hospital is arranging the funeral. Parents must also be made aware of the legal implications of asking the hospital to arrange the cremation and that if the Funeral Director signs the Form A application as Applicant, it is the Funeral Director and not the parent to whom the crematorium will seek instructions on the disposal of any ashes.
Formal joint training based on reliable advice and guidance should be produced for all those involved in this most sensitive of responsibilities and such training should be mandatory.

18. MORTONHALL CREMATORIUM

It is remarkable that in all the years since the general use of the metal tray to contain ashes was withdrawn at Mortonhall, only two employees agitated for change. These two employees sought to improve the prospect of gaining ashes. Similarly, the lack of curiosity at Mortonhall about what was happening at Seafield and Warriston Crematoria resulting in the consistent recovery of ashes for foetuses and babies there is also astonishing.

The apparent absence of curiosity may well be a consequence of the style of leadership over many years. Anne Grannum, the Superintendent until 2011, was described consistently by staff as utterly devoted to her job but wholly consumed by efficiency and averse to change or suggestions for change. She was perceived as demonstrating little compassion by many of the parents we interviewed and by several members of staff at Mortonhall who were clearly inhibited by what they considered to be an unapproachable and rigid style of management.

Anne Grannum told the Investigation she had always believed there were no ashes from babies. She was not alone in that belief. Her belief was based on the assertion that ashes were the calcined bones of the cremated individual and nothing else. Any residual remains from the process at Mortonhall were in her view simply refractory dust, metals and coffin ash.

Based on that understanding, which appeared to be shared by Mr. Bell, there was no sustained effort to secure a more effective way of recovering ashes for parents at Mortonhall from the cremation of non-viable foetuses, stillborn and neonatal babies. However, given that Anne Grannum and George Bell told the Investigation of how consistently unsuccessful the overnight cremation process had been at Mortonhall over many years, it begs the question why then did they continue year after year with the same overnight process of cremation using the residual heat from the adult cremations earlier in the day.

The view of several employees, which I accept, is that, until recently, this was not an effort at Mortonhall which was principally motivated by the objective of obtaining ashes from babies but an expedience which prevented the interruption of the adult cremations during the working day and which required minimal devotion of resources to be diverted to supervise the process.

It may have given the cosmetic appearance of an effort to obtain ashes but the results over many years, according to Anne Grannum and George Bell, were that no ashes, as defined by them, were obtained, save in one instance where Julie Wilson presented bones to Anne Grannum. Mr. Bell was unaware of this instance. Mrs. Grannum wholly denies the accounts given by Paul Jackson and Hazel
Strachan of seeing bones from foetal cremations on a number of other occasions. Mrs. Grannum said she was never shown bones or ashes or told about them by these employees.

Anne Grannum was, according to a number of the employees there, so dedicated to her job that she rarely took holidays and was “always there”. She was also ordinarily the individual who switched on the cremators early in the mornings. She was almost always the first to arrive. Two retired members of staff described that on the occasions she was not there, they would do what they understood was always the practice, of not opening the cremator door but simply switching the cremator on for the day.

Even though Mrs. Grannum disputes the evidence of Paul Jackson and Hazel Strachan, which I found to be reliable and credible, her acceptance of the description of the instance when the cremator operator Julie Wilson presented bones from the cremation of a baby to her is at odds with the rest of the information she provided to the Investigation.

Given her stated, firm, belief that there were no bones to be recovered, the presentation to her of such bones might be a situation which would have caused her to question her understanding of whether bones could be recovered from the cremation of babies. Likewise, such an incident might also be thought of as of such significance that she would communicate the event to her superiors. She did not. George Bell states he was unaware of any bones being recovered and shown to Anne Grannum.

The explanation she gave to parents on occasion that ashes could not be guaranteed at Mortonhall, sits uneasily with her explanation to the Investigation of a continuing, unqualified belief that bones/ashes could not be obtained. That belief is also difficult to reconcile with her description of the allegedly futile, continuous and unsuccessful attempts at Mortonhall to achieve ashes from babies by overnight cremation year after year. Attempts which ran contrary to her own account of a belief that there were no ashes to recover from foetuses.

Mrs. Grannum’s failure to make any enquiry about what was happening at Seafield Crematorium over many years, where she understood it was said ashes were being recovered, is also very difficult to understand. As business competitors it may have been seen as inappropriate to make a direct approach to Seafield but the matter could have been referred to her senior managers or to one of the professional organisations to pursue.

She was not alone in this apparent inertia. NHS staff and Funeral Directors, amongst others, were all aware of the assertions by the staff at Seafield Crematorium that they were recovering ashes yet no one investigated these claims until the writer Lesley Winton visited Seafield in 2012.

Mr. Bell visited Seafield as an examiner but even then did not appear to have obtained an explanation. He did not probe or question the assertions made at Seafield and Warriston about their success in recovering ashes, including bones,
but did observe they had a modern single-ended cremator unlike the double-ended cremators at Mortonhall:

“I recall discussion at a staff meeting where we discussed Seafield Crematorium recovering ashes. I didn’t think of going to Seafield as I had no remit or authority to inspect their crematorium. It didn’t occur to me at the time that they might have had different equipment.

I only learnt later when conducting a Cremator Technician’s exam at Seafield that they were using a modern single-ended Cremator. Therefore the chances of recovering ashes were greater. There was a lot of competition between the 3 crematoria in Edinburgh and Mortonhall is a very successful business for the Council. In 2009 Mortonhall did 3000 cremations and Warriston did 1800.”

Mr. Bell and Mrs. Grannum both also told the Investigation that they had discussed the possibility of getting a baby cremator but having raised the issue verbally with his managers Mr. Bell states the Council had said it was not financially viable, that their operation had been unsuccessful in one instance of which he was aware and that because the crematorium was listed as a Grade A building it would not be possible to get planning permission. There is no record of these discussions.

Looking at the evidence of the employees at Mortonhall overall, they appear to be, and to have been, a dedicated and hard working group of individuals who followed the practices and beliefs handed down from their very experienced Superintendent and Bereavement Services Manager. The role of cremator operator is extraordinarily challenging and from my observations of cremations and interviews with staff at Mortonhall I gained the impression of people who genuinely cared about what they did.

Both George Bell and Anne Grannum were well respected and dedicated staff but there appears to have been a complete lack of a sustained or any genuine interest in achieving or improving the prospects of recovery of ashes from the cremation of infants and foetuses.

In the early 1990s the NHS representative at Simpsons Memorial Maternity Hospital asked the crematorium to find ways of reducing the already modest fee paid by the NHS to Mortonhall for each baby cremated at the crematorium. Mr. Bell said he was also approached by the local NHS representative to consider communal cremations of non-viable foetuses. Mr. Bell stated he resisted the latter requests until the practice received UK wide approval by the FBCA (Federation of Burial and Cremation Authorities) in August 2001. Records at Mortonhall indicate that this practice actually started in July 2000.

Mortonhall had no obligation in law whatsoever to cremate non–viable foetuses. But they did. They did so when other crematoria declined. The suggestion, however, that their working practices were genuinely designed to achieve ashes from foetuses, stillborn and neonatal babies in the face of, apparent, routine
failure over many years is a difficult assertion to treat as either logical or sensible.

Several of the employees and former employees at Mortonhall speak to the recovery of baby bones from the cremation process and others who, at the very least, saw ashes which they considered were likely to be coffin ash or refractory dust. In none of these instances was there any evidence to demonstrate the remains were returned to parents. Instead, Mrs. Grannum said they should be interred in the Garden of Remembrance.

Julie Roberts, the Forensic Anthropologist engaged by the Investigation to examine the evidence in this matter has stated that the presence of foetal bones among the ashes of a cremated non-viable foetus, even in a metal tray is not easy to ascertain:

“Expertise in foetal skeletal anatomy and interpretation of burnt remains was required to identify the individual bones and bone residue. Untrained or inexperienced staff might find this difficult, particularly in the case of a young foetus.”

The possibility of identifying the very small bones of foetuses and stillborn babies could also have been rendered less likely where the baby was cremated in Mortonhall in a double-ended cremator which was raked in red hot conditions across the full length of the hearth and when visibility was very poor. The very delicate and small bones could be damaged and further dispersed by the raking process. The absence of a tray to help contain these ashes and avoid the need for raking further aggravated the situation.

In such circumstances the prospects of recovering or recognising discernible cremated remains from non-viable foetuses, stillborn and neonatal babies was much reduced. That does not mean, however, that the ashes did not exist or could not have been recovered consistently if greater care had been taken to modify the process, as in Seafield, or as in some other crematoria where the use of a baby or infant cremator had been introduced.

If the small quantities of ashes produced from non viable foetuses, stillborn and neonatal babies were not recognised as ashes by Anne Grannum and therefore left in the primary chamber when the equipment was switched on by her or another employee each morning, the prospects of discovering the possible location of the disposal of any remains of these babies become grim.

When the cremator operators arrived in the morning to see the equipment already switched on by Anne Grannum and they charged the cremator with the first deceased adult, it is likely that some of the delicate remains of the baby from the overnight cremation would be mixed in with the remains of the first adult to be cremated that morning.

Both Bill Stewart and George Scott, retired cremator operators from Mortonhall, confirmed that it was their understanding that the door was not opened in the
morning after an overnight baby cremation until the first deceased adult was placed into the primary chamber. The cremator was simply switched on. This is what they did when Anne Grannum was on leave and understood to be the normal practice.

Additionally, some of the remains of the baby and the baby’s coffin could be blown into the secondary chamber with the gases, or into the flues, along with some of the ashes from the cremation of the adult. This likelihood was reinforced by the information provided by Bill Stewart, George Scott, Paul Jackson, Hazel Strachan and the expert witness, Dr Clive Chamberlain.

Some of the ashes that enter the flue would have travelled up and out into the external atmosphere but there were also quantities of ash which became trapped in the secondary chamber and in the flue. These areas of the cremator were hoovered regularly at Mortonhall and the contents would be vacuumed from these areas of the cremator into hoover bags. According to Anne Grannum,

“The cremators are designed for adult cremations and not NVFs. Metals are taken out and buried in a separate area of the Garden of Remembrance. Ash from the coffin mostly disappears up the flue – when the flues and cremators are cleaned out and hoovered everything is placed in bags and interred in a separate area designated by the Council adjacent to the skip. Only cremated remains are buried in the Garden of Remembrance.”

In light of Anne Grannum’s view that any residue from the cremation of foetuses and neonatal babies was not cremated bone and therefore not human remains, then the residue found in the secondary chamber and flue would not, in her belief, be ashes.

For those babies where, on occasion, the staff actively recovered ashes and placed them in ad hoc envelopes there is, on the balance of probabilities, the likelihood that these ashes were interred in the main Garden of Remembrance in a proper lair. It is not however possible to say which babies these were because of the uncertainty of the dates on which staff can recollect seeing these remains.

There are only a very small number of cremations where it can be said with any certainty that the disposal is clear. This is in the very few cases where ashes were returned to parents. Anne Grannum was not the signatory on any of the cremation cards in these particular cases. In one of these cases the cremation was carried out during the day. It is unknown at what time the other two babies were cremated. The fact that ashes were returned to parents in these very few cases did not appear to influence the normal working practices followed for the cremation of babies.

If Mr. Bell and Mrs. Grannum did not believe these remains to be from the baby or foetus, it also begs the question what did they consider was being handed over to the parents in such instances.
There is complete inconsistency in the rationale deployed by management at Mortonhall to explain why ashes were not provided to parents at Mortonhall and many significant variations and discrepancies exist in and between the accounts given by staff over a number of years. Other crematoria using the same working practices as Mortonhall were recovering ashes for the bereaved parents.

The contrast between the working practices and the approach to the cremation of babies at Mortonhall with the approach at Seafield and Warriston is stark. The obvious care taken at Seafield and Warriston to provide the very best possible outcome for the parents of the foetus or baby is exceptional. As a consequence of misunderstanding and poor advice in the NHS leaflets, many parents were led to believe that there would be a charge made for a funeral at these private crematoria where ashes were being recovered for parents. Neither of these crematoria have ever charged parents for such cremations.

The great tragedy of the outcome of the vast majority of baby cremations at Mortonhall is that so many parents were told there would be, and were, no remains following the cremation of their baby. They accepted those explanations in good faith.

It is only since the appointment of Charlie Holt as Bereavement Services Manager in May 2011 that the culture at Mortonhall began to change and serious and successful attempts were made to recover ashes from these babies. This included the reintroduction of the metal tray to contain the ashes of the baby.

Following the discovery in 2012 by Dorothy Maitland of the inconsistent entry about her baby daughter in the Register, the circumstances leading to this Investigation came to light. At that point in time a number of parents were shown to the Garden of Remembrance by Mortonhall staff and were given information about where their baby was likely to be.

Crude steps were taken by staff at Mortonhall to mark out on the grass with spray paint the locations of lairs corresponding with the date of alleged interment there. Since that time many of the parents have suffered tremendous distress. Many did not wish their child to be interred at Mortonhall while others were relieved to find that they may now have a focal point for their continuing grief.

The outcome of this Investigation will cause more pain and distress for most of the parents of the 253 babies who are the subject of this Investigation: It cannot be said with any certainty what remains of which babies are interred in the Garden of Remembrance. The precise extent to which remains of babies have been mixed in with an adult cremation that followed the baby’s cremation is also unknown but appears likely to be extensive. The presence of ashes of an adult from a previous cremation can be seen during the subsequent cremation of another adult in the photograph at Production 9-39.
The quantities of ash would be very much smaller for a foetus or baby and therefore difficult to see, rake and recover across the length of the hearth. Neither can it be said with any certainty the number of times where the remains or part of the remains have been trapped in the secondary chamber or flue and then buried in the strip of land adjacent to the Garden of Remembrance. (Photographs at production 9-79, 9-81, 9-79) Similarly, many of the remains may have been perceived, wrongly, as refractory dust and coffin ash and cleaned out into bags or the containers for metals and interred in the same strip of land.

19. OVERNIGHT CREMATION

Although overnight cremation has persisted as the method of cremation for foetuses, stillborn and infant babies at Mortonhall, its efficacy in producing the best possible outcome in terms of recovered remains has been less certain in the absence of the use of a metal tray to help confine the very delicate ashes,

On the longstanding practice at Mortonhall of overnight cremation of foetuses and babies Mr. Bell explained:

“Up until 1994 there was no legislation covering pollution from a crematorium but since then SEPA (Scottish Environmental Protection Agency) issues permits and you are compelled to operate at minimum temperatures – 800 degrees Celsius if abated, 850 degrees Celsius unabated. It would be a breach of your licence to charge a coffin at a lower temperature. The secondary chamber must always be at the minimum temperature. There is no dispensation to permit cremating a coffin containing foetal or baby remains at a lower temperature. Crematoria submit six monthly reports to SEPA to show minimum, average and maximum temperatures. This also applies to private crematoria.”

This description of the regulatory framework by Mr. Bell is correct but as SEPA explain (see Section 2.6 of this Report), the terms of the permit also extend to overnight cremation, rendering the practice at Mortonhall unlawful unless the permit terms are varied and the minimum permitted temperature of the secondary chamber maintained and monitored.

As mentioned above, it is recommended that immediate steps are taken to request the Scottish Government to commission research to find the most effective, and safest method of lawful recovery of the remains of non-viable foetuses, stillborn and neonatal babies for the future. Such research should take into account the restrictions imposed for environmental reasons.

20. INTERMENT OF ASHES

Assertions have been made in the media of a mass grave of babies at Mortonhall.
The term “mass grave” has a very sinister connotation. During the course of the Investigation I visited Mortonhall Crematorium on several occasions. During the first visit the groundsman showed me how ashes from the crematorium are interred in a collective lair in the Garden of Remembrance. Each set of ashes is placed in an individual container and interred in a large lair in the ground along with hundreds of other containers until the lair is filled and grassed over.  

Until this matter came to the attention of the media in December 2012 the remains of some babies and infants were interred in the same lairs as adults. That has now changed and a special lair has been created to contain only the ashes of babies. According to generations of managers and staff, ashes have never been scattered at Mortonhall. The word “dispersed” at Mortonhall is used to describe interment. Apart from a small number of upright private niches and individual graves, there are, in general, no markings indicating where any particular deceased’s cremated remains are interred at Mortonhall.

Accordingly, where foetuses, stillborn or neonatal babies or infants were interred in the Garden of Remembrance at Mortonhall it is correct to say that the ashes of some babies and foetuses were interred in a collective grave in precisely the same way as deceased adults were and are. Groundsmen at Mortonhall are able to identify the approximate areas of interment according to the year of interment from 1982 onwards.

**It is recommended that the location of the interment of the cremated remains of a baby should always be recorded with their records.**

Likewise, where remains were hoovered from the secondary chamber or flue of the cremator or cleaned out with the metals on the understanding these were refractory dust or coffin ash from the process, these were conveyed to a common “lair” but in an area of ground adjacent to the Garden of Remembrance next to skips and tractors. The appearance of this ground was wholly inappropriate for the solemnity and decency of interment.

**20. LAND ADJACENT TO THE GARDEN OF REMEMBRANCE**

This ground was undulating, as if there had been several holes or lairs dug and covered up with turf over a period of time. Over one large and deep open hole next to some trees there was some rough decking, placed loosely. I understood this piece of land to be that described by Mr. Bell as the “land adjacent to the Garden of Remembrance”. It was in such a condition that it was clearly not part of the Garden of Remembrance.  

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100 Productions 9-70 and 9-71
101 Production 9-84
Anne Grannum had been employed in an administrative capacity from 1981 to 1996 and became the Superintendent of the Crematorium in 1996. She explained during the Investigation that:

“Metals are taken out and buried in a separate area of the Garden of Remembrance. Ash from the coffin mostly disappears up the flue – when the flues and cremators are cleaned out and hoovered everything is placed in bags and interred in a separate area designated by the Council adjacent to the skip. Only cremated remains are buried in the Garden of Remembrance.”

Since Mrs. Grannum told the Investigation that she understood there were no ashes from babies or foetuses, any residue from the cremation would, in her opinion, be refractory dust or coffin ash which, if it remained following the cremation would be hoovered and the hoover bag placed with the metals in the land adjacent to the Garden of Remembrance.

Contrary to her expressed belief, according to the expert witness Dr Roberts, the so called refractory dust or coffin ash may well have contained the tiny bones of foetal, stillborn or neonatal babies. It is also likely that some of the ashes of these babies will have been mixed in with the next adult to be cremated the following morning or hoovered up and interred in the land adjacent to the Garden of Remembrance along with the metal residue from the cremation.

Essentially, this means that some of the remains were not interred in the Garden of Remembrance but interred in a place that would not be considered by any objective observer as a decent area for the interment of remains. (See Annex I of this Report.)

It is recommended that consideration should be given to consulting parents about whether, and if so, how this land can be developed into a dignified memorial to the babies whose remains may be interred there, if that is considered appropriate and desired by those parents. Alternatively or additionally, a suitable memorial should be created elsewhere given the feelings of many of the parents towards Mortonhall.

21. RECORD KEEPING AT MORTONHALL

Form A – THE STATUTORY APPLICATION FORM

The apparent casualness with which this formal statutory application has been completed in the many cases involved in this Investigation has been based on an understanding by the Funeral Directors in the Edinburgh and Lothians area that ashes would not be recovered from a cremation of a baby at Mortonhall. This was an understanding that was also widespread among NHS staff and other Funeral Directors over many years and encouraged by the acceptance by Mortonhall of Forms submitted with this section of the form left blank.
The presumption that ashes would not be recovered does not, however, explain the number of forms where the word “disperse” appears on the form at this section and why next of kin in those cases did not have their attention drawn formally to the professionals’ understanding about the prospects of obtaining ashes at Mortonhall. On only a very few number of Form A applications do the words “disperse, if available” appear.

**Cremation Cards – THE RECORD OF THE CREMATION**

The Investigation was informed that cremation cards are always and have always been completed before the cremation takes place. We were also told by Jamie Reece, Crematorium Manager at Mortonhall that the description of the disposal method on the card is therefore an intention or prediction of what the author of the card considers is going to happen and not a confirmed outcome.

Accordingly, what appears to be a record since it is recorded in the past tense, is not. It is, instead, a prediction that with the rare exceptions when ashes were retained for parents was therefore almost universally inaccurate; an inaccuracy which was repeated over many years and compounded by being copied and repeated in the formal Register. It is wholly misleading that this section was completed in the past tense as if it was a final outcome that was being recorded. There was no evidence of any occasions in the cases examined before 2012 when anyone altered or revised the “prediction” following the completion of the cremation.

**Statutory Register of Cremations**

The statutory term for the Register is Form G. Cremations of adults, children, babies and stillborn babies are all recorded in the Register. However, babies born before 24 weeks (or before 28 weeks up to 1 October 1992) are not recorded in the Register. There is no legal requirement to keep any record of cremation of these non-viable foetuses. A non-statutory Register has been kept at Mortonhall since 1993 (see below).

The Investigation found one case where this general rule was not applied. In 1991 a baby recorded as 23 weeks gestation was given a cremation number and registered in the main Cremation Register. The mother of this baby confirmed that she had been told at the hospital that her baby was classed legally as a “miscarriage.” The Investigation found no explanation for this non-viable baby being included in the Statutory Cremation Register.

Information for the Register was taken by administrative staff at the Crematorium from hospital forms, the Form A and the Cremation card and typed into the Register by administrative staff at the crematorium. Given that none of these documents was actually a record of the outcome of the cremation and all had been completed before the cremation took place, the Register was not
therefore completed using any document that was an actual record of what had happened.

The Investigation has not received any account from any member of staff at Mortonhall to explain how the Register could be completed accurately when none of the sources of documentation used by them to complete the Statutory Register provide any actual record of the outcome of the cremation.

As there was no statutory provision to regulate the cremation of non-viable foetuses there would be no obligation to complete a Form A or a Cremation Card and the cremation would not be entered in the Register. Since 1993 the cremation of non-viable foetuses has however been recorded by hand in a ledger book but this does not include any information on the disposal of any remains.

Since hospital records, the Form A application or the Cremation Card were not a record of the outcome of the cremation there was no written, formal source of information of which this Investigation has been made aware or discovered to allow the Register to be completed as a true and accurate record of the cremation process for stillborn or neonatal babies. As such, the statutory Register cannot be relied on unless there is extraneous, independent evidence to support the accuracy of the entry.

The Investigation found there were no incidents of babies or stillborn baby cremations recorded as “no remains” in the manual Register before the introduction of BACAS in June 2000. This is in stark contrast to the computerised Register from June 2000 – May 2011 when almost all disposal methods are recorded as “no remains.”

There is no reasonable explanation for not recording “no remains” in the manual Cremation Register if that was in fact the position. The Register could easily have been printed with all of these options, including no remains.

The phrase “Interred in the Garden of Rest” where it appears in the manual Register cannot be considered a reliable record about the actual outcome for the remains of these babies. I have not received any reasonable explanation from anyone interviewed during this Investigation to properly explain or mitigate this state of affairs.

**From June 2000 – BACAS**

BACAS is the name of the computer system used at Mortonhall. The system was installed at Mortonhall in June 2000 and replaced the manual Cremation Register referred to above. Crematorium staff enter information from the Form A Application for Cremation onto this system.

The BACAS computer system was installed and came into operation in June 2000. As there was no change of cremation equipment or working practices at that time, there was no immediate explanation for a change in the likelihood of
recovery of ashes. The disposal section of the Register recording the cremation of babies however changed immediately from almost all “interred in Garden of Rest” to almost all “no remains.”

Current and former staff members at the crematorium were interviewed to try to understand this change. The Investigation looked at the BACAS system to see if there was a default position of “no remains” and we examined the legislation before the BACAS system was introduced to determine if there was a list of terminology that had to be used in the cremation Register (Form G). Neither of these is the case and so neither provides an explanation.

These details are entered into the BACAS system before the cremation takes place and yet are printed in the past tense as if they state an outcome and not an intention, thus repeating the problem encountered with the Cremation cards in the context of the previous manual system. This information is then transferred to a printed label for the green or pink cremation card. The information on the card is therefore also misleading as it does not represent a record of the cremation but a presumption inserted before the cremation takes place.

The Investigation found that there are a small number of recent records for cremations of babies where the disposal type recorded on the BACAS system states “collected.” (See passage on Crematorium Ledger below.)

On cross-referencing, however, with the Crematorium Ledger it was found that these ashes had not been collected. It would appear then that the second step recorded in the User Manual - *Note: when the remains are disposed of, you will need to come back to the appointment and select the Complete button and enter the disposal date, Save and Exit.* – was not always completed.

**Backdating of BACAS**

The Investigation was informed by Jamie Reece, the Cremation Officer, that a decision was taken by Anne Grannum to enter pre-2000 manual records into the BACAS system when time allowed as this would make the task of searching for records simpler in future. However this has led to discrepancies in records relating to the same baby as the manual records disposal method was usually described as “interred in Garden of Rest” and the BACAS disposal method was usually described as “no remains.”

Rather than entering onto BACAS the exact same information as the manual record, in some cases the disposal method in the record created retrospectively in BACAS states “no remains.” The parents of these babies are now faced with two sets of records which state different outcomes and no way of knowing if in fact remains were recovered after cremation or not.
Crematorium Ledger – the release of cremated remains

The Crematorium Ledger is a typed list of all the cremations which were carried out on a particular day. The document records instructions for disposal of the cremated remains, the date of collections of the remains, the name of the person collecting the remains, and their relationship to the deceased.

When a Funeral Director or family member comes to the Crematorium at Mortonhall to collect ashes they must sign for the collection on this list.

The Investigation asked forensic accountants from Ernst & Young to cross check cases recorded as “collected” or “retained” with these lists where available. This was to ascertain whether cases recorded as “collected” had actually been physically collected by the Funeral Director or a family member.

Between 1 January 2011 and 31 January 2013, cremations were recorded of 15 stillborn babies, 7 infants and 429 non-viable foetuses. Of these 451 cremations, 27 cases were recorded as “retained” or “collected.” Of these, 17 were “signed for” on the Crematorium Ledger. 6 do not appear on the relevant list for that day and in two cases the list was not available to check. In 2 cases the Ledger has been altered manually to read “no remains after cremation.”

The Investigation asked Council managers to look into 4 cases in 2011 where the Register stated that the disposal outcome was “collected” but the collection was not confirmed by signature on the Crematorium Ledger. The Council’s response was that “collected” had been the intention and recorded before the cremation took place, but as they had not been on the list to be signed out, they concluded there had in fact been no remains.

This reinforces the observation that staff members did not go back in to the BACAS system to record the actual disposal before printing off the Crematorium Ledger.

Non- statutory Cremation Register held at Mortonhall

A Register of Non-Viable Foetus (Cremations) was kept by Mortonhall Crematorium from 1993 to 2000 when BACAS was introduced. This handwritten Register states the date of cremation, baby’s name, Applicant from Form A, date of death and Funeral Director. This non-statutory Register does not have a column for recording disposal of any remains after cremation.

From January 1996 an additional column is added to the Register for the recording of a number. Anne Grannum, Superintendent at Mortonhall from December 1996 to May 2011, explained in a letter dated 20 December 2013 that a cremation of a non-viable foetus was given a number if there was a funeral service booked by a Funeral Director with a day and time in the Chapel, with or without family present. These babies had a Form A application and a letter from the hospital stating the baby was a non-viable foetus.
Entries in the Register from January 1996 without a number assigned to the entry came to Mortonhall from the Pathology Department of the Royal Hospital for Sick Children with a letter giving only the baby’s name, date of death and confirmation that it was a non-viable foetus.

Prior to 2000, all cremations were carried out individually. All babies in this Register are therefore believed to have been cremated individually. There is however no record kept of disposal of any remains. The Investigation was told about the existence of this Register by Anne Grannum and George Bell. It had not been made available to the Council’s own investigation team nor to PwC nor to this Investigation until recently and it is still unclear where it had been held during the earlier part of this Investigation.

Fifteen entries have been identified by this Investigation and confirmed to parents who had previously been told by the Council that no records had been found for their baby. While the Register does not provide information on recovery or otherwise of remains it does confirm that cremation took place at Mortonhall.

Cremation Register for non viable foetuses on BACAS system

From June 2000 a separate Register is kept on the computer system for non-viable foetuses. From this point in time, all cremations of non-viable foetuses are allocated a number. The BACAS system does include information about the disposal method as described above but as with the statutory records no reliance can be placed on these records so far as they relate to the outcome of the cremation process.

Communal Cremations

In July 2000, Mortonhall started to formally accept communal cremations from hospitals. The FBCA wrote to its members in August 2001 stating that while its preferred option remained that all foetuses be cremated individually, it recognised that numbers were growing to a level in some cremation authorities that made this unattainable.

The numbers were growing since hospitals changed their disposal methods and stopped on site incineration. The FBCA relaxed its position to allow communal cremation with parental consent. Communal cremation means that adult sized coffins are sent to Mortonhall crematorium, each containing a number of “individually wrapped foetuses”. The hospital assigns an identification number to each foetus and sends a list of these to the crematorium along with the coffin. Cremation takes place during the day as for an adult cremation and the Investigation was told that the remains are interred together in the Garden of
Rest. Communal cremations are allocated one non-viable cremation number with all the names and/or numbers assigned to the one cremation number on BACAS.

**Crematorium Ledger**

The Investigation found no entries on the Crematorium Ledger for non-viable babies prior to September 2011. This is consistent with the view that there were no remains to be collected before that date.

**22. INDIVIDUAL CASES**

The Investigation found records for twenty-six babies for whom the City of Edinburgh Council had been unable to find any.

In twenty-five cases we found that the baby had not been cremated at Mortonhall, but had been cremated elsewhere or buried. Six cases were babies who died before Mortonhall opened. Four families did not provide enough information for searches to be completed. Two cases were withdrawn by parents.

In fourteen cases the Investigation was unable to find any records at all. Of those five are known not to have been non-viable foetuses at the time of delivery and the gestation period of the other nine is unclear.

The records found for the each baby are described in detail in section Five of this Report.

The only baby remains in this Investigation that can be said for certain to be in the Garden of Remembrance are those of the non-viable foetus that was the subject of a communal cremation in 2013. Some others will also be there but it will never be known which babies are there, which babies may be in the land adjacent to the Garden of Remembrance and which babies are mixed in with the ashes of the deceased adult who was cremated immediately following the baby.

The great tragedy of these events over many years is that many parents will now be left with a lifetime of uncertainty about their baby’s final resting place.