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Aberdeen Crematorium

Management Investigation

Report of Independent Investigator

August 2016

Richard Penn

Independent Investigator

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The brief for my management investigation

I was appointed by the Chief Executive of Aberdeen City Council at the end of June 2016 to conduct an independent management investigation into the actions/inactions of the senior managers within the Communities, Housing and Infrastructure Directorate with operational and strategic responsibility for Hazlehead Crematorium. This follows on the publication of the Report of the National Cremation Investigation on June 27 2016. It was clear from that Report that there had been significant managerial and leadership failings at Aberdeen City Council in relation to the Crematorium. It was equally clear that these failings have existed for a considerable period of time, straddling several management teams (potentially back as far as the 1980's.) What was not clear, however, is the extent to which individuals are potentially responsible.

The management investigation was required to consider whether, since the issue came into the public domain in December 2012, the actions taken by individual senior managers in the Directorate were commensurate with the seriousness and sensitivity of the matter. In particular, to look at all levels of management above the Crematorium Manager up to the Director and assess, at each level of management, individual responsibility for the failures identified and recommend what, if any, action should be taken. I was asked to review the individual contribution of the senior managers concerned and, where shortcomings are identified, specify what a reasonable management response would have been.

Investigator background

. I have more than forty years experience of strategic and high level management in the public sector in County Councils and Metropolitan District Councils. I have nineteen years experience in total as a local authority Chief Executive managing major urban local authorities, including 10 years as Chief Executive of Bradford City Council (the fourth largest metropolitan council in England). I was the Commissioner for Standards for the National Assembly for Wales from 2000 to 2010 and in January 2008 I was appointed as the Chair of the Independent Remuneration Panel for Wales. From 2001 to 2007 I was Chair of the South Wales Probation Board. In 2002 I completed a five-year term as a Commissioner with the

Equal Opportunities Commission and I also was a Commissioner with the Legal Services Commission from 2000 to 2003.

I have demonstrable experience of the successful delivery of change management, organisational development and performance management in a range of public sector organisations and have extensive experience of working with people at all levels both in leadership roles and as a team member. I have also undertaken a range of consultancy assignments for, the Local Government Association, SOLACE Enterprises, the former Audit Commission and the former IDeA.

Methodology

My management investigation commenced shortly after my appointment when I was provided with relevant documentation. During the course of my investigation I have been provided with other relevant documents by those that I interviewed.

My investigation has focused on a number of key events that have impacted on Aberdeen City Council's management of its Crematorium at Hazlehead between 2012 and 2016:

i. the initial findings of the Edinburgh City Council's Mortonhall Crematorium Investigation in January 2013 that led to Edinburgh City Council commissioning Dame Elish Angiolini to review cremation practices

ii. the review of Aberdeen City Council's cremation practices by PWC, the report of which was in the public domain in July 2013

iii. the receipt of a whistleblowing allegation about cremation practices at the City Council's Crematorium, Hazlehead, on 30 May 2014

iv. Lord Bonomy's Infant Cremation Commission (ICC) Report commissioned in April 2013 and the publication of his report by the Scottish Government on 17 June 2014

v. the National Cremation Investigation (NCI) led by Dame Elish Angiolini and publication of her report on 27 June 2016

I was required to consider the response of the City Council's senior management (i.e. those tiers of management above the Crematorium Manager up to and including the Chief Executive) to these key events during this period.

I conducted interviews with:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

I also met with the current Chief Executive, Angela Scott, on a number of occasions. I did not interview the former Chief Executive, Valerie Watts.

The purpose of these interviews was to provide the opportunity for the senior managers that I interviewed to present their response to the brief I had been given.

Findings

[redacted]

However, my investigation has resulted in evidence of:

- [redacted]
  - [redacted]

- there was no evidence that any effort had been made by any of the senior managers concerned at Aberdeen City Council to clarify at exactly what age or stage ashes are available. The senior managers did not challenge what they were told by the Crematorium Manager despite the information and evidence that emerged from the Mortonhall Crematorium initial investigation nor did they seek information from Seafield Crematorium, or even closer to Aberdeen, Parkgrove Crematorium, to ascertain how these crematoria could have been obtaining ashes despite the position at Aberdeen that none existed until the age of eighteen months to two years (para 4.11refers)

- there was no evidence given to the NCI that after the production of the PwC audit report any senior officer at the Council challenged the Crematorium Manager's assertion that there were no ashes to be obtained from babies less than eighteen months old. At the very least the information provided by PwC should have alerted senior management to the inconsistency between the public position and what the audit had disclosed from the past. There is no evidence of the contents of the PwC report being probed or checked to ascertain the reason for the different outcomes in the sampled cases. This information should have been of particular interest given the Council's public position that ashes did not exist for babies under eighteen months to two years (para 4.20 refers)

- [redacted] The BBC documentary, aired some seven months earlier on the 3 April 2013, included an interview with the Superintendent of Seafield Crematorium and she had stated that she always recovered ashes and returned them to parents. Yet it took a recommendation from Lord Bonomy to visit Seafield Crematorium for the senior managers in the Directorate to react (para 4.31 refers)

- Lord Bonomy and his team were available to the senior management of the City Council, and a reasonable step would have been to request that his team review the current procedures in operation at Hazlehead Crematorium to better inform the understanding of the arrangements and practices there. The PwC internal audit did not do this and [redacted]

- [redacted]

- [redacted]

  - [redacted]

  - [redacted]

  - two key items that had been included in the draft remit sent to PwC on 7 January did not appear in the final scope of the PwC audit:

    i. to establish whether the evidence from the record audit, the initial findings and any other interviews indicate failures in professional standards and/or management practices

    ii. to assess and comment on the need to review current policy and practice

[redacted]

- [redacted]

- [redacted]

- **failure to have strategic oversight**

  - it is clear that the Chief Executive of the City of Edinburgh Council had done all she could in 2013 to alert other cities and their Chief Executives in Scotland to the scale of the issue that she was facing, with presumably the expectation that others would follow her lead and undertake the scale of the 'deep dive' that she was instigating in Edinburgh. In comparing the response of Edinburgh and Aberdeen City Councils, it is clear that the Aberdeen response was significantly smaller scale (para 4.3.5 refers)

  - following the decision by the City of Edinburgh Council to commission Dame Elish to lead and direct the investigation into procedures and policies surrounding the disposal of ashes from the cremation of young children and babies at the Mortonhall Crematorium, there were discussions [redacted] about the implications for Hazlehead. The view was that there were no implications for Aberdeen as the focus of media attention in relation to Mortonhall had been about what had been done with recovered ashes and, as the conventional wisdom was that no ashes were recovered at Hazlehead because of the high temperatures and performance of the new cremators, there was no concern by senior managers (para 3.1.9 refers)

- it is instructive to compare and contrast the way that the City of Edinburgh Council and Aberdeen City Council responded to the dramatic story that emerged about Mortonhall and the resulting wide media coverage:

	City of Edinburgh Council	Aberdeen City Council
Immediate response: internal management	a preliminary investigation of the crematorium service carried out by a Head of Service in another Directorate	no equivalent
Immediate response: internal audit	commissioned to undertake a full examination of records held at Mortonhall	equivalent with the PWC audit commissioned by the Chief Executive
Immediate response: service management	policy review led by Communities Directorate in consultation with stakeholders	no equivalent
Immediate response: external	independent Commission established with scope specified	no equivalent

- The [redacted]

- [redacted]

- [redacted]

[redacted]

- [redacted]

  - [redacted]

  - in May 2014, the ICC also advised the City Council to visit other Crematoriums in order to review procedures and share best practice. On 13 May 2014 officers from the Housing and Environment Directorate visited Inverness Crematorium and on 20 May 2014 officers visited Craigton Crematorium and South Lanarkshire Crematorium. Hazlehead Crematorium's cremation procedures met all best practice shown on these visits (para 3.4.4 refers)

  - the Inspector of Crematoria Scotland carried out a one-day inspection at Hazlehead on 30 June 2016 at the request of the Chief Executive. Focus was given to examining current procedures and working practices at the Crematorium to assess what changes had been implemented to ensure that there was no repetition of the unethical and abhorrent practices described in the NCI Report. The inspection found the operational procedures to be of a good standard with a number of positive and good practice was observed along with several other points worthy of consideration by the Authority but there was, no evidence of current working practices comparable to those described in the NCI Report (para 5.19 refers)

- **Role of the Chief Executive**

  The role of the Chief Executive in any organisation is to provide overall leadership and vision; to develop strategic direction and to ensure that strategic plans and operational business plans are implemented effectively (holding Directors to account for the delivery of their service objectives).

  My own long experience as a chief executive of major local authorities, supplemented by my extensive

subsequent involvement in a range of consultancy work, leads me to the belief that the leadership role and style adopted by the Chief Executive has a significant impact on the organisation's culture which can, in turn, influence how an organisation prevents issues from occurring and how it deals with them if they do emerge. Proactivity and visibility are key qualities in this regard.

[redacted]

- [redacted]
- [redacted]
- [redacted]

Recommendations

My conclusion about individual responsibility for the failings and shortcomings identified is as follows:

- [redacted]

- [redacted]

- [redacted]

[redacted]

[redacted]

- [redacted] the NCI investigation that concluded that:

  '*Like Mortonhall this was a section of the City Council working in almost complete isolation without any strategic direction, development or quality control of the service, so far as it related to babies, infants and non-viable foetuses. There was little knowledge by Senior Management of the service provided to the families of these babies. There was insufficient interest taken or leadership shown by management.'*

  and

  '*The most senior level of management at Aberdeen must provide strong leadership and now take full responsibility for the effective management of the crematorium.'*

[redacted]

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1 Introduction

1.1 I was appointed by the Chief Executive of Aberdeen City Council at the end of June 2016 to conduct an independent management investigation into the actions/inactions of the senior managers within the Communities, Housing and Infrastructure Directorate with operational and strategic responsibility for Hazlehead Crematorium. This follows on the publication of the Report of the National Cremation Investigation on June 27 2016. It was clear from the Report that there had been significant managerial and leadership failings within Aberdeen City Council in relation to the Crematorium. It was equally clear that these failings have existed for a considerable period of time, straddling several management teams (potentially back as far as the 1980's.) What was not clear, however, is the extent to which individuals are potentially responsible. The management investigation was required to consider whether, since the issue came into the public domain in December 2012, the actions taken by individual senior managers in the Directorate were commensurate with the seriousness and sensitivity of the matter. In particular, to look at all levels of management above the Crematorium Manager up to the Director and assess, at each level of management, their individual responsibility for the failures identified and recommend what, if any, action should be taken. I was asked to review the individual contribution of the senior managers concerned and, where shortcomings are identified, specify what a reasonable management response would have been.

1.2 The terms of reference for the investigation made it clear that this is **not** an investigation under the auspices of the disciplinary procedure. However, it was envisaged that I should recommend, if the evidence from the investigation indicated that way, that any matters should be investigated further under the disciplinary procedure

1.3 In summary, I was required to investigate and produce a report for the Council's Chief Executive into the actions and/or omissions of the senior managers with operational and strategic responsibility for Aberdeen (Hazlehead) Crematorium.

1.4 My investigation commenced shortly after my appointment when I was provided with relevant documentation. During the course of my review I have been provided with other relevant documents by those that I interviewed.

1.5 My investigation has focused on a number of key events that have impacted on Aberdeen City Council's management of its Crematorium at Hazlehead between 2012 and 2016:

i. the initial findings of the Edinburgh City Council's Mortonhall Crematorium Investigation in January 2013 that led to Edinburgh City Council commissioning Dame Elish Angiolini to review cremation practices

ii. the review of Aberdeen City Council's cremation practices by PWC, the report of which was in the public domain in July 2013

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v. the National Cremation Investigation (NCI) led by Dame Elish Angiolini and publication of her report on 27 June 2016

1.6 I was required to consider the response of the City Council's senior management to these key events during this period. I conducted interviews with:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

1.7 I also met with the current Chief Executive, Angela Scott, on a number of occasions.

2 Hazlehead Crematorium in context

2.1 Hazlehead Crematorium is situated about four miles west of Aberdeen city centre in a woodland setting. It is the only crematorium serving Aberdeen. The crematorium opened in 1975 and is run by Aberdeen City Council. There are two chapels that can accommodate 96 and 270 persons respectively. There is a memorial chapel and a Garden of Remembrance. There is no dedicated children's area in the garden but there is a memorial stone in the garden. Books of Remembrance for babies are displayed within the crematorium offices.

2.2 Aberdeen Crematorium is a member of the professional organisation known as the Federation of Burial and Cremation Authorities (FBCA).

2.3 At Aberdeen, cremated remains can be collected by next of kin or Funeral Directors on their behalf or scattered in the Garden of Remembrance. Remains are scattered one week after the cremation takes place to allow for any change of mind by the next-of-kin. These remains are scattered in a different area of the garden depending on the month in which the cremation took place. Although it would not be possible to pinpoint the exact location, the area in which ashes have been dispersed can be identified by the month the cremation took place. Each month is marked by a large stone though these are not clearly visible to the public. The crematorium deals with a relatively small number of infant and stillborn baby cremations (16 in 2013) but a much higher number of non-viable foetus cremations (1020 in 2013). A large number of the non-viable foetus cremations would have been shared cremations with other non-viable foetuses.

2.4 Aberdeen Crematorium is equipped with four Facultatieve Technologies FT11/FT111 double-ended, gas-fired cremators which were installed in 2010. Prior to the installation of these cremators the crematorium used double-ended Parkgrove Electric Cremators that had been fitted in 1995/6 and upgraded in 2000/1. Prior to 1995/6 the equipment used was the Dowson and Mason Twin Reflux Gas Cremator that had been used since 1975.

2.5 A privately owned crematorium, Parkgrove Crematorium, is situated at Friockheim and has been providing babies' ashes to next of kin since it opened in 1993. Electric cremators have always been used at Parkgrove. The owner of Parkgrove Crematorium installed the same electric cremators in 1995/6

in Aberdeen Crematorium. Parkgrove Crematorium was returning ashes from infant cremations while Aberdeen was not, although they were using exactly the same electric cremators between 1995 and 2010.

2.6 Aberdeen City Council is headed by a Chief Executive who has responsibility for all the Council's services. The Chief Executive from 1 March 2011 to 30 June 2014, Valerie Watts, told the NCI:

> *'I was Chief Executive of Aberdeen City Council. I had about five direct reports. I had a Director of Education and Community and Sports Service, Social Care and Wellbeing, Infrastructure and Planning, Corporate Services and Environment. Over and above that we ran the Office of Chief Executive which included media and communications member support. The crematorium came under the Director of Environment. He had three Heads of Service, one specifically with the remit of refuse collection, grounds maintenance etc. and the crematorium came within the grounds maintenance end of the business. That came under Mark Reilly's remit. Pete Leonard was Director, Mark Reilly was Head of Service and he would have had a number of managers that would have reported into him. If my memory serves me correctly I think the manager of the crematorium would have reported into him directly or directly into his grounds maintenance manager.'*

2.7 Since 2010 Aberdeen Crematorium has been managed within the Directorate of Communities, Housing and Infrastructure (formerly Housing and Environment) of Aberdeen City Council. The management arrangements had been restructured on several occasions during the period since the Crematorium opened in 1975. The Directorate of Communities, Housing and Infrastructure comprises a number of Heads of Service/Assistant Directors. Reporting to the Head of Service is the post of Environmental Manager and beneath that level was the Crematorium Manager (also known as the Superintendent) until February 2013 when the post of Performance and Development Manager was created between the Environmental Manager and the Crematorium Manager.

2.8 The post of Crematorium Manager has responsibility, among other things, for management of the crematorium and its staff, development of policies and strategies, management of finance and maintenance of standards.

2.9 There have been significant changes in the staff holding these posts since the crematorium opened. An organisational review (recommended in 2008 after an Accounts Commission inquiry) led to major changes in 2010. During the period 1993-2014 Derek Snow was the Crematorium Manager at Aberdeen Crematorium. Derek Snow started in 1986 as a Crematorium Attendant. As Crematorium Manager, he had five different line managers between 2002 and 2010. Steven Shaw took up the role of Environmental Manager, and became Derek Snow's line manager, in 2010. The new role of Performance and Development Manager created in February 2013 (reporting to the Environmental Manager and taking over line management of the Crematorium Manager) was filled by Graham Keith in June 2013.

2.10 Derek Snow was responsible for the management of staff and the immediate operation of the crematorium. He was assisted by a number of different Cremator Operators over the period he held the role. Derek Snow was dismissed on 28 June 2014.

2.11 Most line management meetings at the crematorium appeared to focus on budgets and finance rather than policy or practice. Valerie Watts, Chief Executive between 2011 and June 2014, told the NCI:

> *'There were lots of different methods of communicating within and across the Council which I would have used. Everything was driven by the committee system where committee reports were brought to the appropriate committee or indeed the full Council to inform the elected members and the administration and that was largely in relation to the setting of policy and direction. Once the elected members of the committees made those decisions around policy and direction it came back to me as Chief Executive and my management team to enact those policies. Then every week we had senior corporate management team meetings which were a two-way communication system with me communicating issues down to my manager and then they in turn raising issues for the corporate management team table to communicate issues across the wider SMT (Senior Management Team)'.*

2.12 The issue of the cremation of foetuses and babies and whether or not remains were recovered and returned to parents does not seem to have been discussed. There was no overall strategic management of the crematorium. Aberdeen City Council had significant challenges elsewhere. Pete Leonard, Director of Housing and Environment in 2009, told

the NCI:

> *'...in terms of the focus of senior management attention, you focus on the things that you know need fixing and you focus on the things you know to improve and areas where you need to make savings and you've got to try and bring the public and elected members with you, that's very much a focus.'*

2.13 Aberdeen City Council was dealing with financial pressures from around 2008. Dame Sue Bruce, Chief Executive of Aberdeen City Council between December 2008 and December 2010 told the Investigation:

> *'I was appointed at Aberdeen City Council when they were facing a particularly difficult financial time and I had to address major issues across the Council. Throughout my period at Aberdeen City Council I was not aware of any difficulties with the operational practices at the crematorium at Hazlehead'*

2.14 The Chief Executive between March 2011 and May 2014, Valerie Watts, told the NCI:

> *'When I first went to the post £120 million of savings had to be found but at the same time you had to do the right thing, you had to align the corporate plan with the Council policy.'*

2.15 Mark Reilly, Head of Services, said,

> *'When I came in to Aberdeen (May 2010) it was because Aberdeen had gone through quite a difficult time'*

2.16 A significant change for the crematorium was the appointment of the Performance and Development Manager to fill what was seen as too wide a management span and too shallow a hierarchy within the senior management team. Senior managers within the Directorate had very wide and extensive areas of responsibility. It was clear to the NCI that the current Environmental Manager, Steven Shaw, and those above him had remote and ad hoc involvement in the management of the crematorium or the staff. The Investigation was told by the current Crematorium Manager, Angus Beacom, that:

> *'...staff felt that, in their words, not mine, they had been somewhat neglected by senior management'*

2.17 Pete Leonard, Director of Communities, Housing and Infrastructure told the NCI:

'I guess I was fairly light touch in my management in terms of, I don't think I had visited the site for some time.'

2.18 Pete Leonard confirmed that the purchase of new cremators was an expensive capital project and that he:

'*was more focused on keeping track of that*.

I guess the crematorium for me was a case of things seem to be going ok so a light touch management was ok and I wasn't really getting involved.

The crematorium, I guess, never really featured on my radar. I wish it had, but it never featured on my radar so it was kind of left alone.'

2.19 The Head of Services, Mark Reilly, told the NCI:

'...Now there was a gap between Steven (Shaw, Environmental Manager) and Derek Snow (Cremation Manager) that I didn't particularly care for. I wanted to really look at the structure of Bereavement Services and crematoria and how that works and get one manager overseeing both.'

2.20 The NCI found that despite issues about infant cremation coming to public attention following the media coverage about Mortonhall Crematorium in December 2012, no changes in practice were instigated at Aberdeen until November 2013 and July 2014.

2.21 The NCI concluded that a picture had emerged of a crematorium managed with a 'hands off' approach from senior managers. Steven Shaw, Environmental Manager told the NCI:

'The crematorium was not a priority in terms of my management command. Until this [Mortonhall media coverage] *emerged I don't think we ever discussed the cremation of babies and infants, never raised it'*

2.22 Derek Snow, former Crematorium Manager told the NCI:

'My job title is Manager but I was only a manager when the Council wanted me to be a manager. I've had a lot of staffing issues and I went to my then boss Steven Shaw. He didn't want to know, he told me 'you deal with it, you're the manager'. I did not feel supported by my managers latterly, by which I mean since the new regime came in with Pete Leonard as Director. I have four managers. The

only person I felt I got any help with in the end was Graham Keith.'

2.23 The crematorium was regarded by these senior managers as a successful business and as well managed by Derek Snow with very few complaints from next of kin.

2.24 Previous line managers interviewed by the NCI confirmed this impression of Derek Snow and the crematorium. In interviews with former Environmental Managers Sandy Scott (2008-2010) and David Forsyth (2006 – 2008) there was clear evidence of a system of one to one meetings and annual appraisals with Derek Snow. However, the issue of cremation of infants never came up at these meetings

2.25 The media coverage of the practice at Mortonhall Crematorium in Edinburgh regarding the failure to give back baby ashes late in 2012 brought this highly emotive issue into the public domain.

2.26 On April 16, 2013 the Minister for Public Health announced the creation of an Independent Commission to examine the policies, practice and legislation related to the cremation of infants in Scotland. This Commission, chaired by the Rt Hon Lord Bonomy, reported its recommendations to the Scottish Government during June 2014.

2.27 Just prior to the reporting of the Commission an anonymous letter was received by Aberdeen City Council from a former employee which 'blew the whistle' on practices at Aberdeen Crematorium which contradicted the evidence collected by Lord Bonomy's Commission. The letter was referred to the Commission by the then Interim Chief Executive of Aberdeen City Council (Angela Scott).

2.28 Dame Elish Angiolini was asked by Scottish Government at the end of 2015 to conduct an investigation into crematoria practice which reported in June 2016. In her National Cremation Investigation report there is a section that deals with arrangements at Aberdeen Crematorium. The conclusion to this part of the report indicated:

'…. this was a section of the City Council working in almost complete isolation without any strategic direction, development or quality control of the service as far as it related to babies, infants and non-viable foetuses. There was little knowledge by Senior Management of the service provided to families of these babies. There was insufficient interest taken or leadership shown by management.'

2.29 The Aberdeen City Council Chief Executive made the following statement to the Council on the 29 June 2016:

> *'Members will appreciate that having only received the report (national investigation report) on Monday I have not as yet had the opportunity to consider its content fully. It is critical that I do that now and that I report back fully to Council. When I spoke to the Audit, Risk and Scrutiny Committee I indicated that I would submit my report to Communities, Housing and Infrastructure Committee as the relevant service committee for the Crematorium. On reflection, I now believe that it would be more appropriate to bring a report to Full Council and to do this immediately after the recess.*
>
> *As I have already said, I received the report on Monday. Yesterday, I formally instructed the Head of Legal and the Head of Human Resources to review the report fully and to advise me what further action I require to take. I will fully review the report myself and consider the advice I receive from the two Heads of Service before bringing my own report to Council in August.'*

2.30 This report on my management investigation will inform the Chief Executive's report to the August 2016 Council meeting.

3 The key events

3.1 Mortonhall

3.1.1 A preliminary investigation was carried out by the City of Edinburgh Council to establish the facts associated with the cremation at Mortonhall Crematorium of babies who died before, during and shortly after birth since its opening in 1967. This investigation was prompted by 'Sands Lothians', the local stillbirth and neonatal death charity. The preliminary investigation was undertaken by a Head of Service from another City Council Directorate to establish the facts, and reported to Committee on the 15 January 2013 with the following recommendations:

- national guidance from FBCA is clear that sometimes there are no ashes and guidance to funeral directors is that parents must be informed of this possibility in order to make an informed choice

- a suitable independent person should be commissioned to oversee and direct any further enquiries required and to consider recommendations in this report

- the Council, along with a number of bodies, should immediately review current policy, practice, equipment and staff training at Mortonhall

- independent auditors to be commissioned to undertake a full examination of records held at Mortonhall

3.1.2 The report on this preliminary investigation was circulated by the City of Edinburgh Chief Executive to the Chief Executives of Aberdeen, Dundee and Glasgow on the 11 January 2013.

The report highlighted that:

- current national guidance issued by the ICCM indicates that parents should be informed that there might not be any ashes resulting from cremation

- the variance in the likelihood of recovering ashes across crematoria and lack of clarity at Mortonhall

- efforts made to improve the likelihood of recovering ashes by various means such as cremating at the end of the day whilst cremators cooled and the use of metal

trays. This resulted in increased recovery of ashes but there are still occasions where no remains are recoverable

- crematorium staff are not the direct providers of information about baby cremation to parents

3.1.3 Subsequently, on 22 January 2013, the Chief Executive of the City of Edinburgh Council sent the news release announcing the appointment of an appropriate independent expert, Dame Elish Angiolini to lead a further investigation into historic practices. This press release noted the terms of reference as follows:

- to assess and review the initial findings;
- to review the findings of the audit of crematorium records which is currently underway;
- to assess and review the Council's arrangements for communicating with all parents who have registered an enquiry;
- policy and practice recommended in the attached report and contribute as necessary; and who are to receive a full response to their enquiry supported by the relevant documentation;
- to establish whether the evidence from the records audit, the initial findings and any other interviews indicate failures in professional standards and/or management practices;
- to assess and comment on the arrangements to review current
- to assess and comment on the communication process between Mortonhall, NHS Lothian, funeral directors and bereaved parents;
- to review national guidance and policy and practice in other authorities in order to establish whether guidance within Edinburgh requires to be reviewed and refreshed; and
- any other relevant matters relating to this scope according to the progress of the independent investigation.

3.1.4 The press release stated that:

'it is anticipated that Dame Elish will review the files, conduct further investigation and interviews and draw on such other expert advice as she deems necessary to enable her to reach her own findings. The current review by independent auditors PWC into the Crematorium records will feed into Dame Elish's investigation, as will the policy review activity being led by the Council's Services for Communities Directorate in consultation with key stakeholders including SANDS Lothian'.

3.1.5 [redacted]

3.1.6 [redacted]

3.1.7 [redacted]

[redacted]

3.1.8 The consensus view in the Council was that the Crematorium was well-managed, [redacted] and there were no issues about the way cremations were carried out generally nor were there any concerns about the cremation of babies or NVFs. [redacted]

3.1.9 Following the decision by the City of Edinburgh Council to commission Dame Elish to lead and direct the investigation into procedures and policies surrounding the disposal of ashes from the cremation of young children and babies at the Mortonhall Crematorium, there were discussions [redacted] about the implications for Hazlehead. The view was that there were no implications as the focus of media attention in relation to Mortonhall had been about what had been done with recovered ashes, and that the conventional wisdom was that no ashes were recovered at Hazlehead because of the high temperatures and performance of the new cremators.

3.1.10 [redacted]

[redacted]

3.1.11 [redacted]

3.1.12 [redacted]

3.1.13 [redacted]

3.1.14 [redacted]

[redacted] Nevertheless, following the visit to Seafield Crematorium at the suggestion of Lord Bonomy Hazlehead Crematorium started using baby trays and various changes to cremation settings were implemented between 2013 and 2015 to maximise the recovery of baby ashes.

3.1.15 [redacted]

3.1.16 The '*BBC Investigates'* documentary about crematoria in Scotland was shown three months later on 3 April 2013. Hazlehead Crematorium was mentioned as a crematorium that did not recover ashes, and the programme was very critical of this. [redacted]

3.1.17 In his statement to the National Cremation Investigation, Pete Leonard stated that he did not see the '*BBC Investigates'* documentary about the cremation of infants in Scotland which was aired on 2 April 2013, and therefore he was not aware that Seafield Crematorium was using a baby tray and recovering ashes. [redacted]

3.1.18 PWC's work began in early March 2013. The Council Leader made a public statement on 2 April in response to the BBC investigates programme that evening reiterating the 'no ashes' position. The then Chief Executive also issued a public statement stating her confidence in the staff's professional approach but that she had commissioned a precautionary independent audit of the operation at Hazlehead for the sake of openness and transparency.

3.1.19 [redacted]

[redacted]

3.1.20 The then Chief Executive visited the Crematorium on the 10th April 2013 prior to the conclusion of the internal audit review by PwC which she and the Director had commissioned. There is no record of the names of the individuals she met or of the questions asked or answers given. The Head of Service in the Office of the Chief Executive has stated that he is not aware of any specific follow up action that followed from the visit.

3.1.21 It is instructive to compare and contrast the way that the City of Edinburgh Council and Aberdeen City Council responded to the dramatic story that emerged about Mortonhall and the resulting wide media coverage:

	City of Edinburgh Council	Aberdeen City Council
Immediate response: internal management	a preliminary investigation of the crematorium service carried out by a Head of Service in another Directorate	no equivalent
Immediate response: internal audit	commissioned to undertake a full examination of records held at Mortonhall	equivalent with the PWC audit commissioned by the Chief Executive
Immediate response: service management	policy review led by Communities Directorate in consultation with stakeholders	no equivalent
Immediate response: external	independent Commission established with scope specified	no equivalent

3.2 The review of Aberdeen City Council's cremation practices by PwC

3.2.1 [redacted]

[redacted]

3.2.2 [redacted] set out the following remit for the audit:

- to audit the Crematorium records
- to establish whether the evidence from the record audit, the initial findings and any other interviews indicate failures in professional standards and/or management practices
- to assess and comment on the need to review current policy and practice
- to assess and comment on the communication processes
- to review national guidance to establish whether the Aberdeen guidance needed to be reviewed
- to include any other matter relating to this remit according to the progress of the independent investigation

3.2.3 The draft Terms of Reference received from PwC on 25 February stated that:

> *'given the nature of the potential crematorium procedures Council officers have requested that PWC undertake a data collection exercise for a sample of cremation record and review the current procedures in operation to better inform.….understanding of arrangements and practices'.*

3.2.4 However, two key items that had been included in the draft remit sent to PwC on 7 January did not appear in the final scope of the PwC audit:

- to establish whether the evidence from the record audit, the initial findings and any other interviews indicate

failures in professional standards and/or management practices

- to assess and comment on the need to review current policy and practice

[redacted]

3.2.5 The proposed terms of reference were agreed by the Chief Executive and the Director with PwC, and there was no involvement of the Council's Audit and Risk Committee. The only involvement by that Committee was when it received and unanimously approved the report of the PwC audit at its meeting in September 2013. I have been told there was little questioning or challenge about cremation practices by members of the Committee and the minute of the meeting simply records its approval of the report.

3.2.6 [redacted] At the same time as the PwC audit was underway Lord Bonomy was appointed to lead an investigation into crematoria practices across Scotland.

3.2.7 The PwC report was published in July 2013. Its focus was the paperwork involved in the cremation process rather than the policies or practices involved. There were some recommendations but it was very generalized, and even though the scope of the audit had been based on the review in Edinburgh following the Mortonhall report it was not what had been expected, being very light on detail and not of great assistance given its lack of coverage of practices at Hazlehead.

3.2.8 [redacted]

3.2.9 However, there was a significant change in practice from November 2013 onwards following the visit to Seafield Crematorium by Graham Keith and others that had been recommended by Lord Bonomy. As a result of what was learnt baby trays were used again from that time on and whenever possible ashes were recovered.

3.2.10 In his statement to the NCI, Pete Leonard said:

> '*I drew up the terms of reference for the report and cleared these with the Chief Executive but it was based on what Sue Bruce had sent through, it was very similar terms of reference.* [redacted]
>
> - [redacted]
> - [redacted]

3.2.11 The cover report to the PwC internal audit report by the Head of Service, Mark Reilly, summarised the scope of the audit as:

> '*a data collection exercise for a sample of crematorium records and to review the current procedures in operation to better inform the understanding of arrangements and practices'*.

3.2.12 [redacted]

[redacted]

3.2.13 The Chief Executive visited Hazlehead on 10 April 2013 and [redacted]

3.2.14 On 18 April 2013 the Council was advised of the establishment by the Government of an Independent Commission chaired by Lord Bonomy to examine the issues surrounding infant remains from cremation to ensure clarity and consistency across Scotland and to look into the policies and practices in place for handling ashes and cremated remains.

3.2.15 During the period between May and July 2013 more external challenge was being voiced in the media about the 'no ashes' position and it became ever clearer that there was no guidance or at best conflicting guidance available. [redacted]

[redacted]

3.2.16 [redacted] questionnaire that had been received from Lord Bonomy's team. This included a question about whether the manufacturer's manual gave guidance about the use of metal trays for baby cremation. The answer was 'yes', but that this had not been implemented due to health and safety issues in using the trays. [redacted]

3.2.17 The PwC audit was made public on 15 July and both the then Leader and the then Chief Executive made positive media comments about the review, reassuring the public that the Council's procedures were sound. [redacted]

3.2.18 The PwC audit report was approved unanimously at the Audit and Risk Committee meeting in September 2013.

3.3 The receipt of a whistleblowing allegation about cremation practices at the City Council's Crematorium, Hazlehead in May 2014

3.3.1 Aberdeen City Council received an anonymous letter dated 28 May 2014 about practices at the Crematorium. The letter stated:

> *'I have been very upset at the enquiry into the way infant cremations have been handled in certain crematoria over Scotland. As a past employee at Aberdeen Crematorium we were trained in a procedure that we thought to be correct, after reading the report in the media I have been very upset and stressed to think the procedure at Aberdeen Crematorium was wrong and now wait for an enquiry into this. For many years the procedure to cremate babies/infants was to cremate in with an adult be it viable or non-viable, this was carried out as far as I know up until the enquiry came to light. I think it's wrong that you sit on this and nothing has been said. This must be a very difficult situation not only for Aberdeen City Council but for the staff past and present that now know this procedure was very wrong. This is why there were never any remains recovered from children less than two years, they were never cremated on their own, they always went into the cremator with an adult. I am appalled that I myself have been part of this and think the responsibility lies with Aberdeen City Council for allowing this to happen. This needs to be rectified!'*

The practices referred to in the letter have been borne out by the evidence obtained in the NCI.

In response to receipt of the letter the Interim Chief Executive issued a press statement on 9 June 2014 that stated:

> *'I have received a serious allegation regarding practices at Hazlehead Crematorium. The allegation relates to the joint cremation of babies and adults.*
>
> *In light of the allegation I now have to reconsider the findings of our independent audit which were published last year and I have advised Lord Bonomy's Infant Cremation Commission of this development.'*

3.3.2 The Interim Chief Executive shared the letter with Lord Bonomy, Chair of the Infant Cremation Commission as the allegation cast doubt on the reliability of the evidence provided by the Council to the Commission. Angela Scott indicated that on receipt of the anonymous allegation that she would instigate her own investigation bearing in mind that at the time she was not formally in post as the Council's Chief Executive. By the time she had taken up post in July 2014, Dame Elish's National Cremation Investigation was underway and it was agreed that it would take on the investigation of the allegations made in relation to practices at Aberdeen Crematorium. shown by Graham Keith (Performance and Development

Manager) to the Crematorium Superintendent, Derek Snow, who confirmed that there could be '*some truth'* in the letter. Neil Carnegie, a third tier manager from another part of the Directorate was requested by the Head of Service to undertake an internal investigation into whether or not staff had been truthful to Lord Bonomy. Derek Snow was dismissed on 28 June 2014.

3.3.3 [redacted] The anonymous letter was shown by Graham Keith (Performance and Development Manager) to the Crematorium Superintendent, Derek Snow who confirmed that there could be some truth in the letter. Neil Carnegie, a third tier manager from another part of the Directorate was requested by the Head of Service to undertake an internal investigation into whether or not staff had been truthful to Lord Bonomy. Derek Snow was dismissed on 28 June 2014.

3.3.4 [redacted]

3.3.5 [redacted] the informal trial referenced on page 87 of the NCI report happened. This described how shortly after the media publicity about the practices at Mortonhall Crematorium in December 2012, when Derek Snow was away from work, two concerned members of staff decided to cremate a non-viable foetus of 17 weeks and to check to see if there was anything left. This was without the use of a baby tray. They showed the remains to other staff members who say what they described as '*like tiny little bones*' thereby representing first recovery of remains. Staff reported this test to the Assistant Superintendent. They were never told what happened to these remains. No further action was instructed by management to explore in an official or formal manner what had been reported from staff about this informal trial cremation. Steven Shaw in his testimony to the national investigation shows a vague awareness of this incident having had a conversation with Graham Keith and yet no action taken.

3.3.6 [redacted]

3.3.7 The duty of any manager is to ensure that staff have sufficient training, including the required level of accreditation, and that appropriate refresher training is provided. In addition, they must ensure that clear procedures manuals/instructions are in place to ensure staff comply with the law and relevant codes of practice. The National Cremation Investigation exposed the fact that neither the FBCA nor the ICCM training included training on infant cremations. Given these are industry bodies, it is fair for a manager to assume that all the appropriate areas are covered in the training by such national bodies and that those delivering as service had been fully trained in the relevant processes and practices.

3.3.8 [redacted]

3.3.9 [redacted]

3.3.10 [redacted]

3.3.11 [redacted]

3.3.12 [redacted]

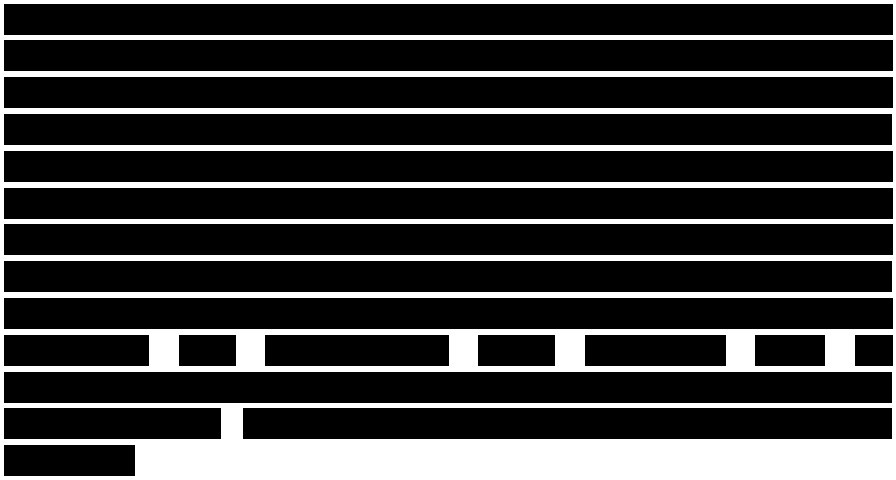
3.3.13 [redacted]

[redacted]

3.3.14 [redacted]

3.3.15 [redacted]

3.3.16 [redacted]



3.3.17 The PwC audit report had stated that:

> '*Following each cremation we were informed the chamber is checked by the cremation staff*'.

The PwC team had clearly not been given the correct information about the processes in place at Aberdeen Crematorium. It was also clear that Lord Bonomy had been misled by those Aberdeen City Council staff who met with him and his team during the Infant Cremation Commission's visit to Aberdeen Crematorium.

3.3.18 Neil Carnegie, Senior Service Manager for Housing Management, was requested by Mark Reilly to undertake an investigation into whether or not staff members at Aberdeen Crematorium had been truthful to Lord Bonomy's Infant Cremation Commission and to senior management about processes, and whether they had withheld information that they were required to disclose about the cremation of babies with adults. In relation to that practice Neil Carnegie told the NCI:

> *'I am satisfied that there was malpractice in terms of they were putting more than one coffin in at the same time as well. In terms of exactly what was happening, I am still not sure. There was malpractice. I think it would have been a fairly regular routine arrangement but I was told different versions of events.'*

3.3.19 These practices may also explain the apparent lack of enthusiasm for exploring other options to enhance the prospect of recovering ashes, such as finding safe working practices to reintroduce a baby tray, the failure to make use of the infant mode profile following its introduction in 2013, manual intervention to moderate the heat and air within the

chamber of the cremator or just simply looking to find ashes.

3.3.20 The NCI Report is critical about the absence of strategic direction and development of the services at the Aberdeen Crematorium. The report notes that the physical separation of the rest of Bereavement Services from the Crematorium was identified as an arrangement that could have been improved if the two teams had been brought together. The previous Assistant Registrar was quite a strong character and so was Derek Snow [redacted]

3.4 Lord Bonomy's Infant Cremation Commission (ICC) Report commissioned in April 2013

3.4.1 On 16 April 2013 the Minister for Public Health announced in Parliament the creation of an Independent Commission, chaired by the Rt Hon Lord Bonomy, to examine the policies, practices and legislation related to the cremation of infants in Scotland.

3.4.2 Lord Bonomy's team requested a meeting and a visit to Hazlehead took place [redacted] Lord Bonomy did recommend that City Council officers should visit Seafield Crematorium in Edinburgh which had a high success rate in recovering infant ashes and was a model of good practice. Officers visited Seafield Crematorium on 21 November 2013 and were shown the processes which included the use of a metal tray, removal of the tray from the insertion end (instead of the ashes recovery end as in double ended cremators) and positioning techniques developed to aid recovery. On 25 November 2013 Aberdeen Crematorium implemented these new processes for still born, small infants and non-viable foetuses in a wooden coffin as per Seafield Crematorium's procedures. NHS Grampian was informed that this new process would be used for non-viable foetuses/pregnancy losses (up to and including 23 weeks and 6 days gestation) if placed in a wooden coffin and that parents require to be informed that this new procedure can be chosen

which may recover cremated remains. To date, these new processes have recovered ashes from all these cremations. The health and safety risks involved in handling an extremely hot tray have been addressed and the processes and risk assessments approved by ACC's Health and Safety section. These procedures have continued to be assessed to ensure the safest possible process is used.

3.4.3 The use of these techniques has now been extended to include all non-viable foetuses received from NHS Grampian. There is no requirement now for a wooden coffin to be provided as the improving processes and techniques can recover ashes from any type of coffin. Parents of non-viable babies have a choice of either individual or shared cremations as well as the alternative of burial. Where parents have chosen shared cremations, the ICC has advised that if cremated remains are recovered they should be scattered in the relevant Crematorium's Garden of Remembrance and parents advised accordingly.

3.4.4 In May 2014, the ICC also advised the City Council to visit other Crematoriums in order to review procedures and share best practice. On 13 May 2014 officers visited Inverness Crematorium and on 20 May 2014 officers visited Craigton Crematorium and South Lanarkshire Crematorium. Hazlehead Crematorium's cremation procedures met all best practice shown on these visits.

3.4.5 Lord Bonomy's Infant Cremation Commission Report was published by the Scottish Government on 17 June 2014 and provided national recommendations for future improvements. The Report contained 64 recommendations, including a number for Scottish Government as well as those directly involved in the cremation of babies and infants, primarily the NHS, Funeral Directors and Cremation Authorities. The City Council responded and was thanked by the Minister who said that he appreciated the steps already taken to improve practice and that he knew an action plan was in place for further change.

3.4.6 Of these 64 recommendations, 28 were for Aberdeen City Council to specifically action, including publishing a Policy Statement Relating to the Cremation of Babies and Infants. In the PWC Internal audit report, there was one management response which stated

> '*Following this report (24th September 2013) the Council will be formalising policy in respect of the remains of infants; stillborns and foetuses. This will include*

consideration of a formal statement which should be provided to all bereaved parents when considering a cremation issued via the crematorium, funeral directors or NHS Grampian to ensure consistency of process. The Council will consider any findings arising from the Governments review of crematorium services and amend policy accordingly.'

3.4.7 The ICC Report at Recommendation No.11 stated:

'that each Cremation Authority should publish a policy statement'

relating to the cremation of babies and infants. The Report also recommended that a working group be set up that included the two main cremation associations - the Institute of Cemetery and Crematorium Management (ICCM) and the Federation of Burial and Cremation Authorities (FBCA) to develop a model policy statement.

This model policy statement was sent to all Cremation Authorities on 19 November 2014 with blank sections for each Cremation Authority to finalise as required. Aberdeen City Council's Policy Statement Relating to the Cremation of Babies and Infants was submitted to the CH&I committee on the 18 March 2015 for approval. The Policy Statement statement was part of a broader update to the Committee on the actions carried out by the City Council following Lord Bonomy's Infant Cremation Commission (ICC) report and its recommendations. It said:

'Policy Statement Relating to the Cremation of Babies and Infants.

Aberdeen City Council, as the Cremation Authority for Aberdeen Crematorium wishes it to be known that it considers the interests of the bereaved family and the baby or infant left in our care to be the central focus of our attention. This will be reflected in all of our administrative and operational practices and procedures.

Definition of 'ashes'

Whilst our employees might use the terms 'ashes' and 'cremated remains' we deem these to be one and the same and defined as 'all that is left in the cremator at the end of the cremation process and following the removal of any metal'. There might be a small number of cases where there are no ashes remaining at the end of the cremation

process. If this is the case our staff will contact the Applicant for Cremation and advise them of this.

Minimising the loss of ashes during cremation

We have developed an approach to the cremation of babies and infants that is designed to minimise the loss of ashes. This includes the use of a cremation tray designed to retain ashes where practicable, and the maintenance of operational conditions that will minimise the loss of any ashes during the process of cremation.

Our staff will be vigilant during the cremation process and adjust operational conditions when necessary in order to protect the ashes of babies and infants and minimise any loss. We will adhere to our identification procedure that guarantees that the ashes resulting from individual cremations returned to parents are those of their babies.

Shared cremations

The location will be recorded for future reference.

Disposal of Ashes

In relation to the disposal of ashes in the case of a private cremation, this Cremation Authority will only act upon the written instruction of the parent who is acting as the Applicant for Cremation.

In the case of shared cremations we will only act on the written instruction of the designated person at the relevant hospital, who is acting as the Applicant.

Where a shared cremation has been chosen by parents, and hence ashes are not individually identifiable, we will take the same care throughout the cremation process and will scatter/bury the ashes within the garden of remembrance.

All cremations of babies and infants will be registered at the crematorium, with all forms and documents being retained for a minimum of 50 years as per the guidance provided in the ICC report of 17 June 2014. If ashes are scattered or buried within the grounds of the crematorium the final resting place will be registered along with any details of any person authorised by the applicant to remove/collect the ashes.

The policy of this Cremation Authority is designed to

provide an audit trail from the receipt of initial funeral instructions to the final disposal of ashes, either by collection from the crematorium or by scattering or burial within the confines of the Gardens of Remembrance.

3.4.8 It had taken from September 2013 (when the Audit and Risk Committee approved the PWC Report) to March 2015 to produce this policy statement. Whilst appreciating the recommendation made by Lord Bonomy for the industry bodies to provide advice re policy statements, the delay has meant that the Council had been without a clear policy position for nearly two years. Given that the PWC internal audit report had been approved by the Audit and Risk Committee, it would have been for that audit Committee to have tracked the completion of this action and therefore to have held officers to account for its completion.

3.5 The National Cremation Investigation (NCI) led by Dame Elish Angiolini

3.5.1 The terms of reference for this Investigation were:

- to investigate the circumstances around the cremation of any infant or baby referred to the investigation by bereaved parents or others, including the work of crematoria, hospitals and NHS Boards and funeral directors as necessary

- to report back to the bereaved parents or others the results of the investigation, particularly in relation to the likelihood of there being ashes following the crenation, and the whereabouts, if known, of any such ashes

- to conduct a more general investigation into practices and operations at any specific crematorium where case-specific investigations give rise to more general concerns

- to report back to the Minister at the conclusion of the investigation with a summary of the work undertaken and the key findings

3.5.2 [redacted]

[redacted].

3.5.3 [redacted]

3.5.4 [redacted]

3.5.5 There was then further work on amalgamating procedures and the FBCA carried out a positive 'critical friend' audit at Hazlehead on 16 July 2105 and reported that 'Aberdeen City Council is making every effort to deliver a high quality service to bereaved parents.

3.5.6 In December 2015 there was an internal audit report to the Audit and Risk Committee that had no adverse findings.

3.5.7 [redacted]

[redacted]

3.5.8 The NCI Report was published on 27 June 2016 and its conclusions about the management of Hazlehead Crematorium were highly critical:

> '*Like Mortonhall this was a section of the City Council working in almost complete isolation without any strategic direction, development or quality control of the service, so far as it related to babies, infants and non-viable foetuses. There was little knowledge by Senior Management of the service provided to the families of these babies. There was insufficient interest taken or leadership shown by management.*
>
> *As with Mortonhall, much of what was learned by Cremator Operators at Aberdeen was received wisdom from more experienced peers. The extraordinary belief that there would be no recovered ashes from babies up to the age of eighteen months or two years was contradicted by what was known to be recovered in many other crematoria as well as in Aberdeen itself in earlier years. It is also clearly contradicted by the evidence of the Forensic Anthropologist, Dr Julie Roberts, who states that bones in cremated foetuses from as young as 17 weeks' gestation can and do survive the cremation process. She stated in her report:*
>
> > *"My previous report prepared for Dame Elish provided evidence that the skeletal remains of foetuses as young as 17 weeks can and do survive the cremation process (City of Edinburgh Council, 2014). Taking that into consideration alongside the data presented in this report, it is inconceivable that there would be nothing left of newborn babies and infants aged up to two years following cremation. The 'no ashes' or 'no remains' policies at the Crematoria of concern must therefore be related to issues surrounding recovery processes, the ability to recognize burnt skeletal remains, and/or individual or corporate management decisions. The same applies to the reasoning that the remains of infants and adults could not be distinguished and separated in instances where they had been cremated together."*

Training was largely carried out in-house and there was no appetite to look beyond and seek best practice from other crematoria, professional organisations or manufacturers of equipment. There was no evidence of any joint training with Funeral Directors or NHS midwives working in this area. The inter agency Bereavement Services Group did not address the issues of baby cremation until after the Mortonhall Investigation. It is incumbent on all those professional agencies involved in the cremation of these babies to ensure that they communicate effectively with each other and have appropriate joint training and joint understanding of their obligations to the parents of these babies.

This inertia allowed unacceptable practices to develop across all the relevant agencies in Aberdeen.

The cremation of babies along with unknown adults is an unethical and abhorrent practice which will offend the sensibilities of the wider community and cause great distress to those whose babies were cremated there. It will also cause profound concern to the next of kin of unrelated adults who may have collected and continue to retain ashes of loved ones cremated at Aberdeen which also contain the ashes of a baby or one or even several non- viable foetuses.

The understanding that there were no ashes or that they could not be recovered was not explained and is inexplicable. The nature of the processes and the expedient way this was done, without any recording to this effect, means that it is not possible to identify those adults and babies who were cremated with each other.

An additional practice carried out at Aberdeen was described to the Investigation. This involved raking adult ashes forward at the completion of a cremation and inserting into the same chamber an infant to be cremated while the adult ashes were still present. The entire contents of the chamber were then raked into the ash pan to cool. For obvious reasons this process was not recorded. It is therefore not possible to identify those unrelated adults and babies to whom this happened.

When obliged to consider this issue with the commencement of the Mortonhall Investigation and during the separate opportunity to explain their position to Lord Bonomy and his team the true picture at Aberdeen

Crematorium was not disclosed. The Infant Cremation Commission was misled about the practices taking place.

It was clear from the interviews of staff in early 2015 that despite the passage of time since the Mortonhall Report, the report of the Infant Cremation Commission and extensive media coverage of the circumstances at Mortonhall Crematorium that staff had not yet been properly briefed or briefed at all to allow them to have an accurate understanding of the physiology of the bones of foetuses, stillborn babies and infants.

The most senior level of management at Aberdeen must provide strong leadership and now take full responsibility for the effective management of the crematorium. It must also ensure that immediate and appropriate training takes place and that effective and ethical practices are maintained. This relates not only to a change of working practices but to an assurance that the culture of the organisation and the knowledge and understanding is such as to prevent any future abuse of the trust of those families who have placed the remains of their loved ones in their care.

It is of serious concern that some of the mothers of the babies referred to this Investigation were unable to give informed consent to the cremation of their child because of the persistent effects of sedating medication or strong pain relief. Some were recovering from surgery and all were suffering considerable grief. Steps should be taken to ensure that any form to be completed by any patient after a foetal loss, stillbirth or infant death is fully explained to the mother at a time when they are fully able to understand that to which they are consenting. Likewise, for those suffering the unexpected loss of an infant baby must be given adequate time and consideration to make a decision about the cremation of their child.

As with other crematoria there was a total absence of any local written instruction or guidance. This remained the case even in 2015 after an audit report of 2013 which highlighted the lack of written procedure. This meant that the actual practices employed in the crematoria were not documented and available for inspection by normal quality assurance procedures. Had such written guidance been available it may have alerted Cremator Operators to the deviant nature of their practices.

By allowing the predicted outcome rather than the actual outcome to

remain in the disposal column Aberdeen City Council created a situation where the inaccurate information was allowed to remain on the Register. Although the inaccuracy was identified no steps had been to correct the accuracy of the Register. This casual and careless approach to a statutory obligation is of considerable concern.'

4 Challenge by senior management

4.1 Prior to December 2012 senior Aberdeen City Council managers had been unaware that Aberdeen Crematorium did not give ashes to next of kin for infants, stillborn babies and non-viable foetuses. They were also unaware that the practice at Aberdeen differed from that taking place at other crematoria and that other crematoria in Scotland were returning ashes to parents after the cremation of non-viable, stillborn and infant cremations. Of all of the management posts, only the Crematorium Manager was based on site at the Crematorium. The others managed the Crematorium remotely. However, despite the concerns being discussed in the media about Mortonhall in 2012, no action was taken to change working practices at Hazlehead until November 2013. This was almost twelve months later and only following a visit to Seafield Crematorium by Aberdeen City Council officers prompted by Lord Bonomy. There was an absence of any strategic management of services and an apparent complete reliance on the account of Derek Snow about the quality of the service provided.

4.2 It was only following the publication of an article in the Edinburgh newspaper, the Evening News, about Mortonhall Crematorium in December 2012 (when the failure to give ashes back at Mortonhall was highlighted) that senior management in Aberdeen began to pay attention to the matter.

4.3 Pete Leonard, Director of Communities, Housing and Infrastructure, told the NCI:

> *'And we had lots of conversations, so we'd be saying, well if some people are saying that they're recovering ashes, how is that? Are they using different temperatures and all this? There's a lot of speculation about 'well, we're not sure how they're doing it, but they're probably doing things like turning the ovens off at night and leaving the baby in to 'slow cook' and do we really want to be doing that and what if the parents found out about that?' and there were issues being thrown in around emissions and if you turn the heating down then you might be breaking the emissions law. There didn't seem to be any shared industry knowledge or best practice.'*

4.4 Mark Reilly said that he had a conversation with Derek Snow in January 2013 in which he had been told:

> *'we don't get any children's ashes because of the burner*

and the fierceness of the burners...and I was told we particularly didn't get anything up to about eighteen months-it could be sixteen months or whatever, it could be twenty months.'

4.5 Steven Shaw said of that explanation:

'To be honest I didn't really give it that much thought at the time. It wasn't until everything blew up that I started asking these sort of questions and trying to learn more about it.'

4.6 Pete Leonard, referring to a conversation with Derek Snow and a Cremator Operator, told the NCI:

'0-3 years is what they said roughly but then they kind of said all depending on the weight of the child etc."

When he was asked if the term '*up to eighteen months'* ever came up, he said:

'It probably was eighteen months actually, yes, but I'm sure they said up to three years old as well, but certainly eighteen months was mentioned but up to three certainly came into it sometimes."

4.7 Steven Shaw said he had spoken to Derek Snow at this time and he had confirmed that the long term practice of not giving ashes for non-viable foetuses, stillborn babies and infants under eighteen months to two years was correct. This assurance was accepted by senior management. Steven Shaw told the NCI:

'I think the age of eighteen months seems to ring a bell. He gauged that up to eighteen months there is no ashes. From eighteen months up to maybe two years we would maybe get something.'

Steven Shaw also said that he had found out that they used to get ashes when baby trays were used but that the trays were stopped by 'Health and Safety'. No evidence of any injury was presented to the Investigation. No records of any Health and Safety reports or intervention relating to the use of a baby tray were provided to the Investigation. He advised the Investigation that he had been told:

'It was all down to supposedly having the most up-to-date cremators in the country.'

4.8 Pete Leonard appears to have accepted this assertion despite Aberdeen Crematorium's failure to return ashes predating the

installation of these up to date cremators by many years. No effort was made by anyone at Aberdeen City Council to reconcile whether or not baby ashes existed or whether staff simply did not recover them. Neither was there any probe nor questioning as to whether the type of cremator equipment or working practices at Aberdeen Crematorium affected either position. The cremators at Aberdeen referred to by Pete Leonard were also the type most commonly used in Scotland. Other crematoria were using them in such a way as to be able to successfully retrieve remains.

4.9 Steven Shaw said that he had been told by Derek Snow that what happened at Mortonhall Crematorium did not apply to Hazlehead Crematorium:

> *'I was told 'no not at all because we don't have any remains' and I accepted that explanation from Derek (Snow) at that stage. I knew after speaking with Derek that we didn't give ashes because there were no ashes.'*

4.10 Mark Reilly commented:

> *'Over that period there was a lot of information coming out. Somebody was saying every time I cremate I can always get ashes, some people were saying oh we don't get ashes, some people say sometimes we do, sometimes we don't and we knew the sort of information coming out varied.'*

4.11 There was no evidence that any effort was made by anyone at Aberdeen City Council to clarify at exactly what age or stage ashes were available. The senior managers did not challenge what they were being told despite the information emerging from the Mortonhall Crematorium investigation nor did they seek information from Seafield Crematorium, or even closer, Parkgrove Crematorium, to ascertain how these crematoria could have been obtaining ashes despite the Aberdeen position that none existed until the age of eighteen months to two years.

4.12 On 3 April 2013 the BBC broadcast a documentary, 'Scotland's Lost Babies' which reported that the issues about the failure to return babies' ashes to families might not be confined to Mortonhall Crematorium. The documentary included an interview with the Superintendent of Seafield Crematorium who said that she always recovered ashes and returned them to parents.

4.13 Steven Shaw told the NCI that:

'it wasn't until I watched the BBC documentary...that I started to question it...I was a bit surprised and a bit horrified because we had always stuck by our statement of no remains.

We stuck with the line that Aberdeen Crematorium did not recover ashes. I was looking for comfort and confirmation from Derek, because to me Derek was my expert and I had no reason to not believe him.'

4.14 There was of course considerable information emerging to suggest that he should have had reason to test the explanations presented to him by Derek Snow.

4.15 Pete Leonard, Director said:

'I did not see the BBC documentary and was not aware that Seafield were using a tray and getting ashes.'

Nor did Pete Leonard appear to have been briefed at the time by any of his staff on the content of the documentary [redacted]

4.16 [redacted] the results of the sample testing for the period 1984 and 1985 clearly evidenced that for the 62 cremations (children aged 5 or younger including stillbirths) recorded in the Crematorium ledger, show that ashes had been created and either dispersed in the garden of remembrance, taken away for burial or taken away for scattering [redacted]

4.17 Pete Leonard told the Investigation:

'Around about that time we received a letter from Sue Bruce (then Chief Executive of City of Edinburgh Council) with the scope of the inquiry that she had asked Dame Elish to perform and I had a conversation with Valerie Watts, then Chief Executive of Aberdeen City Council. I

said I'd been to see the crematorium team, they assure me everything is okay but I really think we need to get some objective people in to do an audit and investigation into some of the processes and ask them questions. That led PwC to do an investigation, which was very much process based. At the same time, myself and Mark Reilly went to visit the team, got more behind the scenes.

I think not getting ashes had been for as long as they could remember. Certainly with the new cremators they didn't. With the older ones I don't think they did, but I think they said previously they may have done in the dim and distant past, there might have been something. I think they gave some examples there, but I can't really recall.

I think it pretty much reflected what the guys said and looked at the records. On reflection I think we didn't focus enough on behaviour. When subsequently things changed in terms of what people's story was, my own reflection on myself was perhaps I could have been a bit more challenging around some behaviours.

I drew up the terms of reference for the report and cleared these with the Chief Executive but it was based on what Sue Bruce had sent through, it was very similar terms of reference.

I am asked if the auditors looked at records as opposed to wider processes. Yes, that was the case. I am asked if anyone was examining the actual operational processes of cremation itself. No there was not. I think the years picked for audit were aligned with the different types of cremators from what I can see. I think there were different changes to the record keeping and we kept records up to a certain date. I think somebody had written to say they'd had some issue around 2008 and that they received ashes so on the back of that, we said can you go further back and examine what the practice was then'

4.18 The audit by PwC was duly commissioned and terms of reference agreed in March 2013. The auditors reported on 9 July 2013. This audit was limited in scope and did not look at the actual cremation operational processes but rather traced a sample of cremations to the supporting records and administrative process in respect of the cremation of stillborn babies and infants under the age of two. The audit report describes its work as to:

'*undertake a data collection exercise and review the*

current procedures in operation to better inform the Council Officers' understanding of arrangements and practices.'

The report was based on the documentation available but there is no indication of the senior management of the Council considering that what was required in all the circumstances was an audit of the actual cremation working processes by a suitably qualified cremation industry expert or body such as the FBCA.

4.19 The PwC report was apparently relied on by Aberdeen City Council senior management to support their continuing position. Pete Leonard, Director, told the NCI:

'There had been a conversation about use of trays and what have you and I was very nervous about health and safety and I guess I placed a lot of reliance on the internal audit which we scoped out in March and it reported in July 2013.'

4.20 There was no evidence given to the NCI that after the production of this audit report anyone at the Council challenged Derek Snow's assertion that there were no ashes to be obtained from babies less than eighteen months old. At the very least the information provided by PwC should have alerted senior management to the inconsistency between the public position and what the audit had disclosed from the past. There is no evidence of the contents of the report being probed or checked to ascertain the reason for the different outcomes in the sampled cases. This information should have been of particular interest given the Council's public position that ashes did not exist for babies under eighteen months to two years.

4.21 As of 10 July 2013 it had therefore been brought to the attention of Aberdeen City Council that during the period 1984 - 1985 the records reported that ashes did exist at Aberdeen, contrary to the Council's public position. This does not appear to have been taken further. Despite these findings and inconsistencies with what the Council understood to be the position, no further formal investigation was carried out at that time nor was a more probing audit commissioned.

4.22 On the 15 July 2013, the then leader of ACC Barney Crockett issued a statement on behalf of the Council that said:

'*I hope the families here in the North east will take some comfort from knowing that we have had a close look at our*

own procedures at Hazlehead crematorium and found them to be sound. We remain fully confident that our crematorium staff at Hazlehead have carried our their duties with the utmost professionalism and have always approached their very sensitive work in a caring and considerate manner.'

4.23 [redacted]

4.24 Over time what was emerging was that there were a range of different practices and results in other crematoria but it was only when an authoritative view came from Lord Bonomy's investigation that we decided to test this again. The visit to Seafield Crematorium at the suggestion of Lord Bonomy was a key event in learning about this.

4.25 [redacted] During Lord Bonomy's visit to the Aberdeen crematorium on 15 November 2013, Lord Bonomy had recommended that officers visit Seafield crematorium in Edinburgh which had a high success rate in recovering infant ashes. Officers [redacted] then visited Seafield on 21 November 2013 and were shown the processes used there which included the use of a metal tray for infant cremation. On 25 November 2013 Hazlehead Crematorium implemented these new processes for still born, small infants and non viable foetuses.

4.26 [redacted]

4.27 [redacted]

[redacted]

4.28 Procedures at Aberdeen Crematorium continued unchanged until, at the prompting of Lord Bonomy, staff visited Seafield Crematorium in Edinburgh in November 2013.

4.29 The explanation given and accepted by Crematorium staff to the Director, the Chief Executive and PwC for why ashes had not been produced over the two sample periods (1 August 1999 to 31 July 2000 and 1 April 2007 to 31 December 2012) and (1984 – 1985) was due to the specification of the cremators in place over these periods not being the same.

4.30 [redacted]

4.31 [redacted]

[redacted] The BBC documentary, aired some seven months earlier on the 3 April

2013, included an interview with the Superintendent of Seafield Crematorium and she stated that she always recovered ashes and returned them to parents. Yet it took a recommendation from Lord Bonomy for the senior managers in the Directorate to react and change practices.

4.32 [redacted]

4.33 During my investigation I explored certain areas which, although not directly contained within my remit, would provide some valuable context to enable me to understand and pass meaningful comment on the role played by managers. One such contextual consideration relates to health and safety – a key management function in any organisation. In this regard I was particularly interested in the suggestion that baby tray usage had discontinued because of 'health and safety' concerns.

4.34 [redacted]

4.35 Lord Bonomy and his team were available to the senior management of ACC and a reasonable step would have been to request that his team review the current procedures in operation to better inform the understanding of arrangements and practices, in a way that the PWC internal audit did not do. [redacted]

4.36 Practices only changed at Hazlehead Crematorium in November 2013 following the visit to Seafield which was prompted by Lord Bonomy. [redacted]

4.37 This was despite it being very clear that the Chief Executive of the City of Edinburgh Council had done all she could in 2013 to alert other cities in Scotland to the scale of the issue that she was facing, with presumably the expectation that others would follow her lead and undertake the scale of the 'deep dive' she was instigating in Edinburgh. In comparing the response of Edinburgh and Aberdeen City Councils, it is clear that the Aberdeen response was significantly smaller scale.

4.38 [redacted]

5. The adequacy of strategic leadership and direction by senior management, and the effectiveness of governance structures and assurance arrangements

5.1 [redacted]

5.2 [redacted]

5.3 [redacted]

5.4 [redacted]

[redacted]

5.5 [redacted]

5.6 [redacted]

[redacted]

5.7 [redacted]

5.8 [redacted]

5.9 [redacted]

[redacted]

5.10 [redacted]

5.11 [redacted]

5.12 [redacted]

[redacted]

5.13 [redacted]

Committee	Date	Report Title	Report author
Audit and Risk Committee	10 July 2013	Hazlehead crematorium restricted scope internal audit	[redacted]
Audit and Risk Committee	December 2015	Internal Audit Report Crematorium	Internal audit team
C, H & I	18 March 2015	Infant Cremation Commission report and recommendations	Steven Shaw
C, H & I	20 January 2016	Aberdeen Crematorium and Hall of Remembrance Management rules	Steven Shaw
C, H & I	17 May 2016	Aberdeen crematorium and hall of remembrance management rules	Steven Shaw

5.14 A redacted version of the PwC internal audit report was

shared with the Audit and Risk Committee rather than the full version. Given the internal audit report was submitted to the Audit and Risk Committee in September 2013 after the BBC documentary was aired in April 2013, it is surprising that the report was redacted. The minutes of the meeting of the Audit and Risk Committee do not record which officers were in attendance for the item but simply records that the Committee noted the content of the report. It is difficult to arrive at any conclusion about the effectiveness of the Audit and Risk Committee given it received a redacted version of the report [redacted]

5.15 The purpose of the Council's governance structures is to hold officers to account for the management of performance and the management of risk, [redacted] In fact, there have been five reports submitted to the Council's governance structures as detailed below. [redacted]

5.16 There was no challenge from the Audit and Risk Committee in terms of whether the audit met the scope as agreed. This is reasonable given the scope, as set out in the internal report matched the audit undertaken. [redacted]

5.17 Aberdeen City Council is a member of the Federation of Burial and Cremation authorities (FBCA) as a crematorium authority. The FBCA provides advice, guidance and training to its member organisations. Technical officers periodically visit and inspect crematoria with a view to upholding standards in the industry. Reports from an industry/independent body assessing the Council's services should always be submitted

to the relevant service committee. [redacted] The reliability of such inspections is called into question by the fact that the FBCA uses its own members who themselves are employed by crematoria authorities to undertake these reviews rather than the full-time officials of the FBCA.

5.18 [redacted]

5.19 An Inspector of Crematoria for Scotland was appointed in March 2015 in fulfilment of the ICC report recommendation. This role currently covers functions laid out in the 1993 regulations but the inspector role will change as the legislation is repealed to allow the new Burial & cremation (Scotland) Act 2016 to come into force.

The Inspector's current role is to:

- ensure crematoria are operating in line with the principles set down by Lord Bonomy and in line with the new code of practice
- report any criminal or potentially criminal activity to Police Scotland
- visit every crematorium in Scotland at least once every year
- deal with queries or complaints from the public
- provide an annual report to Ministers on activities, but can also report to Ministers on specific issues or concerns if needed

5.20 The Inspector of Crematoria Scotland carried out a one-day inspection at Hazlehead on 30 June 2016 at the request of the

Chief Executive. Focus was given to examining current procedures and working practices at the Crematorium to assess what changes had been implemented to ensure that there was no repetition of the unethical and abhorrent practices described in the NCI Report. The inspection found the operational procedures to be of a good standard with a number of positive and good practice was observed along with several other points worthy of consideration by the Authority but there was no evidence of current working practices comparable to those described in the NCI Report.

6 Conclusion

6.1 The Report of the National Cremation Investigation published on June 27 2016 made it clear that there had been significant managerial and leadership failings at Aberdeen Council in relation to the management of its crematorium at Hazlehead. It was equally clear to the Commission that these failings had existed for a considerable period of time, straddling several management teams (potentially back as far as the 1980's.) What was not clear, however, was the extent to which individual managers were responsible for these failings.

6.2 The objective of the management investigation I have carried out was required to consider whether, since the issue came into the public domain in December 2012, the actions taken by individual senior managers in the Directorate and to assess, at each level of management, individual responsibility for the failures identified and recommend what, if any, action should be taken. I was asked to review the individual contribution of the senior managers concerned and, where shortcomings are identified, specify what a reasonable management response would have been.

6.3 My investigation has reviewed events since the issue of infant cremation was first brought into the public domain in 2012 by 'Sands Lothians', the local stillbirth and neonatal death charity which exposed the practices at Mortonhall Crematorium in Edinburgh. My investigation has focused on the way that senior management in Aberdeen City Council's Housing and Environment Directorate responded to a series of key events since 2012:

i. the initial findings of the Edinburgh City Council's Mortonhall Crematorium Investigation in January 2013 that led to Edinburgh City Council commissioning Dame Elis Angiolini to review cremation practices

ii. the review of Aberdeen City Council's cremation practices by PwC, the report of which was in the public domain in July 2013

iii. the whistleblowing allegation about cremation practices at the City Council's Crematorium, Hazlehead, on 30 May 2014

iv. Lord Bonomy's Infant Cremation Commission (ICC) Report, commissioned April 2013, and the publication of his report by the Scottish Government in June 2014.

v. the National Cremation Investigation (NCI) led by Dame Elish Angiolini and publication of her report on 27 June 2016

6.4 In my management investigation I have drawn on the reports of the various investigations, reports commissioned or produced by the City Council and interviews with the Aberdeen City Council senior managers concerned.

6.5 [redacted]

6.6 However, my investigation has identified evidence of:

- [redacted];
- [redacted]
- [redacted];
- [redacted];
- [redacted]
- [redacted]
- [redacted]
- [redacted];
- [redacted]

6.7 [redacted]

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- [redacted]

- [redacted]

- [redacted]

[redacted].

[redacted]

- [redacted] the NCI investigation that concluded that:

  '*Like Mortonhall this was a section of the City Council working in almost complete isolation without any strategic direction, development or quality control of the service, so far as it related to babies, infants and non-viable foetuses. There was little knowledge by Senior Management of the service provided to the families of these babies. There was insufficient interest taken or leadership shown by management.'*

  '*The most senior level of management at Aberdeen must provide strong leadership and now take full responsibility for the effective management of the crematorium.'*

[redacted]

6.8 [redacted]

- Dame Sue Bruce was Chief Executive of Aberdeen City Council between December 2008 and December 2010, [redacted] She told the NCI:

  'I was appointed at Aberdeen City Council when they were facing a particularly difficult financial time and I had to address major issues across the Council.

  Throughout my period at Aberdeen City Council I was not aware of any difficulties with the operational practices at the crematorium at Hazlehead'

- Valerie Watts was Chief Executive between March 2011 and June 2014. [redacted]

- Angela Scott was the Interim Chief Executive during June 2014 before she took up the permanent post in July 2014 that she currently holds. [redacted]

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[redacted]

Richard Penn

Independent Investigator

August 2016