Lothian NHS Board

Burial and Cremation (Scotland) Bill

Thank you for giving us the opportunity to submit our views on the Burial and Cremation (Scotland) Bill. NHS Lothian’s comments are set out below.

(1) General principles

Modernising legislation in this area is welcomed, and in general the Bill seems to provide a robust legal framework for burial and cremation in Scotland.

(2) Applications for burial (Section 8)

The requirement to apply for a burial in a burial ground and to standardise the application forms seems sensible and appropriate.

It would be useful to clarify whether the provisions in Section 16 regarding Private Burial would include pregnancy losses up to 24 weeks’ gestation within the definition of “human remains” (section 16.2). Early pregnancy losses may occur at home without any form of medical certification and informal methods of disposal, including home burial, are generally used.

(3) Meaning of cremation/ashes (Section 36)

The definition of cremation / ashes within the Bill seems sensible and will provide useful clarification.

(4) Applications for cremation (Section 38)

The Bill seeks to create a single application form to cover all cremations. Although it will be useful to provide consistent documentation, we are concerned that a single form for all circumstances could be lengthy, complicated and include questions which will be irrelevant and / or distressing to certain applicants. e.g. for a parent applying for cremation of a pregnancy loss, still-born baby or child, seeing questions about the deceased’s age, marital status, occupation etc can be distressing reminders of the life that their child did not live to experience. Conversely, for a person applying for the cremation of an adult, seeing references to pregnancy loss, still-birth etc may trigger memories of sad experiences in their own life. On a purely practical level, if forms include a large amount of content that is perceived to be irrelevant and / or emotionally difficult, there may be a tendency to skim read and sign. If the content of the form is not read in detail, then authorisation may not be fully informed.

The local crematoria in Edinburgh have developed simplified forms for cremation of pregnancy losses which exclude irrelevant questions and seem to have been well-received by applicants and those supporting them (e.g. hospital staff and funeral directors).
(5) Duty to maintain cremation register (Section 41)

In the policy memorandum to the Bill, it states that the way in which information is recorded on health authority cremation registers (Section 55) will not identify a woman who has experienced pregnancy loss. Instead a unique identifying number will be used. Registers (whether held by the health authority, crematorium, burial ground or local authority re: private burial) should also not identify a woman who has a late termination of pregnancy for medical reasons at a gestation which is legally classed as a still-birth rather than a pregnancy loss.

(6) Relatives’ decision on disposal of remains (Section 47)

In general it seems helpful to clarify which relatives should be allowed to arrange for the disposal of remains in the event of an adult or child’s death or a still-birth. It would be useful if the legislation on registration of death could be amended to incorporate a similar hierarchy of “nearest relatives”, as this is not consistent with the current list of “qualified informants”.

In Section 47 “Arrangements on death of a child” we are concerned about the lack of distinction between the death of a child and a still-birth.

There may infrequently be circumstances when a still-birth occurs and it is not necessarily reasonable or practicable for a parent or “nearest relative” to make the arrangements. In some cases, the mother / parents of a still-born child may decline or feel unable to make arrangements and it may not be possible to contact other “nearest relatives” for legal and / or ethical reasons. For example, there would be particular difficulties with a late termination of pregnancy for medical reasons, occurring at a gestation which legally requires registration and recognition as a still-birth, if the mother declined or was incapacitated / unable to make the arrangements. In such a scenario the health authority may not be able to contact another relative without breaching the woman’s right to confidentiality (particularly re: the Abortion Act). Who then would be able to arrange disposal? It would be helpful to clarify whether the health authority would be able to arrange disposal in such circumstances or in other scenarios where there is “cause shown”. Would the health authority have to apply to the sheriff under Section 49 in these circumstances?

An alternative route might be the current National Assistance Act and Section 56 of this Bill, which allow for the local authority to make arrangements for disposal of remains where “a person dies or is found dead within the area” and “it appears to the authority that no arrangements are being or have been made”. However we are not sure if the definition of “a person who dies” would include a still-born child, nor whether this legislation (which unfortunately continues to be associated with historical ideas of “paupers’ funerals”) would be the most appropriate means of addressing this issue.

(7) Disposing of remains from pregnancy loss at or before twenty-fourth week (Sections 50-53)
We have a number of concerns about the measures contained in the Bill regarding “arrangements on loss during pregnancy”.

Section 50(1) refers to the “fetus” and “the remains of the fetus”. We think it would be useful to define these terms and clarify whether the section is intended to include all pregnancy losses, “irrespective of cause or origin, where no signs of life have been detected following the loss, and whether or not fetal tissue can be identified” (Infant Cremation Commission Report section 9.39 and SGHD/CMO(2015)7). This is especially important when considering that remains from earlier losses at the embryonic rather than fetal gestational stage may more often be described as ‘products of conception’ or ‘pregnancy tissue’ by healthcare professionals.

Section 50(2) of the Bill states that before the expiry of the initial period (of 7 days from the date of the pregnancy loss) the health authority must give the woman who has experienced the loss the opportunity to decide about arrangements for disposal.

The Explanatory Notes (Section 135) acknowledge that, “some women may choose not to engage with the health authority or may be physically unable to do so. As such, the health authority is expected to try to find out the woman’s wishes, but is not under an obligation to do so”. However we don’t see that this is clear from the Bill itself, which makes no specific reference to circumstances where the woman is incapacitated, unwilling to engage, or in the event of maternal death.

Section 50(4) states that as soon as practicable after the expiry of the initial (7 day) period, the health authority must record the woman’s decision on the prescribed form and seek to obtain her signature. It would be helpful to be able to complete this paperwork earlier if the woman felt able to make an informed decision within the initial 7 days. Otherwise, the current wording of the Bill would seem to imply that in a significant number of cases women would be asked to return to the hospital or unit where the loss occurred in order to sign the prescribed form. Whilst we can see the benefit of allowing time and space to make a decision, we are not sure how a requirement to routinely wait 7 days before completing the paperwork would work from either a practical point of view (when, where and how the health authority reconnects with these women, and what additional resources this would require) or in terms of sensitive, person-centred care. For example:

- Women who experience a pregnancy loss may find it difficult to return to the place where the loss occurred.
- Women having termination of pregnancy often authorise disposal as part of the consent-taking process prior to the procedure and generally do not exercise their right (under current SGHD guidance on disposal of pregnancy losses) to revisit or change their decision at a later date. It is difficult to imagine many of this cohort of women wishing to return to the hospital 7 days after the procedure to sign the prescribed form.
• The requirement to wait until the expiry of the initial 7 day period could also cause difficulties if a woman wishes for religious or cultural reasons for the disposal to take place within a shorter timescale.

Sections 50(4)(b), 51(4)(b), 52(4)(b) and 52(6)(b) refer to the health authority taking “reasonable steps to secure” the woman / authorised individual’s signature. It would be helpful to clarify what would be considered “reasonable steps”.

(8) Disposal of remains by Health Authorities (Section 54)

Section 54 requires the health authority to make arrangements for disposal of remains “as soon as practicable” if a woman or authorised individual has not done so after the end of the relevant period (6 weeks from the date of the pregnancy loss). We are concerned that this may mean overriding the wishes of women who want to make their own arrangements but are unable to do so within the timeframe (e.g. due to their own health or lifestyle issues, grieving process, financial capacity, waiting for a decision from DWP re: Social Fund Funeral Payment, etc). It may be better if this section of the legislation was permissive rather than mandatory, i.e. if the health authority was able to arrange disposal after 6 weeks but not required to do so if there were mitigating circumstances.

(9) Register of disposal of remains (Section 55)

It is appropriate that the Bill provides a duty on each health authority to maintain such a register.

In the policy memorandum to the Bill, it states that the way in which information is recorded on the cremation register will not identify a woman who has experienced pregnancy loss. Instead a unique identifying number will be used. Registers should also not identify a woman who has a late termination of pregnancy for medical reasons at a gestation which is legally classed as a still-birth rather than a pregnancy loss.

NHS Lothian