The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 12 January 2016

Session 4

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CONTENTS

HEALTH AND SPORT COMMITTEE
3rd Meeting 2016, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jim Brodie (National Society of Allied and Independent Funeral Directors)
Andrew Brown (National Association of Funeral Directors)
Dr Simon Cuthbert-Kerr (Scottish Government)
Graham McGlashan (Scottish Government)
Natalie McKail (City of Edinburgh Council)
Tim Morris (Institute of Cemetery and Crematorium Management)
Caroline Pretty (NHS Lothian)
Maureen Watt (Minister for Public Health)
Sandy Young (NHS Lothian)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 12 January 2016

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the third meeting in 2016 of the Health and Sport Committee. As I usually do at this point, I remind everybody to switch off mobile phones, as they can interfere with the sound system. People in the room will notice that some of us are using tablet devices instead of hard copies of our papers.

Agenda item 1 is to decide whether to take item 4, under which the committee will consider a draft letter to the Finance Committee, in private in this meeting and in future meetings. We would normally take such items in private. Does the committee agree to do that?

Members *indicated agreement.*

Burial and Cremation (Scotland) Bill: Stage 1

09:31

The Convener: Our second item is our third evidence session on the Burial and Cremation (Scotland) Bill. I regret that I have to announce apologies from Dr Gillian Smith of the Royal College of Midwives, who is unavoidably unable to be with us.

As I said last week, bills by their nature have to be very precise in their meaning and in the language that they use. As such, language or terminology may be used this morning in relation to the Burial and Cremation (Scotland) Bill that those who are with us or those who are watching and listening to the proceedings may find upsetting. We apologise in advance if that is the case. It is not our intention to cause upset, but we have to work with the precise terms of the bill and how it is phrased.

As we normally do with a round-table discussion, we will go round and introduce ourselves. I am the convener of the committee and the MSP for Greenock and Inverclyde.

Tim Morris (Institute of Cemetery and Crematorium Management): I am the chief executive of the Institute of Cemetery and Crematorium Management, which represents burial and cremation authorities throughout the United Kingdom and provides training and educational opportunities to those who work in those services.

Bob Doris (Glasgow) (SNP): Good morning. I am a member of the Scottish Parliament for Glasgow and the deputy convener of the committee.

Andrew Brown (National Association of Funeral Directors): Good morning. I am the operations manager for Scotland and Northern Ireland for Co-operative Funeralcare and am representing the National Association of Funeral Directors.

Dennis Robertson (Aberdeenshire West) (SNP): Good morning. I am the MSP for Aberdeenshire West.

Nanette Milne (North East Scotland) (Con): Good morning. I am an MSP for North East Scotland. In view of the fact that the National Association of Funeral Directors has stated that it has been involved with the cross-party group for funerals and bereavement, I should say that I am a co-convener of that group.

Jim Brodie (National Society of Allied and Independent Funeral Directors): Good morning.

I have a slight stammer, for which I give apologies; I am sent to such meetings to slow things down. I am an independent private funeral director based in West Lothian and am representing the National Society of Allied and Independent Funeral Directors Scotland. I am a third-generation funeral director and have been a funeral director for more than 30 years.

Colin Keir (Edinburgh Western) (SNP): Good morning. I am the MSP for Edinburgh Western.

Richard Lyle (Central Scotland) (SNP): Good morning. I am an MSP for Central Scotland.

Sandy Young (NHS Lothian): I am head of service for spiritual care and bereavement for NHS Lothian. In particular, my bereavement casework has for many years been to help those bereaved in the context of pregnancy and baby loss.

Caroline Pretty (NHS Lothian): Hello. I am bereavement service co-ordinator for NHS Lothian, and I work with a particular focus on women's and children's services.

Rhoda Grant (Highlands and Islands) (Lab): I am a Highlands and Islands MSP.

Natalie McKail (City of Edinburgh Council): I am a senior manager in the City of Edinburgh Council and have responsibility for the Mortonhall improvement programme. I work to the chief executive's working group.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I am the MSP for Edinburgh Northern and Leith.

Mike MacKenzie (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands.

The Convener: Thank you all for that. I say to each of the witnesses that we will cover a wide range of topics. Some of them will be applicable to you and you will feel that you can answer them. There is no pressure to respond to every subject if it is not in your area of interest, although the point of having a round-table discussion is to get your input, so when we address your area of interest, please participate if you feel that it is appropriate. You do that just by catching my eye, and I will bring you in. I have told Tim Morris that he should just nudge me because he is out of my eyeline.

To get things going, we will have a question from Malcolm Chisholm.

Malcolm Chisholm: I thank the witnesses for their useful written evidence. I will try to break it down into different areas and will start with the disposal of remains from pregnancy loss at, or before, the 24th week. There were many interesting comments on that, but I will focus on those from NHS Lothian. NHS Lothian raises some important concerns in general that we need to think about, but it has a couple of concerns about the disposal of such remains, one of which relates to the seven-day period, which also came up last week when we met informally some of the parents who have been affected by such loss. If we could think about that to begin with, that would be useful.

Some of the witnesses might want to comment on another issue that came up in that informal meeting. Because of the way that the bill was worded, people seemed to think that, before 24 weeks, the mother was allowed to arrange the funeral herself and could leave the hospital with the fetus.

There is a range of issues. Perhaps NHS Lothian might start off by discussing the concerns that it raised about the period up to 24 weeks.

Caroline Pretty: There is a huge range of circumstances of loss in the period up to 24 weeks. The current guidance from the Scottish Government on disposal of losses under 24 weeks covers everything from a very early miscarriage, to terminations of pregnancy for medical and non-medical reasons, later miscarriages and ectopic pregnancies. It is a huge range of different circumstances. It is difficult to navigate that complicated territory in terms of clinical care—the medical support to women—as well as the different emotional and psychological interpretations of the women involved.

We are concerned about some of the timescales and processes. There might be, as I think was discussed last week, a robustness in asking people to come back and confirm their authorisations for disposal at a later date or in holding off from signing any final authorisation until a later point. On the one hand, that serves the purpose of allowing people space and time to make an informed decision at a point when they are not so emotionally vulnerable. On the other hand, some women do not want to think long and hard about that issue. In many cases, disposal is authorised prior to a termination or the medical management of a miscarriage, and the women involved do not necessarily want to revisit that or be followed up about it.

The current guidance allows a seven-day cooling-off period—for want of a better term—which seems to work effectively to allow those individuals who want to leave the hospital undecided and get back to us with a decision at a later date to do so or to allow people a period during which they can revisit their decision, change it and contact a designated person to discuss things in more detail. For me, it would be worrying to put a routine seven-day delay into legislation when that would not best serve a person-centred and flexible approach to the care of women in those varying circumstances.

Sandy Young: It would also create particular difficulties for us. The bill focuses on what we would think of as minimum good practice for early loss, not best practice. In some health boards, for people who have suffered losses under 24 weeks and for people who have suffered a stillbirth the hospital will offer an individual hospital arrangement for a funeral with or without a ceremony, rather than offering them the group default arrangement.

We welcome the fact that the recommendations of the Mortonhall report and the Scottish Government's commission are feeding into the bill and focusing on such things as giving time and space for decision making and the opportunity to reconnect. However, when there is only one choice—to either let the health board continue with a group arrangement or opt out for an individual, private process—that is a fairly simple choice in sad and tragic circumstances. When a health board offers a range of possibilities to people who have lost a child up to 24 weeks and people who have suffered stillbirth, it becomes a much more complicated process.

The bill addresses in detail the healthcare provider's responsibility in circumstances of early loss under 24 weeks, but it lets the stillbirth group sit alongside those who have suffered a perinatal or a neonatal death, with the assumption of private family responsibility. That is not currently how it is done under the auspices of many health boards in Scotland.

The Convener: Will you give us an example to help us understand the difficulties around that?

Sandy Young: An example would be the group of bereaved families in difficult circumstances who have made difficult decisions about the termination of a pregnancy for medical reasons—perhaps of a little one who has a condition that is incompatible with life outside the womb.

In NHS Lothian, when that happens in the second trimester—in the 12 to 24-week period—the majority of people opt for the hospital to help make an individual arrangement. Some make a private arrangement, but when both the private and hospital-supported options are offered, the majority ask the hospital to help make the arrangement.

There are rare circumstances in which friction arises from different pieces of legislation, and we need to work with people who are caught in those circumstances. The pieces of legislation are the Abortion Act 1967 and the legislation that governs the registration of births, deaths and marriages. The 1967 act allows for a person in circumstances that are rare—although they certainly occur—to have a medical termination in the third trimester of pregnancy. However, the legislation that governs the registration of births, deaths and marriages requires that person to register a stillbirth. That is a particularly challenging situation.

If health board staff do not continue to offer support to people for individual hospital arrangements for funerals, those people will not only have to face difficult decisions about their loss, and register the stillbirth of that little one, but make private arrangements for the funeral. Our question is whether we can have more consideration of third trimester circumstances of loss and the complexities that go with them. In addition, there is a question of whether those who suffer a stillbirth should be treated in an entirely analogous way with those who have suffered the perinatal or neonatal death of a baby. We think that they are different circumstances and there is a range of complexity and nuance in them. What we currently think is best practice allows hospital staff to help people towards an individual arrangement, whether or not it is private. If the bill is passed as drafted, there would be no legislative framework to support that work on loss in the third trimester.

09:45

Caroline Pretty: The worst-case scenario would be that, in the event of a stillbirth, we would be left with no means of arranging a funeral if the woman who experienced the stillbirth was either unable or unwilling to make such arrangements. If the reason for a termination in the third trimester is not a medical abnormality, it is likely that it will be happening because the woman's own medical or psychiatric health is at grave risk, and in such circumstances we could be left with no means of arranging a funeral or disposal for a stillborn baby, because in the bill the list of nearest relatives who can make such arrangements includes no one who is unrelated to that baby.

The Convener: This evidence session gives us an opportunity to ask about the different terms that are being used. For example, we have heard today about a campaign highlighting the extent of miscarriages in the United Kingdom, which I believe amount to 250,000. We have had references to "miscarriages", "stillbirths", "infant mortality" and so on, and it would certainly help me if someone could explain the differences in the terminology.

Sandy Young: Neither I nor Caroline Pretty is a clinician, so—

The Convener: I know, but you said earlier that you provided services right across the board.

Sandy Young: As far as NHS Lothian is concerned, at the point at which a lady stops being a gynaecology patient and becomes a maternity patient—in other words, the beginning of the second trimester—she will, if she suffers a loss of

any sort, be offered support for an individualised process. From 12 to 24 weeks, basic Government guidance allows for a minimum standard of hospital group arrangements or a private opt-out for an individual funeral; in NHS Lothian, the individual option for a hospital-supported or funded arrangement continues through the second trimester.

This is where my clinical knowledge is obviously lacking but, with regard to the circumstances of loss that a person might suffer, I believe that miscarriage is more common in the first trimester and becomes less common in the second trimester. As for the second and third trimesters, there are many tragic and unanticipated circumstances of loss, but most of those losses are known about some time before the delivery of the fetus or baby either because of a planned medical termination of a pregnancy or because tests have shown that there is no fetal heartbeat and that the fetus has died in the womb. In our context, that means that midwives will be talking to people on the basis of a shared understanding that a loss has already occurred and that the little one is going to be delivered.

That also raises questions for us with regard to when we consult people and the seven-day period. It is good practice for a midwife speaking to a woman who is about to go through a procedure that will lead to the birth of a stillborn child—or a fetus, if we are talking about earlier in the process—to tell her and discuss with her what will happen afterwards, and some of that discussion will focus on whether she wants to see and spend some time with the baby and an explanation of how they might proceed with final act of care choices and decisions. The range of circumstances in a hospital setting and the nuances that come with that are not provided for in a legislative framework at the moment, and the risk—which would be tragic, given the genesis of all of the work that has been done in recent years—is that we take a risk-averse and safe approach to practice in which we minimise what we do and go back to simply observing the Government standard for the under-24-week period of having a group arrangement or the individual proceeding privately.

The Convener: With regard to the 12 to 24-week period, do we know how many women will find themselves in the situation that we are talking about? What are the national figures? How many families will find themselves affected by the legislation? We can always ask the minister that when she comes along.

Sandy Young: My knowledge is not current but, the last time I looked, I found that 2 to 2.5 per cent of pregnancies that get to the beginning of the second trimester end in some form of loss. Therefore, in hospitals where there are many thousands of births of little ones annually, there will be a few hundred circumstances of loss.

Bob Doris: Last week, the committee took evidence on the issue from impacted parents. I wonder what the reality is for national health service staff across the country who have to deal with pregnancy loss on a daily basis—sometimes, unfortunately, at very early stages. That pregnancy loss might be a miscarriage and sometimes miscarriages are predicted, so mum and dad will know that the baby will not survive. However, the miscarriage might take place at home, or mum and dad might have to go into hospital, whether that is planned or happens unexpectedly.

I wonder how aware NHS staff are of how to deal sensitively with, for example, a mum who appears at accident and emergency with severe pain because the failing pregnancy did not go as anticipated at home, or a mum who just goes into hospital. It is not always specialists who deal with that at the coalface in the NHS. I know that there are systems in place in NHS boards across the country to deal sensitively with that, but I suspect that it might not always be possible for staff to do that, because they do not have the experience or training.

What is the situation like? Does the bill present an opportunity for the NHS to deal more sensitively with, in particular, mums before 24 weeks of pregnancy who would usually be dealt with differently in the NHS? Where are we with that? Is this an opportunity to improve what we do?

Caroline Pretty: It is a significant challenge to ensure that midwives in particular are up to date, well informed and as confident as one can be in such a difficult and sensitive situation as dealing with individuals who have experienced pregnancy loss and stillbirth. There is probably a lot more that could be done.

Concerns about previous practice have brought a lot of focus to the area, and there has been really good work to improve staff development as well as the development of resources, information and processes. However, it is necessarily difficult and complicated—and will always be hard—for generalist staff to hold in their minds the detail that is necessary on occasions when they need to support women and their partners who have experienced pregnancy loss and the death of a baby. Those occasions are common but not everyday occurrences. That is a challenge with any type of specialist knowledge that needs to be delivered by generalist staff.

We could probably do more generally to develop specialist roles in midwifery, maternity and

bereavement services in the NHS in Scotland. We recognise that those services may be some way behind what is provided in major hospitals south of the border, where it is far more routine to have a bereavement department and specialist staff, which is not the case across the NHS in Scotland.

The introduction of the bill, together with recent changes to death certification, cultural change and social issues around funeral poverty—which the bill and the committee are interested in—might provide, as Bob Doris said, an opportunity to improve and develop the way in which the NHS supports bereaved families in relation to pregnancy loss and stillbirth, as well as, more generally, bereavement and the death of patients.

Jim Brodie: I am also part of the national committee on infant cremation. It has an education part and we are quite far on with having advanced information and training modules to go through the whole NHS in Scotland. The modules cover a code of practice and education that all staff in the NHS will have to go through as part of their continuous professional development.

Natalie McKail: Through the focus that we have following on from Dame Elish Angiolini's investigation, the Bonomy report and the contents of the bill, there is an opportunity to ensure significant collaboration across the agencies that are involved in supporting the bereaved in Scotland. We have been focusing on that and working closely with NHS colleagues to address the loss of confidence that some midwives have expressed in the explaining of the cremation process here in Edinburgh.

Dennis Robertson: I am looking for a bit of clarification on some points that have been brought up. We hear about support being offered and I gather that it is generally midwives who offer that support. Is that true of all health boards? Do we have specialist nurses, whether they be midwives or others, providing that support?

At what point is the offer to meet a funeral director given? Sometimes cremation is not the preferred choice; it could be burial. How sensitively do we approach that and at what point can the funeral director come in?

Caroline Pretty: Different health boards follow different processes. As Sandy Young said, some have for some time followed the model in current Scottish Government guidance for under 24 weeks, which offers a shared cremation or an opt-out to make private arrangements. Others, such as NHS Lothian, offer a range of options that depend on the circumstances of loss and the parents' choice.

In maternity services, we would generally expect midwives to have most such conversations, but that is also often done by chaplains, other specialists, those who have a particular interest in bereavement or, in some cases, bereavement services people such as me. The situation varies.

At such a time, women and their partners are incredibly vulnerable so, although we want people to have good detailed knowledge and access to a specialist resource to answer any detailed questions, we do not necessarily want even more unfamiliar faces parachuting in while people feel vulnerable in a difficult and intimate experience. We have to strike a balance between having front-line staff who are able and confident enough to provide necessary information and providing a specialist resource that the parents or families can draw on as required.

As Ann McMurray said at last week's meeting, there is perhaps one designated specialist bereavement midwife in the NHS in Scotland. That type of role can benefit staff support, training, development and role modelling, but it is not necessarily the answer to having a resource that is available at all times, because it is person dependent. That midwife will probably be allowed to go on holiday, be sick or have other things going on, so having someone in a specialist role is not necessarily a panacea for all health boards. It might be better for them to think more broadly about what specialist resources are required for bereavement in a range of circumstances.

Jim Brodie: From the independent funeral director's point of view, the majority of families who have lost an infant have a burial. We do very few infant cremations. We often deal with the situation when there has been a breakdown in trust between the family and the NHS, but the infants whom we handle are usually for a burial.

Most of the hospital-organised cremations are done through contracts or agreements with funeral directors. That usually involves the larger hospitals in metropolitan areas. In my 30 years, I have probably handled 1,000 infant deaths, of which easily 900 or 950 were earth burials—there have been very few cremations.

10:00

Andrew Brown: Many members of the National Association of Funeral Directors carry out contract funerals on behalf of NHS boards, but there is quite a variety of ways in which that is treated. Caroline Pretty and Sandy Young talked about the arrangements in NHS Lothian, where people can arrange an individual cremation through the hospital, irrespective of the gestation period. It would be a shame to lose that flexibility.

As I said, the situation varies from one place to another. In some places, the only thing that is on offer is a shared cremation but, in other places, an individual hospital contract funeral is available. We

have experience of families who do not want a shared cremation but who also do not want to take on the full responsibility of going to a funeral director of choice to arrange the entire funeral. It is important that the bill allows for that.

Sandy Young: I have a small point of clarification. In NHS Lothian, hospitals offer the possibility of individual cremation and individual burial, where there is a designated baby area in a cemetery. That very much involves working in consultation with local authorities.

The Convener: We will come on to some of those issues.

Nanette Milne: I, too, was at the informal meeting last week, at which the point came across that there is a lot of good practice in Lothian that is not necessarily repeated across the country. Concern was expressed that, in a busy unit with busy midwives, the midwives might not have time to give the support that is necessary. It is felt that there is a need for someone whose role is purely to counsel in such situations. I know that people from SANDS—the Stillbirth and Neonatal Death Society—are training to be counsellors to cope with such situations.

What are the witnesses' views on having a counselling service in hospitals across the country? The aim would be to support people not just in deciding what to do but in completing forms. There is concern that forms are put in front of parents and more or less filled in for them, then they are told, "Sign here." Because of their emotional turmoil, they are not terribly sure exactly what they are signing up to. Are there any comments on that?

The Convener: Before we get on to that issue, which is about arrangements after the loss has happened, I want us to cover one other issue. Although we understand that the vast majority of such situations will happen in a hospital in the NHS, the issue of prison and residential settings has been raised with us, so I want to tidy that up. Does anyone know what arrangements would apply in those settings? We can visualise that in the hospital setting. Perhaps such situations would not happen in a prison setting, because the person would be taken to hospital.

There appears to be no knowledge round the table of the arrangements. Does anyone know whether there are similar arrangements involving undertakers in relation to prison or residential settings?

Jim Brodie: No.

The Convener: We can perhaps raise that with the minister.

We will move on to some of the issues that arise after the loss has happened and engagement has begun to take place. We then get into bureaucracy and form filling, to use negative terms. There are questions about time, and religious and cultural issues that relate to when a burial, cremation or service should take place. Can we pick up on some of those issues?

Sandy Young: It might be helpful to understand how a lady's care is managed during her time in hospital after a pregnancy loss or a stillbirth. If the lady is fit and well physically after the delivery of the little one, in most cases she will go home in one or two days. I make a clear distinction between grief and bereavement counselling, which in most circumstances of loss belongs some way after the loss, and the giving of accurate and clear information to facilitate decisions about the final act of care.

A good thing in the bill is the provision that it makes for time for decision making. We absolutely support that. In the majority of cases in health boards, time for decision making about, for example, individual reconnection with health board staff is a different matter from time for making the sad but simple choice between proceeding privately and going to a default group arrangement system. How we manage that effectively in NHS Lothian or any other health board that chooses to continue to exceed a basic standard is a significant challenge. How can we create a single point of contact for someone who is reconnecting with a hospital after the seven-day period has passed and who wants to meet someone? If a board employs one bereavement counsellor, how will that work in practical terms to meet people's needs?

Generalist approaches need to continue so that the staff who work with people in the short periods for which they are in hospital can engage effectively with them. Specialist roles are helpful, but we are not in a world in which we are resourced to provide such a specialist in the eight, 12 or 24 hours for which someone might be in hospital.

Nanette Milne: We have found that there seems to be a gap when women in this situation are presented with the forms that have to be filled in. Not all the staff involved seem to have what I might describe as the appropriate clinical attitude to form filling; sometimes, a businesslike attitude is adopted, whereby people are simply asked whether they want this or that and are given a form to sign. Some women felt that they did not have the time to think about their choice. That is understandable in a busy maternity unit. Is there a way round that sort of problem?

Jim Brodie: The national committee on infant cremation has developed a new code of practice, under which the parents will be handed a copy of everything that they have signed. Regardless of

what has been filled in, they will get a copy of it. That code of practice has been adopted, but it has not yet been rolled out. A huge amount of work has been completed in that area, so the issue that you describe will start to fade. The problem is that the forms are not conducive to making things easy for a parent who has just been through a loss.

Holding off for one week is helpful, because it gives the parents the chance to get their heads round what has happened, but the most important thing is that there must be transparency. That is coming through slowly and gradually, but it is coming through. The code of practice will address quite a lot of what Nanette Milne was talking about.

Natalie McKail: As a cremation or burial authority, we would want to be assured that the individual and their family had been afforded appropriate levels of support. One thing that has come through strongly in the Mortonhall response and on-going engagement with affected parents is that, as Nanette Milne described, they felt that on occasion they did not really understand what was being asked of them or the potential consequences of completing the paperwork. To be reassured that we are carrying out the appropriate final act of care on behalf of the affected individuals, we need to know that due time and support have been put in place because, ultimately, it is a final act of care.

Tim Morris: The information that is given to bereaved parents is vital. It needs to be consistent—the same information needs to be delivered by all who are involved. I believe that that will also come out of the national committee. A level standard must be set and bereaved parents must be provided with the information that they need to make decisions that are correct for them.

Caroline Pretty: There is a balance to be struck. Some women might want to have a period in which they can revisit their decision, although they might be quite secure in what they have decided, while others might go away undecided and need time to reconnect. My concern is that, if we have to routinely wait seven days, it might be difficult to re-engage with some women, which will raise the issue of not having any authorisation whatsoever.

My preference would be to get authorisation, in cases in which the woman can give it, around the time of the loss but to have absolutely robust processes to allow people to reconnect, revisit their decision and change it if necessary. That means that, for women who did not come back a week later to go through paperwork, we would have something that was authorised in their name and, after a week, rather than not being sure whether they had not signed because someone had not given them the form or because the form was not well explained, we could presume that they had decided to remain with their decision.

Jim Brodie: The code of practice says that, if there is no engagement on the part of a parent after a period, the health board has the right to carry on. That is in the code of practice, not legislation.

Caroline Pretty: As we mentioned in our submission, the bill does not talk about a right to proceed; it talks about a duty to arrange the funeral or the final act of care after the initial period and the relevant period have expired. In that version, the board has a duty to proceed six weeks after the loss.

We are familiar with circumstances in which a woman might want to make her own arrangements but has not been able to do so in that timeframe. That might be because of a need to wait for genetic testing for confirmation of gender, which can take several weeks, or for results of a post-mortem examination. Further, if people do not want to use a baby area, where a lair is typically provided free of charge, they might want to arrange a burial in a paid-for lair. A significant cost is attached to that in most areas, and the parents might need to apply for a funeral payment, which can take several weeks.

There are all sorts of reasons why I would be concerned about the six-week cut-off placing a duty on a health board to act. I am happier with the wording that Jim Brodie talked about, which involves a right to act or a duty to act unless there is cause shown as to why the board should hold off or try to reconnect with the woman.

Colin Keir: The bill has a ranking of relatives who would be able to make a decision. Is that helpful? Are there problems with that ranking? Further, given the fact that, after 24 weeks, terminations are considered to be stillbirths, there are possible issues of confidentiality. What are your thoughts on that issue?

Sandy Young: In general terms, when people are bereaved in pregnancy, the earlier the loss, the smaller the number of people who will be in the know. Obviously, with a later loss, there will be much greater knowledge in the family.

Of course it is helpful to have that list of responsible people, but it still remains for the woman herself—and for her partner, if there is a partner involved at the time—to make the decisions about how much of their personal experience they want to share with those relatives. In cases of earlier loss, when the circle of those in the family who have already been included in knowledge about the loss is relatively small, the use of that list could be difficult. It would also be difficult when, because of other sad and difficult

circumstances, people have disordered or chaotic lives.

10:15

Caroline Pretty: In general, the list of nearest relatives is helpful from a healthcare perspective. The fact that it mirrors the Human Tissue (Scotland) Act 2006 is useful.

Jim Brodie: That is where it came from.

Caroline Pretty: People are familiar with that framework in terms of post-mortem examination authorisation, mostly outwith the area of maternity and obstetric loss that we have been thinking about. In cases of adult deaths or, sadly, some child deaths, sometimes there are disputes within a family and it is useful to have that type of hierarchy. It would be useful if other relevant areas of legislation, such as the registration of deaths, had the same hierarchy, because otherwise we would have the anomaly that a qualified informant would be a relative but that only a nearest relative could then go on to organise the funeral.

It would be useful to resolve that anomaly, but leaving that hierarchy of nearest relatives for an adult death or a baby's death or stillbirth without recourse to other arrangements being made is a bit of a problem for me, particularly in the circumstances that we have described where it is a stillbirth or where there may have been a termination for medical reasons after 24 weeks. The Abortion Act 1967 and regulations would preclude us from contacting any other nearest relative; we would not be able to register and proceed with a funeral in that case.

The 2008 regulations in England and Wales, which I know are under review, are quite useful in terms of putting a fallback position in regulation so that, aside from the list of nearest relatives, there is also a form of words about another individual being able to approach a cremation authority and apply to arrange a funeral on cause shown. It might be useful to think about that, because there will also be circumstances in which the person might not be a blood relative, an executor or a friend of long standing. I am thinking about people who die in care homes or nursing homes, where the management of the facility may organise funerals for residents who die in their care and do not have any known next of kin and have not left instructions. That seems an appropriate arrangement but it is not covered in the bill.

The Convener: Does Jim Brodie want to supplement that in any way?

Jim Brodie: No, I am happy with that.

The Convener: That is fine. Does anyone else want to comment?

Andrew Brown: As funeral directors, we would agree with that. It is rare, but we occasionally encounter situations in which there is a dispute in the family and uncertainty from our perspective as to who to take instruction from, so a hierarchy would certainly assist. Likewise, when there are no family members, in circumstances such as those that Caroline Pretty described, when people are in a care facility, it would certainly be to our benefit.

Richard Lyle: The committee has heard from two types of witness regarding the number of forms. One witness suggested that there should be quite a number of forms to cover all the different situations, and there are many different situations for deaths of children, adults and elderly people in ordinary circumstances. The bill explains that a single application form will be used to record all applications for cremation, including cremation of remains from pregnancy loss. NHS Lothian's submission raises some concerns about a single form being used to cover all cremations, arguing that it could be distressing for parents to see questions about the marital status or occupation of the deceased, which are irrelevant, or even to see a form that is like "War and Peace", in which they have to tick lots of boxes.

The Institute of Cemetery and Crematorium Management suggested that

"a separate form for infants, stillbirths and pregnancy loss is considered preferable so as to remove inappropriate questions".

I ask two people who know exactly what is happening whether they would prefer one form or multiple forms to enable us to be very supportive of people who have sadly just had a loss.

Jim Brodie: My opposition to the proposed new form has been noted several times. I know that having one standard form for everybody is considered ideal, but 99.9 per cent of the cremation forms that are filled out for cremations in Scotland are completed by the funeral director who asks the client the questions and explains the form. Clients are not interested in looking at the questions; they have lost someone and they just want the cremation to happen. I believe that the forms date back to 1902, when cremation was extremely rare; now, it is probably the method of disposal in 75 to 80 per cent of cases in Scotland. To be honest, people see the forms as a necessary pain. No matter how much we educate and train funeral directors or arrangers, there are guys who will just rattle through the form.

At a recent meeting an affected parent vented her frustration that nothing seems to have happened since the scandal broke. My answer to her was that actually everything has changed dramatically. Within a matter of months of the scandal breaking, virtually every crematorium in Britain—especially those in Scotland—had

changed their own, non-statutory, forms, to make ashes instruction very clear. We have to go through the forms very carefully with the client to get the information. Even then, most crematoriums will not dispose of ashes until 28 days after the cremation has taken place, so that people can still change their mind. A huge amount had happened even before the infant cremation steering group started its work.

My major problem with the form is that the vast majority of cremations in Scotland are adult. Typically, I walk into a family home and meet a lady who has lost her husband and who has arthritis, or whatever. I have to get her to sign a form, sometimes six times, and then I have to go through another form—the crematorium's non-statutory form—which asks basically the same questions. That makes things a lot harder for the clients.

I have spent a lot of time in America. Believe it or not, in a lot of the states once someone gets the death certificate—the funeral director is a registrar, licensed by the state—they can do what they want. If someone has the death certificate, there are no application forms for cremation or burial. I am not in favour of that, but times have changed so much and cremation is now the norm.

Over the past few months I have asked several crematorium staff what information they need on the application form. They told me that they need the basic information about the person who has died, but they do not need a lot of medical information because we do not have a medical referee; the superintendents of the crematorium have no medical expertise, so a lot of the medical questions are a waste of time. They need to know that the death has been legally registered and they need a form 14 from the registrar that allows the cremation to take place. They also need clear instructions regarding the disposal or retention of ashes and a clear affidavit from the funeral director that the construction of the coffin meets environmental protection requirements.

The long and the short of it is that there should be one form for adults, one form for children and one form for infants and termination—otherwise there would be a massive number of forms, which would be cumbersome. If we move to a digital format, that is slightly different—for example, if one question is answered, a lot of others could be automatically missed out—but at the moment you are talking about five or six pages of pain that the family really do not want to go through.

Andrew Brown: The key factor about the application form for cremation is that it is the same across all crematoria. At the moment there is a wide variety of forms. As Jim Brodie said, crematoria have introduced supplementary forms, many of which ask exactly the same questions. I understand that some crematoria have specific questions, because they may have an alternative music system or they may offer the opportunity to webcast the funeral. Those options are not offered by every crematorium, so a separate document would be required. The key thing is that the questions and the forms are the same across all crematoria.

One of our concerns is about having the same form for adult, stillborn and non-viable fetus. The NAFD would certainly prefer there to be either three separate forms or, if it is to be one form, one form with selectable parts, so that the funeral director could print off the relevant part of the form to ensure that someone who has just lost an elderly member of their family is not presented with a form that contains detail about infant death, which is irrelevant to that family and may upset them further.

Likewise, the bill's intention to have a standard application for burials would be extremely helpful. As the population of Scotland is becoming more mobile, more people will perhaps arrange a funeral in one part of the country for a service and cremation or burial that takes place in another part of the country. There are all sorts of practical reasons for it being useful to have the same form for every burial authority and every cremation authority.

As I said, it would still be preferable for there to be individual forms for the three categories of cremation.

Tim Morris: The institute obviously supports separate forms. I will dwell on the application form for pre-24-week babies. As Andrew Brown said, a statutory form for those instances will promote standardisation across all cremation authorities, which is vital.

I agree with the introduction of a statutory burial form, because when a lair purchaser purchases a right of burial, which is registered in a statutory register, the proper information needs to be transferred from the application to the statutory register. When it comes to reopening a lair for a second or subsequent burial, the authority would have to ensure that the registered owner's rights were being maintained, so a statutory form for both initial purchase of a lair and its subsequent use is ideal.

Natalie McKail: Speaking on behalf of a cremation and burial authority, I reiterate the points that have been made. We would like to see a consistent approach across Scotland. Andrew Brown made the point that our customers are very mobile, but we also want to ensure that the expectations that there are on staff—whether they are in the private or public sector—are clearly articulated. Consistency of approach in terms of

documentation will reinforce that, so we will have the same type of practice across Scotland and, I hope—through changes that are taking place—down south, so that a network of common practice is created across the UK.

Sandy Young: Consistency would be a great help in our setting, because health board areas are not coterminous with single local authorities, so in NHS Lothian we are dealing with four local authorities. A small example is that in some set aside baby areas, the local authority treats the bereaved woman or family as a lair holder and gives them papers of ownership, whereas in other local authorities they do not. The amount of information that people who are having first consultations in a health board context currently need to know—when there is not consistency across the country—is potentially vast. That is why, increasingly, the midwife who is working directly with the person concerned needs to call for additional help because questions are asked that relate to all that complexity and to the plethora of possibilities given that there is not a standard approach across the country.

10:30

Bob Doris: I will not ask about whether there should be one, two or three forms, but what I took from another evidence session was that whatever key questions have to be asked should be asked very sensitively and consistently and that families should properly understand what they are agreeing or not agreeing to.

That led on to the idea that all the paperwork could be perfect and we could check it properly. However, the paperwork involved in the babies' ashes scandal often appeared to be perfect; the issue was that people did not know what they were signing up to or whether they had, indeed, signed up to something. It does not matter how fantastic we make the forms, or whether it is one form, three forms or five forms. In one respect, that is powerful and important, but in another respect I suspect that it is not the issue for many parents. For them, the issue is knowing, and being able to trust, that their wishes are clearly requested and clearly carried out.

How do we make sure that what is said on the form happens and that the parents who have suffered a loss are very clear that it has happened? That was raised in evidence at last week's meeting. How we do put checks and balances into the system without retraumatising bereaved parents? That seems to be a significant challenge. Suggestions were made last week about how we do that, but the best way ahead was unclear.

I would be interested to know what people think about that. It is difficult to legislate for a sensitive, sympathetic, empathetic conversation between parents and a funeral director or a nurse in a hospital. How can that be built into the system so that there is a check and balance to ensure that it is not just the paperwork that is right and that there is proper comprehension of it when it is signed?

Jim Brodie: Again, that is quite well handled by the code of practice, because it covers all three parties: the hospital, the funeral director and the crematorium. We can train people to the nth degree but we cannot train them to care or empathise. However, the vast majority of funeral directors can do that. I am quite sure that every funeral director will explain to every client that the scattering of ashes is an irreversible act, as is the process of cremation.

Part of my argument against the new forms is about having fewer signatures. However the most important issue is that the disposal of ashes is clearly explained and signed for. Currently, that aspect is not included on the plan A funeral form but is on every crematorium's supplementary forms, which have to be clearly signed.

I would say that a lot of the errors and mistakes of the past would not happen again even if we did not change a thing.

Natalie McKail: There are a number of points that I would make—

The Convener: Excuse me, but I want to give Tim Morris the floor. I will bring you in after that.

Tim Morris: As has been discussed at national committee level, we can achieve consistent information and an audit trail of decisions made.

Natalie McKail: In relation to that, it is proposed that openness and transparency around record keeping and decision making are much improved. For example, it is important that individuals have a copy of the form that they completed at the time so that they can perhaps consult friends and family at a later stage about the documentation to ensure that the register is openly and publicly accessible with regard to whatever final act of care they have chosen. Those are important steps for individuals who want to be reassured that the final act of care has been carried out according to their wishes.

I know that documentation is not the be-all and end-all in that scenario, but additional training and collaboration across the different agencies can allow a supportive decision to be made, then checks and balances can be implemented through review of the documentation. I think that that provides a much more supportive and open atmosphere for individuals.

Andrew Brown: Although documentation does not prove that those conversations have taken

place, having a statutory document for pre-24-week babies forces the conversations to happen. Many of the issues around the ashes scandal were for pre-24-week babies. Because there is no statutory document, documents were submitted to crematoria with minimal information, and clearly the questions had not been asked. The documents will force those questions to be asked, either by a funeral director or by somebody in a hospital setting.

As Jim Brodie said, the code of practice insists on adequate training being in place. Certainly, from the funeral director's perspective, it is not unique to infant funerals. Any funeral that we arrange is with bereaved people who are not perhaps taking in all the information that we are giving them. The documentation for everything around funerals is critical. Having copies of everything that has been agreed is important so that bereaved people can reflect on decisions that have been made once they are perhaps in a better frame of mind to do so.

The Convener: I would like to cover areas that have not yet been covered. They are, I suppose, some of the more sensitive areas.

We understand that the vast majority of child deaths will be given burials; that was what you said earlier.

Jim Brodie: No. I am sorry. For independent funeral directors, the children who we tend to deal with are mostly burials. It is mostly the corporates that handle the hospitals.

The Convener: There is a presumption now that ashes will be recovered in every case.

Jim Brodie: In 30 years, I have never not got ashes when I asked for them. Now, the code of practice means that every effort will be made to retain ashes, and that if there are no ashes Her Majesty's inspector of crematoria for Scotland will investigate why.

The Convener: In what circumstances could there be no recovery of ashes?

Tim Morris: A pregnancy loss at a very early gestational age that is cremated in a cardboard container will not, in some circumstances, although they are very rare, produce ash. When a wooden coffin is used, there will certainly always be ash.

Natalie McKail: All of our infant or NVF cremations have resulted in ash. One of the things that we have been discussing through the national committee and the subgroups is that all operators should ensure that they maximise recovery of ash. That has been championed by Willie Reid in particular—I know that he gave evidence to the committee. All the efforts of our operatives are now focused on maximising recovery of those ashes. I know that that is happening across Scotland.

The Convener: That is happening now and there is every expectation that when ashes are requested they will be available, and there is nothing to prevent that happening other that what Willie Reid described.

Tim Morris: Very rarely would there be no ashes.

The Convener: Did I read in the briefing for this meeting—the written evidence—that other methods are now being developed?

Tim Morris: There is operational guidance from the national committee that sets out the cremation conditions that are ideal for maximising recovery of ashes.

The Convener: The bill specifies that ashes should exclude metal. Should the bill specify what should happen in those circumstances? Tim—you are on a run. I will take others if they feel a need.

Tim Morris: Although his recommended definition of ashes says "following the removal of any metal", Lord Bonomy made the comment that that does not preclude recycling of that metal for charitable purposes.

At the present time, 60 per cent of UK crematoria and only five out of the 28 in Scotland recycle metal that is recovered with the specific consent of the applicant for cremation. A scheme that is administered by the Institute of Cemetery and Crematorium Management generated in the past 12 months £700,000 for charities that were nominated by scheme-member crematoria. The other 40 per cent of UK crematoria and the 23 in Scotland that do not recycle are probably burying that metal within the grounds of the crematoria without consent. The ICCM feels that, whatever the method of disposal of that metal, consent should be obtained from the applicant for cremation—the bereaved parents or the applicant for an adult cremation. In other words, all cremations should have consent for disposal of metal and applicants should be told the options that are available to them.

The Convener: Are there any other comments? Does anybody wish to add anything to Tim's response?

Nanette Milne: There seems to be a little bit of disagreement between the bill's definition of ashes and what Lord Bonomy said. What are the views round the table on that?

Jim Brodie: Just about everyone has agreed to and adopted the Lord Bonomy definition of ashes' being all that is left in the cremator after removal of metal.

Tim Morris: Although there is a need for the legal definition, there could be some sort of explanatory note in the bill stating that the legal definition that is contained in the bill and the definition that Lord Bonomy gave are one and the same.

Caroline Pretty: NHS Lothian endorsed the words in the bill for clarity, but I noticed that some of the other written feedback asked whether the grinding, or cremulation, part of the definition is required. It might offend the sensibilities of certain faiths or cultural groups who would not normally apply that process following cremation. There is a question about whether it is necessary to include that or whether to use the simplified Bonomy definition—everything that is left—without including the cremulation part of the process in legislation through the definition of cremation and ashes.

The Convener: I think that we have covered all the points that we wanted to cover. I am looking at Bob Doris and some other members. If Bob has a wee point to make and is looking for some clarity, we will do that first and then ask the panel whether there are any areas that we have not covered this morning and give them a last chance. We will then wrap the meeting up because we should be hearing the minister by now, I think.

Bob Doris: I apologise to the witnesses. This is not a question that I was going to ask but I spotted the matter in our briefing and I think that we should ask it for completeness in the evidence.

There might be a new criminal offence created by negative instrument for people who fail to meet their obligations under the terms of the new act. It would be punishable by a fine not exceeding level 3 on the standard scale. I do not want to finish on a negative note, because so much that is positive has come out of the meeting—however, it is only right to ask. If that negative instrument is passed, what do the panel think would be an appropriate sanction—fine or imprisonment—for those who would be prosecuted? Let us hope that there never are prosecutions because the system is already changing and will continue to improve with the passage of the bill. However, there might be such a provision in the bill, so it would be good to get something on the record about it.

Tim Morris: The appropriate level of punishment is not something that springs to mind. I can speak only for crematoria, but anyone who wilfully flouts the law deserves to be punished. If a person who works in a crematorium were to lose their job for breaking the law, that would be more significant for them than being fined.

Natalie McKail: The only thing that I will say about that is about the expectations of individuals who are affected by the services that we provide. In the past few years in Edinburgh, we have been building trust and respect among the people whom we serve. I will not comment on the nature or level of sanction, but it should afford the people whom we serve assurance that there is a real legacy, and that if there is any wrongdoing in the future, appropriate action will be taken.

10:45

Caroline Pretty: We do not have a general concern about such negative instruments, except in so far as they would apply to private burials. In our written response, we said that the bill's definition of "human remains" is lacking, except for the fact that it excludes cremated remains, and that there is a lack of definition in respect of pregnancy loss at under 24 weeks. In some circumstances—for example, a medically managed early miscarriage or early medical termination—the woman might pass the pregnancy tissue at home, outside the hospital setting. In those circumstances, informal arrangements are sometimes made—burying the tissue in private ground, or under a tree. Things like that happen. I want to be sure about whether the definition of "human remains", as it pertains to private burial, would include pregnancy tissue. If it did, that may have the unintended consequence of bringing such informal private arrangements under legislation through which there could be a penalty, or a year's imprisonment, for not following the correct procedure to have such a burial approved by the local authorities.

Nanette Milne: My question is on criminality and people breaching the law. Should that be determined by regulation or should it be in the bill? The committee has had some concern about that.

Natalie McKail: As long as what those who work in the industry are expected to perform in terms of their duties and the consequences is clearly articulated, the City of Edinburgh Council has no preference about whether the provision is in the bill or done by regulation.

Jim Brodie: I agree.

The Convener: Do panel members want to say anything about areas that we have not covered?

Jim Brodie: I will be brief, because this is a huge area. We have not touched on the regulation and licensing of funeral directors, which is like trying to knit fog. When I read the committee's comments, I noticed that you spotted that there are a lot of holes in that regard. In defence of the Government, with which we have had a lot of conversations on the issue, I should say that because the matter is so complicated and involves so many factors, the Government is looking at it as a whole, over a period of time. We agree that the Government should do it that way.

To put that provision in the bill now would be virtually impossible. I will say only that the Government seems to have taken Lord Bonomy's recommendations as being written in stone. There is a sense that we need to meet all the recommendations as hastily as possible, but there is a reason why the laws in this area have not been looked at for 150 years: they are extremely complicated and they affect many different areas that have different traditions and ideas.

I am whole-heartedly in favour of the bill; the fact that it has a few holes can be addressed later. We need to have a chat with the powers that be about licensing and regulation of funeral directors: there are many arguments for and against.

The Convener: It is useful that you have put that on the record. You will know that more than one committee is looking at the bill. Obviously, we have a different focus from the Local Government and Regeneration Committee, which has focused on some of those issues.

Natalie McKail: I have a final thought for committee members. It has been clear in my mind that we need continually to improve collaboration across the agencies that support the bereaved at a very difficult time. Is there an opportunity almost to require public agencies and statutory agencies to continue that collaboration? This is a significant opportunity for us to revise the legislation and I want part of the legacy of the bill to be our working together effectively in the future.

The Convener: That is useful.

Tim Morris: I endorse that. It would be good, even after the national committee on infant cremation has finished its work, if that collaboration continued.

From a cremation authority's point of view, the crematorium rarely sees a bereaved family before the funeral, so it relies on consistent information that is based on considerations by the crematorium, the funeral director and the hospital. There should be consistent information, please.

The Convener: Thank you for that.

No one else wants to speak, so I thank you all for your time, for the evidence that has been provided this morning and for the written evidence that we have received. I hope that we can reflect it all in our final report.

10:50

Meeting suspended.

10:56

On resuming—

The Convener: We continue our evidence-taking session. I welcome to the committee Maureen Watt, Minister for Public Health, Dr Simon Cuthbert-Kerr, bill team leader, and Graham McGlashan, principal legal officer, all from the Scottish Government. I invite the minister to make opening remarks; we will then move to questions.

The Minister for Public Health (Maureen Watt): Thank you for the opportunity to speak to the committee today about the Burial and Cremation (Scotland) Bill. I will focus my opening remarks on the part of the bill that this committee is considering.

The bill contains a range of provisions that address the issues identified by Lord Bonomy to ensure that previous mistakes are not repeated. The bill provides a consistent legal process for the burial and cremation of all human remains, including those of a pregnancy loss.

In the case of a pregnancy loss, the woman who has experienced the loss is placed at the centre of the decision-making process. The bill requires that her options are explained to her and that she will have the sole right to make key decisions. Each key decision must be recorded, and the bill provides for forms to be prescribed, so that the process is followed and the information recorded is the same each time.

The bill will ensure a clear audit trail of decisions made and actions taken. Registers in which the information is recorded will be open to the public. However, in the case of pregnancy loss, the woman who has experienced the loss will not be identifiable. The provisions will introduce important consistency and accountability.

The bill defines "ashes", removing any uncertainty that what remains after a cremation will be regarded as ashes. People who apply for a cremation of any sort will be required to state on the application form what they want to happen to the ashes. A cremation will not be allowed to take place without that information. The bill also sets out what may be done with ashes that are not collected.

Although Lord Bonomy's work was concerned with infant cremation, we are taking the opportunity to make improvements to the cremation process generally. That will ensure that, in every cremation, there will be clarity about what is being done, what is expected and what will happen to ashes.

The bill will deliver a strong package of measures that fully reform the legislative framework for cremation, making it fit for purpose

for today's needs. It will implement Lord Bonomy's recommendations and make important changes to the processes that are involved in the cremation of pregnancy losses and babies, as well as bringing about improvements in the cremation process as a whole.

I look forward to the committee's questions.

The Convener: Thank you, minister.

11:00

Bob Doris: A lot of positive things have come up in evidence so far, but I hope that you will forgive me asking about areas in which people have suggested that the bill needs more clarity or might need to be improved.

One of the things that were welcomed is the proposed seven-day period in which, when a tragedy has occurred and a mum has lost her baby, hospitals should seek to establish the wishes of the mum; the further six-week period following that in which, if no decision has been made in the first week, the mum can make arrangements; and the further seven days in which the mum can change her mind. The bill says that, after six weeks, the health board would have a duty to decide how the baby's remains would be handled. This morning, it was suggested in evidence that that should be a right rather than a duty, because there could be reasons why six weeks was not long enough for the mum to make a decision. Another suggestion was that, if there were a duty to proceed, there should be a caveat that that duty would apply only if there were no stated reasons why a decision could not be made by that time. Have you given consideration to whether including the duty without such a caveat is too firm? Do you think that there might be a need to allow more discretion and flexibility?

Maureen Watt: First, I say that this is a sensitive subject and my heart goes out to some of the witnesses to whom you have spoken. In drafting the bill, as you know, we have been careful to consult widely, and we have worked in conjunction with people who have been in this situation and with charities such as SANDS, so that we can reflect their concerns and wishes, as far as possible.

It is absolutely right that we put the woman at the heart of this matter, as we are dealing with her loss. It is a terribly traumatic time, and we have to realise that a person might change their mind during that time. There might also be a requirement to examine the tissue or the fetus. Because of those factors, six weeks was considered to be roughly the right amount of time. However, of course we would expect health officials to deal sensitively with the matter, and it would be perfectly acceptable for further time to be allowed.

Bob Doris: That is helpful. If it is a duty, consideration might have to be given to ensuring that some NHS boards do not kick in with that duty automatically after six weeks without showing discretion and flexibility—I am delighted to hear you would like common sense to prevail at that point. Is that something that you might consider, on reflection?

Maureen Watt: I think that the duty is to ensure that the action is taken only after six weeks, not before, so that a woman is given the right to change her mind if, after the initial trauma, she reflects on her decision and decides that she wants to do something different with the remains. We want to ensure that she has six weeks in which to do that. However, if that is not enough time, we would expect the authorities to be sympathetic.

Bob Doris: That is helpful. Witnesses earlier also welcomed there being two clear options for how a hospital would seek to support a mum who has lost an unborn child—whether she wants to deal privately with that or whether the NHS would make arrangements, which would, quite often, be group arrangements. We heard from NHS Lothian that its approach is quite nuanced. It is quite supportive of mums and families who want to use bespoke, private arrangements, and it does not leave them to their own devices.

Again, it is about ensuring that the bill does not lead to unintended consequences. There is the option of the NHS taking care of the matter at a time of distress if that is what the mum wants, the option of the mum going off and arranging something privately, and the spectrum in between in which NHS boards can sensitively help and support. I want to ensure that the bill does not squeeze out what could be best practice or emerging best practice in NHS Lothian and other NHS boards.

Maureen Watt: Obviously, I am open to other suggestions, but the bill sets out the options that are available for a woman. There will be those who choose to take the remains and dispose of them privately through a funeral director. I think that the committee has heard that funeral directors in the main are also experienced in dealing with that situation. It is important that women have the chance to talk and reflect with midwives or doctors and pastors or hospital chaplains post the event and to have flexibility for up to six weeks to choose what they want to do.

Bob Doris: That is helpful.

I will ask a final question, as I know that other members want to ask questions. NHS Lothian and perhaps other boards are seeking reassurance

that the legislation does not preclude them from providing additional support to mums who have lost their babies. I see Dr Cuthbert-Kerr agreeing that that is not the intention, but I want to get that on the record to reassure the NHS. The minister now has the opportunity to do that.

Maureen Watt: If Simon Cuthbert-Kerr is nodding, I will let him answer that question.

Dr Simon Cuthbert-Kerr (Scottish Government): That is absolutely right. As the minister has said, the key to the bill is to allow the flexibility of approaches. The reality is that not all health boards necessarily have the same procedures in place as NHS Lothian does. However, nothing in the bill would prevent a health board from offering what has been described, whereby a family is supported in what is essentially a private cremation by the health board. We very much expect all health boards, when they begin to discuss the options with the woman who has experienced the loss, to explain to her the various options that are open to her and what they all mean.

Maureen Watt: There are chief medical officer guidelines and advice, which have been updated regularly. Those will, of course, be updated again as a result of the bill.

Bob Doris: That is very helpful. Thank you.

The Convener: NHS Lothian, which is doing a lot of good work in the area, raised the point that the proposed duty does not give it that flexibility. It feels that what is in the bill is a duty that it must act on at the six-weeks point.

Another issue that has been raised in evidence is the seven-day period and the time to reflect. Issues come out of that to do with religious and cultural beliefs that would impact on that. The point has been made that applying that standard would be best served by having flexibility around that, as well.

Maureen Watt: We are very mindful of that, and I think that flexibility will be in-built in the guidance.

Simon Cuthbert-Kerr and I recently talked about the fact that we now live in a multicultural society. As the convener suggested, some faiths will want to dispose of remains as quickly as possible. We are mindful of that. In drawing up the guidance and the forms, we will continue to consult widely.

The Convener: So that point will be addressed in the forms, but the bill will say that there is a requirement.

Maureen Watt: Most people want to have people buried as quickly as possible. The six weeks gives the woman who is at the centre of this issue the flexibility and time, because of the trauma of the situation, to reflect and to decide what to do. I do not think that anybody would want to drag the process out unnecessarily.

The Convener: The earlier stage places a duty on everybody to wait until seven days after the decision has been made and to reflect on whether that decision is what they really want. It is not a very apt description, but it is almost a cooling-off period and it would impact on those whose religious or cultural practices require a very quick disposal or ceremony. The legislation would apply to everyone, would it not?

Maureen Watt: It is not set in stone that you would have to wait seven days. Perhaps Simon Cuthbert-Kerr will want to answer this.

Dr Cuthbert-Kerr: The seven-day period is a response to engagement that we have had with pregnancy loss charities such as SANDS, which the minister mentioned earlier, and others. Their experience is often that a woman might make a decision about how she wants the remains to be handled but, having reflected on it, she might choose to make a different decision. We therefore felt that it was important to have a period in which nothing would happen that would allow the woman to change her mind.

However, we have subsequently had representation from the likes of the Muslim Council of Scotland, which has noted that the provision might prevent a burial from taking place sooner rather than later. We are now going to consider lodging a stage 2 amendment so that a woman, whether it be for a religious or cultural belief, or just because she is clear in her mind that she knows what she wants to happen, can waive the seven-day period.

The Convener: That is helpful.

We heard this morning that a woman who suffers a pregnancy loss might be in a hospital environment for 24 or 48 hours. We know that there is one midwife in the whole of Scotland who has some training in the issues. The minister placed some responsibility for the bereavement process on doctors, nurses or possibly hospital pastors. The success of the process depends on good communication. Are we confident that we have the capacity? Do we have the people in place who have the training and expertise? If not, how will we implement the legislation to make a difference to people who have suffered a pregnancy loss?

Maureen Watt: Convener, we can always do better, but this is being done at the moment and I am not aware of any complaints about what happens just now. There is already training available in the hospital setting and a woman will be discharged to her own general practice, which will be aware of the situation and be able to follow it up.

The Convener: Some of the other members might want to refer to it but we have had engagement with women parents who have suffered such a loss. They described their experiences of busy maternity wards. Perhaps Nanette Milne can describe some of that for us.

Nanette Milne: I was going to ask about the application forms. Some bereaved parents who had lost a baby or had a stillbirth felt that a member of staff presented them with the form and asked them various questions, and then the form was essentially filled out for them. They did not have any real idea of what they had signed up to and felt that the process was a bit rushed. Some of them felt that at that stage perhaps there should have been counselling with someone who had the time to sit down with them. I appreciate that, in a busy maternity ward, midwives do not have time to deal with a bereaved parent when they are rushing to do a delivery. I see how such situations can arise, but concern was expressed about the point at which people are asked to fill out what are fairly complicated forms.

11:15

Maureen Watt: In other situations, we hear of funeral directors filling in forms for bereaved relatives without necessarily really delving into what the form and the questions on it actually mean. We want to make sure that the forms are as streamlined as possible and that they have specific sections covering children and adults.

I think that the fact that there will be a period of delay will mean that if women feel that the form has been filled out in a rush, they can ask to go back over it. There is CMO guidance already, and there will be further CMO guidance on that particular part of dealing with a death.

The Convener: How many women will benefit from the legislation? I suppose that I am asking how many people currently find themselves in such a situation, from pre-24 weeks right through to suffering pregnancy loss in the broadest terms.

Maureen Watt: I ask Simon Cuthbert-Kerr whether he has the figures.

Dr Cuthbert-Kerr: No.

Maureen Watt: I can get you the figures on pregnancy loss and stillbirth, convener; they are out there. They are declining. I am currently having a maternity review carried out that covers infant mortality and maternal health and which will also help with that information. As you know, the CMO is very experienced in that area, and we are determined to get the numbers down still further. When it comes to how many people are affected, we can certainly get you those figures.

The Convener: I ask the question because the legislation will place a lot of requirements on a lot of different organisations in relation to record keeping, counselling and so on. We are creating demand, and there will be an expectation that people will be communicated with effectively and their wishes will be respected. If we do not know the actual number of women who need to have access to the new regime, how can we understand the resources that we need to make it effective?

Maureen Watt: It is not a new regime; it builds on regimes that are in place at the moment. As I said, there is CMO guidance already.

The proposal is the result of Lord Bonomy's report and the baby ashes scandal. We want to make sure both that the process reflects what happened and that it never happens again.

Richard Lyle: Good morning, minister. I return to the fact that the bill explains that a single application form will record all applications for a cremation, including the cremation of remains from pregnancy loss, stillbirth or the loss of a baby.

We have had evidence from several people on the preference for more than one form. To me, a single application form is a piece of A4 paper on which you put everything to do with the death. We have all experienced deaths during our lives, as well as births. A single form could be expanded to become a booklet, in which case it would no longer be a single form.

We could be asking questions of women who are burying their husband but who sadly experienced pregnancy loss many years ago, and they would be traumatised by having to go through that form with anyone. Why can we not have three separate forms? NHS Lothian and the Institute of Cemetery and Crematorium Management have raised concerns about having a single form. The suggestion is that there should be three forms, with one form for infants, pre-24 week and other stillbirths and pregnancy losses. What was your original reason for having only one form to cover all circumstances?

Maureen Watt: It has not been decided yet what the form will look like or how long it will be—that will be decided in consultation with organisations, health boards and funeral directors. However, you can rest assured that we want to keep the form as sensitive and precise as possible, while making sure that we have enough information so that our records are accurate and consistent. As I said, we do not have consistent records across Scotland.

Richard Lyle: Are you aware that some crematoria have introduced their own form? There could be a wide range of forms in use in crematoria across Scotland.

Maureen Watt: Yes, and that is why we want the forms to be consistent, so that every organisation uses the same form.

Richard Lyle: I have other questions, but I know that other members want to come in, so I will leave them until the end.

The Convener: You will have the opportunity to come back in. Rhoda Grant is next.

Rhoda Grant: I will ask questions around confidentiality, especially with regard to post-24 week stillbirths. The bill seems not to afford the same level of confidentiality as existed previously. Has the minister given any thought to that issue, particularly with regard to late terminations?

Maureen Watt: Yes, there is guidance on that area. Post-24 weeks is regarded as a stillbirth and must be recorded, whereas pre-23 weeks and six days need not be recorded. The forms will ensure that the person affected is not identifiable.

Rhoda Grant: I presume that that applies to all cases. Okay.

The bill states that the person who makes arrangements must be aged 16 or over. What regard is paid to a mother who is under 16 and her wishes relating to disposal?

Maureen Watt: That, again, is a sensitive situation. We would hope that either a close relative would be involved or, if the under 16-year-old does not want relatives to be involved, the NHS would provide that support.

Rhoda Grant: That does not seem to be in the bill.

Maureen Watt: We can check but, in general, we have said that if a woman does not want relatives to be involved, her wish should be respected and the NHS should provide the service.

Rhoda Grant: Okay. Perhaps I need to look at that issue again, because my understanding is that that is not the case for mothers who are under 16.

Maureen Watt: We can check that out.

Nanette Milne: My questions about the form have been answered, so I will cover the definition and treatment of ashes. The bill's definition of ashes differs slightly from Lord Bonomy's definition. The previous panel said that although the bill's definition was fine, for absolute clarity, it should perhaps include Lord Bonomy's definition, too. There was also a question about whether the means of dealing with ashes—grinding or whatever—needed to be in the bill, because it might upset some people.

Maureen Watt: It is a very sensitive area. I visited a crematorium to ensure that I knew exactly what happened there—I am sorry; I have lost the thread of your question.

Nanette Milne: It was really about the definition in the bill—

Maureen Watt: Of ashes, yes.

Nanette Milne: And the use of Lord Bonomy's definition.

Maureen Watt: The stakeholders thought that the definition of "ashes" in Lord Bonomy's report was not quite what they had expected and, as a result, we have redefined the term with their agreement.

As for what happens in a crematorium, it has been suggested that there be separate trays for baby ashes or that people can opt for a completely separate cremation in a small cremator. Those options are available and should be explained to people.

Nanette Milne: Another issue is the availability of ashes. The people around the table in the previous evidence session thought that, in the vast majority of cases, ashes would be recoverable and that, in fact, it would be very rare for that not to be the case. I think that everyone accepted that.

Of course, both definitions exclude metal in the remains. The question is: what happens to that metal thereafter? I honestly cannot remember whether the bill says anything about what should happen to it, and I would welcome your thoughts in that respect.

Maureen Watt: Metal can be separated from the ashes. I believe that in the previous evidence session someone said that £700,000 of metal had been recovered, although I do not know over what period. If the metal can be put to some good use—perhaps in the form of funding for counselling charities—that sounds like a good idea, and we will definitely take it away from this morning's session and have a look at it.

Nanette Milne: I might have more questions later, convener, but that is it for now.

The Convener: Do you want to follow up on that, Bob?

Bob Doris: I thought that the idea from the previous evidence session sounded really interesting and positive. However, it was also suggested that even if the metal in question was not deemed to be part of the ashes relatives would still need to consent to its use. They would need to be informed of its recovery and the intentions for its disposal and would have to sign up to that as part of the process. Has the Government considered setting out in the bill, in regulations, in best practice guidance or elsewhere how

cremation authorities or funeral directors—whoever that responsibility would fall to—ensure that families know what is happening? After all, the metal could be from keepsakes that were in the coffin with the loved one who was being cremated, and the family might want it back or be keen to have it buried in a garden of remembrance; indeed, they might want to sign up to a recovery scheme. It is all about empowering the families and giving them a choice in the matter. Given that the issue goes wider than infants and babies, I do not know whether it needs to be considered elsewhere other than in the bill, but I would suggest that it definitely has to be considered.

Maureen Watt: It is something that there would definitely have to be a question on the form about. You can already see the form getting larger in order to take such matters into account.

Bob Doris: That was helpful, minister.

The Convener: Speaking of this ever-longer form, should the bill specify how crematoria should dispose of unclaimed ashes?

Maureen Watt: That is a big problem. Indeed, when I visited Seafield crematorium, I was taken into a room that contained unclaimed urns.

The bill will specify what crematoria or funeral directors should do with unclaimed ashes. We would expect funeral directors to take them back to a crematorium, which would dispose of them periodically. However, in all cases, we would expect that there would still be attempts to contact the relatives. It is an on-going issue, and it will continue to be an issue for crematoria and funeral directors. I can understand that sometimes people just do not want to claim ashes, but they should be able to say that and let the crematoria or funeral directors deal sensitively with the ashes after having kept them for a while.

11:30

The Convener: Members who have not yet asked a question do not wish to ask any at this point, so I return to Richard Lyle.

Richard Lyle: Most of the questions that I was going to ask have been answered.

In my experience of burying loved ones, I have come across some wonderful undertakers who have been very sensitive when working with the family. What is the Government's position on licensing undertakers? If someone knowingly breaks the law, what can be done to take that person to court?

Maureen Watt: We want to regulate the funeral industry more. There are increasing concerns about the industry, with people thinking that it is easy to set up as an undertaker, which is clearly not the case. The bill will give ministers powers to regulate the industry.

The Cabinet Secretary for Social Justice, Communities and Pensioners' Rights, Alex Neil, and I will also consider funeral costs. Costs are not dealt with in the bill, as it is not appropriate to do so, but Alex Neil is undertaking some work on that area. We have all seen Citizens Advice Scotland's report, "The Cost of Saying Goodbye", which shows that funeral costs are clearly to the fore.

Richard Lyle: I will not go into funeral costs, but we know that funerals are very expensive.

Another point that several people, including one witness in particular, have made relates to the inspector. Although we will have an inspector who will go out and inspect, will that person have someone to help them, given that there are 24 or more crematoria in Scotland? Will the inspector be just a one-man band—sorry, a one-person band—or will they be able to appoint someone to help them, just as prison visitors used to be appointed by local agencies? Further, will the inspector be able to fine someone, or recommend that they be fined, if they are found to have broken the new law?

Maureen Watt: We have one inspector at the moment, but the bill will allow me or any subsequent Minister for Public Health to appoint as many inspectors as are required. I hope that we will not have a situation where we need a lot of inspectors, but maybe one is not enough. We will certainly make sure that people feel confident that crematoria are working well and to a good standard.

Simon Cuthbert-Kerr will deal with the question of penalties.

Dr Cuthbert-Kerr: I suppose that there are two different approaches. The bill sets out a range of specific offences that attract particular penalties. An inspector or an individual member of the public will be able to report a breach, so there are various routes by which those formal penalties can be enforced. More generally, however, we see the role of the inspector as being one of ensuring that whatever business or organisation he or she is inspecting is doing what is expected of it. Our intent is set out in the section of the bill on the inspector's powers, which we expect to range from providing advice to a crematorium about how to comply with the law through to recommending to ministers that the operation of a particular crematorium be suspended. That is a decision that would be taken by ministers, but we would certainly view that as one of the options that an inspector could recommend.

Bob Doris: I want to ask a little more about how we deal with pregnancy loss before 24 weeks. Of

course, there are various distinctions that kick in in terms of timescale and terminology. The word "fetus" implies a pregnancy that ends at eight weeks or earlier. Eleven weeks also kicks in at a certain point within the bill. Perhaps by that point a woman will be booked in for a 12-week scan, and how that pregnancy loss is dealt with by midwives and specialists would kick in at that point.

I wonder whether thought has been given, or further thought could be given, to the very early miscarriages or pregnancies that end where mum is told that the pregnancy is likely to be unsuccessful but, as it is still at a very early stage, she should just go home and go through what she has to go through for the pregnancy to end. The baby's remains may be at home, or mum may have to go to accident and emergency, because early miscarriage does not always go to plan either. At that point, a person would be dealt with by non-specialists in the wider NHS, who clearly try to do as good and sensitive a job as they possibly can but who may not see those things very often.

At what point would the option be offered for how someone would like their unborn child or fetus—the terminology becomes important emotionally in those situations—to be dealt with sensitively? Is there standard and common practice across the NHS or should the bill act as a focus to improve how we deal with those situations, particularly on the non-specialist side of NHS care for the very earliest of pregnancies that end in miscarriage?

Maureen Watt: It is our intention, having studied the bill further and had more consultation, that the bill should apply to embryos, and we will lodge a stage 2 amendment to make that clear.

Section 50(2)(a) says that a woman may decide to make her own arrangements for the disposal of remains, rather than authorising another individual or the health authority to make those arrangements, and the woman would be given guidance on what she can do if she wants to make her own arrangements. There is CMO guidance on pregnancy loss up to and including 23 weeks and six days, recognising that the woman already has the right to make personal arrangements. It is currently possible for a woman to make her own arrangements for the disposal of those remains, but the bill will formalise that process and provide additional clarity and consistency.

Bob Doris: I welcome that. It is reassuring. I just wonder whether that can and does happen in practice. It might not happen consistently across the NHS at the moment, or perhaps it has never been done consistently across the NHS. It is about driving up standards. It goes back to that thing about the fact that a lot of front-line NHS workers may very rarely come face to face with a mum who may have recurrent miscarriage and pregnancy loss and who turns up at hospital. You have signalled that provisions will be introduced via an amendment, which I really welcome, but will you also consider providing wider awareness training for non-specialists in the NHS?

Maureen Watt: I caution against saying that there is not consistency at the moment, because there are clear CMO guidelines out there already and there will be new CMO guidelines that take into account the provisions of the bill once they come into force. Health boards have a duty to make sure that all those involved in this area are aware and get training on the CMO guidelines.

Bob Doris: Apologies, minister, but I just want to clarify my question. I did not say how significant consistency or inconsistency is in the NHS; I merely said that there is an opportunity to ensure that there is consistency. In any huge organisation there will be individual cases where people are not dealt with sensitively; that is just the nature of any huge organisation. It is about driving up standards and consistency, even when things are working reasonably well. My question was: will you use this bill as an opportunity to make sure that there is consistency and that front-line NHS workers who might not see these situations every day are made aware of their duties and responsibilities in a supportive fashion?

Maureen Watt: Absolutely. There will be an implementation programme, of which training will very much be a part.

The Convener: On the ambition to regulate, keep records and monitor, who monitors output in relation to the guidelines that are currently in place? When did we last evaluate whether they were being implemented consistently?

Dr Cuthbert-Kerr: There is not necessarily any external scrutiny of NHS internal records in that regard. We see that as one of the roles for the inspectors. In the case of pregnancy loss, we would look to the inspector of crematoriums or the inspector of burial, depending on what route had been followed, to carry out that role. There are clearly data protection issues involved. We would need to make sure that an external inspector was able to inspect records to the extent that they could satisfy themselves that things were being done properly, or to make recommendations where they were not being done properly, while protecting the confidentiality of individuals whose records were being scrutinised. That is one of the functions that we would envisage for the inspector.

The Convener: I am trying to get to one or two points. Who evaluates the implementation of the CMO guidelines that the minister referred to? How do we know that they are being implemented and that they are effective?

Maureen Watt: The CMO herself would make sure that she monitors the implementation of the guidelines in conjunction with people on the health boards.

The Convener: So we do not know, because the guidelines are not independently assessed, inspected or evaluated.

Maureen Watt: Not that I am aware of, but we can certainly let you know.

The Convener: We are talking about what is applied in regulation, what is in the bill and what becomes a legal duty. If we do not put some of these measures into regulations or make them legal duties, how will we ensure that the bill will establish and improve best practice? Who will monitor that? Who will inspect it? Who will tell us when things are going wrong and when they are going well?

Maureen Watt: It is very much part of the duties of the inspectors of crematoria to make sure that best practice is implemented in relation to burial and cremation.

The Convener: I was thinking particularly of the situation in hospitals. Who will ensure that the discussion has taken place and has been registered? Who will ensure that all that is proposed actually takes place?

11:45

Maureen Watt: At the moment, if anybody is not happy with a situation, there is a complaints procedure that they can go through. Things like this are often flagged up through patient feedback and they can go to the Scottish Public Services Ombudsman.

The Convener: Minister, we are dealing with the bill because people went through such a traumatic experience that they could not or did not have the will or confidence to ensure that what was in place meant that their wishes would be respected. You seem to say that they can complain and that the complaint will trigger notice of a failure in the system, but how do we prevent the failure in the first place? That is more important. That is what the legislation is about, is it not?

Maureen Watt: Yes, and that is why there will be guidance as a result of the bill and the inspectors' job is to make sure that that guidance is adhered to.

The Convener: I was thinking mainly about the situation as it develops in our hospitals when such an event happens. Who will ensure that the discussions take place and that the midwife or designated person has engaged with the parents?

Maureen Watt: I think that we are straying on to the duty of candour, which is in another bill of mine that is going through the Parliament. It will still be for the inspector to do that in hospitals.

The Convener: The crematorium inspector will have the right to inspect the NHS processes.

Maureen Watt: The process in relation to the disposal of the remains of children and ashes, yes.

Dr Cuthbert-Kerr: We view the whole process, from the point of the loss through to burial or cremation, as a single process. It is therefore valid for the inspector of crematoria or inspector of burials to have the power to review a hospital's practices. That might not be done in isolation; the inspector might do it alongside quality assurance staff in a particular NHS board.

We view inspection as part of the process. There are not two separate processes, whereby a pregnancy loss occurs and a process happens in the hospital, and then a second process takes over to deal with the disposal. I realise that I am repeating myself, but we very much see it all as a single process from the point at which a loss occurs through to the point at which the disposal happens. That process will happen in different contexts, such as the hospitals, crematoriums and burial grounds, and it will bring into play different professionals such as crematorium staff, burial ground staff and, of course, hospital staff.

We think therefore that it is absolutely valid that the inspector should have a role—

The Convener: The crematorium inspector will have the ultimate responsibility to pass judgment. He will have access to those records.

Dr Cuthbert-Kerr: As I said in my earlier answer, we expect the inspector to have access to the records in order to establish that the processes are being followed properly under the terms of the bill. He or she will not necessarily be a medical practitioner so parts of the record might have to be redacted, but their role will be about making sure that the process is taking place properly, that forms are being completed properly, that the options that are open to the women are being explained properly and that timescales are being adhered to.

The Convener: You can test that against people's experiences. Will inspectors be speaking to people who have suffered a loss to check that they are satisfied?

Dr Cuthbert-Kerr: That is not necessarily something that we have considered the inspector doing. We have viewed the role of the inspector as being about looking at the process, but I do not think that there is anything in the bill that would prevent him or her from speaking to people. In fact, we know that the current inspector has

spoken to individual members of the public about their experience of cremation, although not necessarily in the context of pregnancy loss.

The Convener: We heard in evidence that that is a new experience, because it is not typical that someone who runs a crematorium would engage with the public at all; that is done by funeral directors, doctors or whomever down the line. It is an interesting idea, but the issue is with evaluation. How can we find out whether we are making a difference with all the form filling and so on if we do not speak to people who have been through the system to assess whether they felt involved, whether they were empowered to make decisions and choices, whether they were satisfied that their choices were acted on and whether they were satisfied with the services?

Maureen Watt: Most people who have been in hospital are given the opportunity to provide feedback on their experience if they so wish.

The Convener: Yes, but there is sometimes a difference between the experience that they relate in the hospital and the experience that they describe to you or me as MSPs, minister.

Bob Doris: I have a question on the same theme. Is it not the case that much of this is already inspected but we just do not tie it together? The new inspector post will be able to look at individual cases and follow them through every step in the process, from mum turning up at an A and E unit in significant pain all the way through to whether there is a cremation, and to identify where problems arose, such as ashes not being recovered. I am clear about that.

However, separately from that, A and E units are reviewed and assessed. A review has been carried out of maternity services in Scotland. I do not know whether that is still going on—I apologise if I missed the conclusion of it. I would imagine that that review would look at such matters. Individual maternity units are also assessed. There are many different inspection regimes in play in the NHS at any one time. I would like assurance that in future, when all those inspections kick in, they will be given cognisance as part of such reviews once the bill is on the statute book. Will it be the case across the spectrum of services in the NHS that, in any future review of maternity services, individual maternity units or A and E departments, we will, where appropriate, assess to make sure that we are meeting the obligations in the bill?

Maureen Watt: Yes. We must stick to the fact that we are considering the Burial and Cremation (Scotland) Bill and are talking specifically about women who are in this situation. With the bill, we are trying to make sure that the baby ashes scandal never happens again. In putting new legislation in statute, we have consulted as many people as possible and I think that a clear majority of stakeholders are in favour of what is proposed.

Bob Doris: I agree with that.

I have a final question. I want to make sure that we do not set any hares running. Bereaved parents can be incredibly vulnerable and they might or might not wish to be contacted again. How can we ever know that? Last week, we heard that some parents might want to be contacted and some might not. There is a risk of retraumatisation. Part of the baby ashes scandal was about the fact that parents who had sought to deal with what had happened to them and move on—to the extent that that is possible in such situations—were retraumatised by reading about the scandal in the papers. I have a slight concern about contacting an impacted parent at a later date. I am not saying that we should not do that, but I do not think that we got an answer at last week's meeting about how we could do that in a way that would not risk further emotional impact and distress; as a group, parents might not even have a view on that.

Maureen Watt: Things have moved on greatly. Any person who finds themselves in this situation is signposted to counselling services. I do not think that we would actively seek people out. However, through the media, people are often asked if they want to come forward.

Nanette Milne: I have questions on the keeping of registers of cremations and burials. The bill says that ministers will be able, through a negative instrument, to make it an offence for health authorities, crematoria or burial authorities to fail to keep their registers in the form that is specified. The Delegated Powers and Law Reform Committee has criticised the fact that that will be done by regulation rather than in the bill, so perhaps the minister can give us a bit of clarity on that. What behaviour in relation to registers that are kept by health authorities, crematoria and burial authorities is likely to result in a criminal offence?

Maureen Watt: Generally, we do not see any particular problems with the proposal on registers. Other registers, such as those for births and deaths, are already public documents. We do not see any reason why the registers under the bill should not be made public. Obviously, there are data protection issues to consider. As I said, in the case of a pregnancy loss, the public register will not identify the woman who has experienced the loss. In that case, a unique identifying number will be used. That is about having an audit trail without revealing the identity of the woman.

Concern has been expressed that the registers might be used by debt-recovery companies, for

example, to attempt to trace money that is owed by deceased persons. I do not think that will be a big problem because, obviously, there are other sources from which people can get that information.

Dr Cuthbert-Kerr: On what would constitute an offence in relation to registers, the bill talks about

"failing to prepare or maintain"

a register in the way that is prescribed. That would include not having a register at all or failing to record the information in the prescribed manner—it could be wrong information, incomplete information or information in the wrong format.

Nanette Milne: What is the reason for not having that in the bill but instead setting it out in regulations?

Maureen Watt: We have taken into account what the Delegated Powers and Law Reform Committee has said and, where we can, we are looking to lodge stage 2 amendments that will include that in the bill.

Graham McGlashan (Scottish Government): The offences that Nanette Milne is talking about are in the bill already, in sections 11 and 42. Those offences are not left to regulations; they are set out in the bill in relation to the register.

Nanette Milne: What about the other provisions in that regard?

Graham McGlashan: There are other such provisions. We are reviewing those in the light of the DPLRC's report, with a view to rationalising them.

Nanette Milne: Given that we are in the 21st century, should it be specified that the records should be kept in electronic form?

Maureen Watt: We have not specified that. We would obviously like to get to that point, but different organisations are at different stages of computerisation, and we do not want to force costs on crematoria or undertakers.

The Convener: It was good to hear from Mr McGlashan.

We heard earlier about the various legislation in the field; we heard from the minister about the register of births and the legal requirements on that. Am I correct that there is a requirement to register a stillbirth at more than 23 weeks and five or six days?

Dr Cuthbert-Kerr: Yes.

The Convener: I just want to get clarity on the earlier assurances from the minister about anonymity. Will anonymity apply to all stillbirths after 24 weeks, or just to terminations?

12:00

Maureen Watt: My understanding is that all stillbirths—[*Interruption*.] Currently stillbirths over 24 weeks are recorded and the name listed.

The Convener: Pardon? [*Interruption*.] Can we put the sound up a wee bit? It is probably me, minister—I have a cold and a problem with my hearing, too—but it seems to me that the sound is lower than normal.

Go ahead, please.

Maureen Watt: Currently a stillbirth over 24 weeks is recorded, as is the name.

The Convener: Will that continue?

Maureen Watt: We will look at the matter, but we think that it will.

The Convener: What about terminations at 24 weeks?

Maureen Watt: We will need to look at that.

The Convener: The question is whether in such cases you can still provide anonymity.

Maureen Watt: Perhaps Simon Cuthbert-Kerr can come in here.

Dr Cuthbert-Kerr: Absolutely, minister.

We have not considered the particular distinction between what happens at 23 weeks and six days and at 24 weeks, as set out in the Registration of Births, Deaths and Marriages (Scotland) Act 1965. We have developed the bill on that basis, and our understanding is that any delivery beyond 24 weeks that is dead, regardless of how that has come about, must legally be registered as a stillbirth, which means that the name of the mother is recorded. We could certainly look at whether we could do something to ensure that, in particular circumstances, the mother's anonymity is maintained.

The Convener: The issue was raised with us in respect of late terminations in which the mother might wish or require anonymity.

Another issue that has been raised is the legal requirement for a stillbirth after 24 weeks to be registered, as it relates to abortion legislation. We have had evidence that a lot of that law might conflict with the bill's aims, so I wonder—I am looking at your legal adviser, minister—whether that issue has been examined.

Graham McGlashan: As members will be aware, abortion legislation is reserved at the moment, which means that we cannot amend anything that is set out in the 1967 act.

As for what is recorded, we are, in the bill, simply taking on the current position on stillbirths as set out in the 1965 act. We can certainly go

away and reflect further on the evidence that you have received, but at the moment there are limits on the Parliament's legislative competence with regard to what we can do with the 1967 act.

The Convener: I am aware of that, but the general question is whether, irrespective of the death involved, a late termination after the current 24-week limit would still need to be registered as a stillbirth.

Graham McGlashan: Yes. That is the current position.

The Convener: So how much flexibility do you have in that respect? Would you need to amend the 1965 act if you wanted to do something different?

Graham McGlashan: I can certainly go away and reflect on the question. You will appreciate that these issues are complex and that we have not been presented with this late termination issue—

The Convener: That is fine. I am not arguing one way or the other. The matter has just emerged from the evidence that we received.

Maureen Watt: At the moment, a termination after 24 weeks would happen for medical reasons only.

The Convener: We understand that, but—

Maureen Watt: Beyond that, we go into hypotheticals and suppositions.

The Convener: Of course—it is all hypothetical until it happens.

Bob Doris: Can I come in here, convener?

The Convener: Yes, please.

Bob Doris: Just getting back to the facts, convener, I seek some clarity for myself.

My understanding is that, because of the reserved nature of some of the legislation, the current practice for how stillbirths are registered will remain, irrespective of whether it is a post-24-weeks termination or a pregnancy that did not make it to full term. The bill will not change that. For my part, I would not like to get into a discussion about whether we should change that; there is a whole other area and discussion about whether stillbirths should be registered after 24 weeks. The substantial issue for the committee might be the anonymity of those who have terminations. That takes the other aspect of the discussion out of the equation.

Currently, do individuals who have post-24-weeks terminations have the right to privacy and anonymity? Will the bill change that? To me, that is the substantive question, rather than whether there should be registration, which takes us to a whole other discussion.

Maureen Watt: As Simon Cuthbert-Kerr said, where there is a stillbirth after 24 weeks, the person is normally named in the register, but we will go away and have a look at that.

Bob Doris: I am just seeking a wee bit of clarity about where there is and is not confidentiality. We might consider that further, as it has started to emerge as a theme.

The Convener: Bob Doris has hit on an important point. There are provisions in the bill about notifying the nearest relative and so on, but I suppose that it is more about whether people have confidentiality and whether the bill changes the relationship.

We have talked a lot about pregnancy loss happening in hospital settings such as accident and emergency departments, which are not always the setting, as Bob Doris pointed out. In evidence, the issue was raised of pregnancy loss that happens outwith hospitals—in prisons, residential care or the home. Have you considered that?

Maureen Watt: When a pregnancy loss occurs in prison, the health board will be involved, because in 2011 care of prisoners became the responsibility of the NHS; a prisoner will receive medical care from the NHS throughout the pregnancy, just like anybody else would. For a person in residential care, again, medical care will be provided by the NHS board.

The Convener: So there will be somebody who will engage with the woman. In a hospital setting, the role is clearly defined, but in the settings that we are discussing, there will be a designated person from the health service or local government who will take on the role of dealing with the woman.

Maureen Watt: I do not see that there would be discrimination in respect of care of a pregnant woman because of the setting.

The Convener: Regardless of the setting, there will be a designated person from the health board or the local authority to inform the woman of her options and choices.

Maureen Watt: The health board will be in charge of the person regardless of their setting, and they will have a midwife, as anybody else would.

The Convener: Okay. Thank you for that.

Rhoda Grant: I have a supplementary question. Will a residential or prison setting be the same as a home setting if medical attention is not required for a miscarriage or a stillbirth? Would the duties that fall on the hospital fall on whoever was

employed by the state, or would it be left to the woman herself?

Maureen Watt: In every situation, the health board is the authority that has the duty of care for the person.

Rhoda Grant: When a miscarriage happens at home, the health board does not have to take steps. It remains the woman's decision, surely. When it happens in a hospital, the health board has a duty.

Maureen Watt: General practitioners are contracted to the health board as well, so if the person goes to their GP that is part of the health service.

Rhoda Grant: If there is no medical professional involved, does somebody at the prison or the residential centre take on those duties?

Maureen Watt: Having been a prison visitor for 14 years before I came to Parliament, I think that the duty of care of the prison service would probably ensure that a medical professional was called if someone was having a miscarriage, especially if it was in the later stages of the pregnancy.

The Convener: We may need some clarification on that.

The bill creates an offence of providing false or misleading information. Should it also specify whose role it is to explain the options on the forms for cremation and burial?

Maureen Watt: Are you talking about explaining the options to a woman who has had a stillbirth or—

The Convener: The bill lays out an offence of providing false or misleading information, so should it also lay out who in the hierarchy should be responsible for that? Some people might argue that the false or misleading information was simply incorrect information, but that would be for the courts to sort out. If people might face criminal proceedings—if the person filling in the forms or having the discussion will face a serious consequence if they do not get it right—they might be averse to playing a part in the process. Should the bill not describe who would be ultimately responsible for collecting the information and completing the forms correctly, given that there will be such a consequence if they get it wrong?

Dr Cuthbert-Kerr: The creation of the offence is to deal with people who deliberately provide false information—for example, a person who does not have the right to make an application for the cremation, or who provides false information to cover up a crime. The offence is intended to capture such scenarios, not scenarios in which people accidentally, in acting according to the best of their knowledge, give information that turns out to be incorrect. We would not view as an offence somebody accidentally spelling the deceased person's middle name incorrectly in filling in a cremation application form.

On who should provide advice on filling out the form, we would look to funeral directors in a lot of instances, but also to NHS staff and healthcare staff generally. We will provide guidance to both of those groups as part of the implementation process, and we will work with them to ensure that they understand their responsibilities.

It is also worth saying that the person who completes the form should be the applicant; a funeral director or hospital staff member should not complete the form on a person's behalf unless that person has authorised the hospital to organise the cremation or burial on their behalf.

The Convener: So, there is a form that the applicant will be left with.

Dr Cuthbert-Kerr: The applicant would not necessarily be left with the form, but would be given support there and then to complete the form. The forms have not been finalised, but our intention is that the applicant will sign the form to declare that they understand the consequences of the decision—for example, that they understand that if they choose a shared cremation they will not get ashes back—and that, to the best of their knowledge, they have completed the form accurately and completely.

12:15

The Convener: Funeral directors in our previous panel described taking people through the form, asking questions and completing the form as a key part of their service. Will that practice change as a consequence?

Dr Cuthbert-Kerr: I cannot speak for particular funeral directors, but an issue that we are aware of is that funeral directors are completing forms on behalf of applicants. Therefore, applicants are not necessarily being given the full choice because they have perhaps been told, "There you go. This is what we always do. We will do this again."

We are trying to design the form so that the onus is put on the applicant—the person who is applying for the funeral—to complete the form themselves or, at the very least, to say, "Yes, I have understood everything that has been asked of me, and I have given answers to all these questions." By all means, funeral directors should be there to support and guide a person through the process, but funeral directors should not be the ones to complete a form on behalf of an applicant.

The Convener: We also might have midwives who wish to help someone through the form but who would be uncomfortable about recommending or talking about a cremation or a burial. Given your response, do we not need clarity in and around who should be involved in filling in the form? You clearly said that the key person involved will be the nearest relative or the mother.

Maureen Watt: Initially, when there is a pregnancy loss, the woman is probably still going to be in a hospital setting and will therefore have that discussion with a midwife or a doctor. If she decides that she wants to take control of how the remains are disposed of, that may be the point at which a funeral director comes in.

The Convener: The woman will also have choices at that point on whether she wants to take the remains away.

Maureen Watt: Yes.

The Convener: We have heard this morning that, typically, women are in the hospital setting for one or two days. Therefore, on the day that a woman has suffered pregnancy loss, and she is desperate to get home and get out of the clinical situation, she will be presented with a form, with options and choices to be made.

Dr Cuthbert-Kerr: That is not necessarily the case. The bill says that a health authority must try to ascertain the woman's views within seven days of her experiencing the loss. That period is to allow the woman to recover. We have heard stories, as I am sure that you have, of women being asked to make decisions far too close to the loss occurring to have any understanding of what they truly want. Therefore, we have built in a seven-day period from the loss occurring during which the health authority should try to ascertain the woman's wishes. Whether that means that the woman gives her view while she is still in hospital or goes home and then returns to the hospital—

The Convener: She must go back to the place where she lost the child.

Dr Cuthbert-Kerr: Potentially, yes.

Rhoda Grant: Some of those answers are a bit concerning. A defence for having a single form was that a funeral director would be completing it and some of the questions that did not apply to a stillbirth, for example, would not be put to the mother—that is, marital status, employment and other areas that the child would never experience. It could be quite distressing to have to answer those questions. However, if you are saying that the very opposite is true, and that it is the person who has suffered such a bereavement who must fill in the form, the distress created could be huge.

If the person does not do it there and then and has to go back to the hospital to plough through a huge form, that would be a concern. If they do not want to go back to the hospital and have to do it there and then, that could be hugely distressing. It seems as though what you are telling us about the practicalities flies in the face of the defence of some the bill's measures.

Maureen Watt: As I said earlier, we have not decided on the forms and are consulting on what they should look like. However, the forms will be designed to capture what requires to be captured and to be as sensitive as they can be. We have said that the options for a woman in this situation will have to be explained as soon as possible, but she will then have the option to take time to decide what she wants to do. However, if she wanted to deal with the remains herself, or wanted them disposed of in a certain way in which a funeral director would normally be involved, a funeral director would be involved at that stage. However, in the case of all cremations and burials, what Simon Cuthbert-Kerr was trying to say was that the funeral director sometimes takes too much responsibility on himself or herself, rather than putting the relatives in the driving seat.

Dr Cuthbert-Kerr: I will add one more point on the design of the forms, if I may. As the minister rightly said, the format of the forms is still being discussed. However, a single form would not require every question to be answered by every applicant. The path that led us to think of having a single form was that, when we looked at individual forms for different categories, we realised that there were quite a lot of similarities across the forms.

One of the options would be to have the form divided into sections. The first section would be for the personal details of the person applying for the cremation or burial; depending on who the deceased was, the applicant would then be directed to another section of the form. For example, if it was about a pregnancy loss, they would be directed to a section of the form that would have questions that were relevant to that loss and that would not ask about marital status and so on. That is one of the ways in which we would try to avoid people being asked inappropriate and insensitive questions.

Dennis Robertson: I want to get a little bit of clarity here, if I might. Forms are a barrier for a great number of people. In a bereavement, surely all that is required is that a person has a full and comprehensive understanding of what is in the completed form. A funeral director might have years of experience and be sensitive to bereaved and grieving relatives, so surely it would be okay for that person to aid and assist them with the form and even complete it, provided that a relative signed off the form. You are surely not asking that

the bereaved and grieving parent completes the form, are you?

Maureen Watt: What we are saying is that if a person wants someone like the funeral director to complete the form for them, that is okay.

Dennis Robertson: But is that what the bill says?

Maureen Watt: I think that it is.

Dennis Robertson: Well, I must have misunderstood.

Maureen Watt: As I understand it, the ultimate responsibility for the form rests with the person making the application. You would not want anybody else to fill in the form on your behalf, if it was not correct.

Dennis Robertson: Well, indeed I would. I would prefer someone to guide me through the form and the process who had the knowledge and experience to aid me or anyone else, particularly given that some questions on the form might not be pertinent for a bereaved family. Provided that the bereaved and grieving relatives fully understood what had been completed and signed for in the form, surely to goodness it would be okay for a funeral director with vast experience in these matters to aid and assess them in the completion of the form.

Maureen Watt: The point that we are making is that the responsibility ultimately rests with the applicant. However, we are all agreed that, if a person wants to be guided by a funeral director or someone else in completing the form, that is perfectly all right.

Bob Doris: That ties things up nicely. I think that Mr Robertson and the minister might have been saying the same thing. I do not think that anyone is too interested in whose ballpoint pen has filled out a form, other than the signature. As long as the applicant is fully cognisant of the process and understands the form that is being completed, and that form is completed appropriately and sensitively, that is fine, whether a funeral director is involved or the form is filled out in an NHS setting.

That brings us back full circle to the convener's earlier question about it becoming an offence to provide false or misleading information or advice relating to the completion of a form. The clarity that we were looking for at the start concerns whose responsibility it would be to provide advice and information in relation to the completion of that form. The best example that I can give is, in a situation involving a funeral directing company, would the responsible person be the person who sat with the family member or the manager of that funeral company? In the NHS, would responsibility lie with the midwife or nurse who was sitting with the person and giving them advice and information while the form was completed, the ward manager or a senior clinician?

There is a slight overlap in relation to another piece of legislation that you are bringing through the Parliament. We are saying that, when the forms are filled in, appropriate advice and information should be given to bereaved parents. That might be in an NHS setting or it might be done by funeral directors. However, if that advice is given in a deliberately false or misleading way, that is an offence. We need clarity about who is guilty of that offence. Is it a corporate responsibility or is it the responsibility of the individual who is giving the advice? If that requires more thought, that is fine. However, that is what we are trying to tease out. Hopefully, the situation will not arise, but I think that people want us to ensure that there is clarity about that.

Maureen Watt: It is not the advice that is likely to cause the offence. What is written down on the form has to be accurate. At the end of the day, that is the responsibility of the person who makes the application, not someone who has given advice.

Bob Doris: My apologies; I am reading from our briefing papers and I will need to go back and check the details of the bill.

Maureen Watt: We can go away and see whether the bill needs clarified in that regard. If so, we will lodge an amendment at stage 2.

Bob Doris: The issue concerns the cremation application forms. I assume that someone will be sitting with the bereaved parent while they are filling in that form and that they would provide them with some information. We would hope that that information would never be misleading but, if it were, would the offence be seen to be committed by the person who is giving the advice or by someone else, and how would we know who that person is? That might be a question to come back to us on.

The Convener: There are no further questions. I thank the minister and her colleagues for their attendance.

12:28

Meeting continued in private until 13:18.

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