Carlisle City Council
Report to Audit Committee

Report details

Meeting Date:	8 December 2022
Portfolio:	Finance, Governance and Resources
Key Decision:	Not applicable
Policy and Budget Framework	YES
Public / Private	Public
Title:	Internal Audit Report – Bereavement Services
Report of:	Corporate Director Finance & Resources
Report Number:	RD51/22

Purpose / Summary:
This report supplements the report considered on Internal Audit Progress 2022/23 and considers the risk-based Internal Audit review of Bereavement Services.

Recommendations:
The Committee is requested to

(i) receive the final audit report outlined in paragraph 1.1;

Tracking

Executive:	Not applicable
Scrutiny:	Not applicable
Council:	Not applicable

1. Background

1.1. An audit of Bereavement Services was undertaken by Internal Audit in line with the agreed Internal Audit plan for 2022/23. The audit (Appendix A) provides reasonable assurances and includes 12 medium-graded recommendations.

2. Risks

2.1 Findings from the individual audits will be used to update risk scores within the audit universe. All audit recommendations will be retained on the register of outstanding recommendations until Internal Audit is satisfied the risk exposure is being managed.

3. Consultation

3.1 Not applicable

4. Conclusion and reasons for recommendations

4.1 The Committee is requested to

i) receive the final audit report outlined in paragraph 1.1

5. Contribution to the Carlisle Plan Priorities

5.1 To support the Council in maintaining an effective framework regarding governance, risk management and internal control which underpins the delivery the Council's corporate priorities and helps to ensure efficient use of Council resources

Contact details:

Contact Officer: Michael Roper Ext: 7520

Appendices attached to report:

- **Internal Audit Report – Bereavement Services**

Note: in compliance with section 100d of the Local Government Act 1972 the report has been prepared in part from the following papers:

- None

Corporate Implications:

Legal - In accordance with the terms of reference of the Audit Committee, Members must consider summaries of specific internal audit reports. This report fulfils that requirement
Property Services - None
Finance – Contained within report
Equality - None
Information Governance- None

CARLISLE CITY COUNCIL

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Audit of Bereavement Services

Draft Report Issued: 21st October 2022
Director Draft Issued: 15th November 2022
Final Report Issued: 23rd November 2022

Audit Report Distribution

Client Lead:	Bereavement Services Manager Head of Communities and Wellbeing
Chief Officer:	Deputy Chief Executive Chief Executive
Others:	Infrastructure and Service Desk Manager Safety, Health and Environmental Manager Data Protection Officer
Audit Committee:	The Audit Committee, which is due to be held on 8th December 2022 will receive a copy of this report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Designated Head of Internal Audit.

1.0 Background

1.1. This report summarises the findings from the audit of Bereavement Services. This was an internal audit review included in the 2022/23 risk-based audit plan agreed by the Audit Committee on 15th March 2022.

1.2. The Council has a statutory duty to make provision for the committal of the deceased and is responsible for the three cemeteries and one crematorium in the city. Bereavement services is part of the Health and Wellbeing team, under the Head of Communities and Wellbeing, within Community Services Directorate.

2.0 Audit Approach

Audit Objectives and Methodology

2.1 Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems.

2.2 A risk-based audit approach has been applied which aligns to the five key audit control objectives (see section 4). Detailed findings and recommendations are reported within section 5 of this report.

Audit Scope and Limitations.

2.3 The Client Leads for this review were the Bereavement Services Manager and the Head of Communities and Wellbeing and the agreed scope was to provide independent assurance over management's arrangements for ensuring effective governance, risk management and internal controls of the following risks:

- Failure to achieve business objectives due to insufficient governance and inadequate embedding of risk management controls.
- Council unable to deliver efficient service due to lack of service continuity and none compliance with legislation.
- Loss or breach of information / fines and sanctions / reputational damage due to failure to securely process, retain, share and dispose of records and information.
- Council unable to deliver efficient service due to faulty / ageing equipment.
- Theft/damage to assets due to a failure to properly safeguard against loss.

2.4 There were no instances whereby the audit work undertaken was impaired by the availability of information.

3.0 Assurance Opinion

3.1 Each audit review is given an assurance opinion intended to assist Members and Officers in their assessment of the overall governance, risk management and internal control frameworks in place. There are 4 levels of assurance opinion which may be applied (See **Appendix C** for definitions).

3.2 From the areas examined and tested as part of this audit review, we consider the current controls operating within Bereavement Services provide **reasonable assurance**.
Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4.0 Summary of Recommendations, Audit Findings and Report Distribution

4.1 There are two levels of audit recommendation; the definition for each level is explained in **Appendix D**. Audit recommendations arising from this audit review are summarised below:

Control Objective	High	Medium
1. **Management** - achievement of the organisation's strategic objectives achieved (see section 5.1)	-	4
2. **Regulatory** - compliance with laws, regulations, policies, procedures and contracts (see section 5.2)	-	5
3. **Information -** reliability and integrity of financial and operational information (see section 5.3)	-	-
4. **Security** - safeguarding of assets (see section 5.4)	-	3
5. **Value** – effectiveness and efficiency of operations and programmes (see section 5.5)	-	-
Total Number of Recommendations	**-**	**12**

4.2 Management response to the recommendations, including agreed actions, responsible manager and date of implementation are summarised in Appendix A. Advisory comments to improve efficiency and/or effectiveness of existing controls and process are summarised in Appendix B for management information.

4.3 **Findings Summary (good practice / areas for improvement):**

The recent service restructure has set a clear direction for the service. The team should be commended for their hard work during the Covid-19 pandemic and have worked well under pressure, while under-staffed. The team have retained their Gold standard award for both burials and cremations.

The audit does highlight actions that the team need to implement to strengthen the controls within the service and several outstanding recommendations from the previous audit review have been included within this report.

Controls are in place for data security, but there is a need for further controls to be in place to comply with data protection legislation, including document retention and standardising the retention schedule and privacy statement, ensuring that contracts with 3rd parties are in line with legislation and informing service users when their data is shared with providers.

The ICT system works well for managing the daily operations at the Crematorium and recording information relating to burials. The responsibility for system support and backups lies with the provider and works well.

Procedures, risk assessments and safe working practices need to be reviewed and updated where appropriate.

Equipment is well serviced, and a contingency plan is in place to ensure that service delivery would continue in the event of failure.

Assets are properly safeguarded. There is a need to complete corporate documentation such as the Premises handbook and the CCTV operating procedure.

Comment from the Deputy Chief Executive

We welcome this audit report and the helpful recommendations. Our team will implement and monitor the success of these recommendations.

5.0 Audit Findings & Recommendations

5.1 Management – Achievement of the organisation's strategic objectives

5.1.1 The Bereavement Services Manager post was vacant from April 2021 following a long term absence. The post has been appointed to from December 2021 through an internal promotion. Following a review of service provision, a structure has been agreed with 7FTE posts. Three posts are currently vacant, but action is being taken to fill these.

5.1.2 Job descriptions are in place and the purpose and responsibilities of the roles within Bereavement Services are appropriately defined.

5.1.3 The team is working towards multi-functional roles with all officers taking responsible for front office arrangements.

5.1.4 Procedures are in place for the service; however, they are out of date and incomplete. It would be good practice to review them periodically to ensure that current practices are reflected in the notes. A contents list of all procedures would also be useful.

Recommendation 1 – All procedures should be reviewed and brought up to date where appropriate. They should include version control, date, author, and a review date.

5.1.5 A Service Plan is in place for Bereavement Services which sets out five key service objectives for 2022-23. There are no KPIs or performance indicators for the service, but benchmarking exercises have been undertaken to measure performance (See 5.5.1).

5.1.6 Risks have been clearly identified and documented along with mitigating actions, the risks were last reviewed in February 2022.

Recommendation 2 – Risks should be regularly reviewed in line with the Corporate Risk Management and Assurance Framework.

5.1.7 Budget monitoring is in place and monthly meetings are held between the budget manager and relevant finance officer. A monthly budget monitoring report is produced by Finance to detail the variances in actual and budgeting spend. The latest report up to 31/08/2022 shows an income shortfall for the crematorium of £50,889, this is due to a reduced number of cremations and variations in the mortality rate; this is being monitored. An additional charge has been levied for the live-streaming and recording of cremations as this was free during the covid-19 pandemic.

5.1.8 The approved fees and charges for Bereavement Services as per the budget reports 2022/23 was compared to the fees and charges downloaded from the website on 5th July 2022 this identified that these fees & charges are for April 2021 to March 2022, and as a result these are incorrect as a 3% increase has been approved for 2022/23. This also results in the Council not being fully compliant with the Funerals Market Investigation Order 2021.

Recommendation 3 – The 2022/23 fees and charges for Bereavement Services should be uploaded to the Council's Website.

5.1.9 Senior Managers are kept up to date with any issues arising within Bereavement Services and monthly meetings are in place alongside additional catch ups, organised as necessary.

5.1.10 A replacement plan and funding are in place for the renewal of the cremators. This plan has been delayed due to the covid-19 pandemic and will need to be considered and approved by the new Cumberland Council. The cost is being achieved from a residual draw on income from cremations. The fund is regularly monitored and reported. Provision for full cremator replacement and enhancements to the crematorium are included in the Council's approved capital programme.

5.1.11 Electric cremators are being considered to replace the existing gas ones, this is considerably cheaper and more environmentally friendly to run; however, it is more expensive (The funding allocated in the capital programme allows for upgrades to electric cremators). There should be no service interruption during the cremator renewal process, however a decision will need to be made as to whether cremations will be undertaken onsite or at an alternative site.

5.1.12 There is a contingency plan in place in the event of system failure with the cremators to ensure that service delivery is continued. There is an agreement in place for the Provision of Crematoria Mutual Aid between Carlisle City Council and Copeland Borough Council for short-term delivery and use of the cremators at each other's sites. This agreement was signed in 2016 and has no cessation date. A review of this agreement highlighted that there was no reference to the sharing of personal data even though documentation would mention the next of kin.

Recommendation 4 – In light of the upcoming Local Government Reorganisation (LGR) it is recommended that an appropriate action plan be agreed by both service managers to cover how sensitive information will be securely shared if required.

5.2 Regulatory – compliance with laws, regulations, policies, procedures and contracts

5.2.1 A privacy statement is in place for the Bereavement Services, published on the City Council's website. The statement generally includes relevant information, however the document retention practices do not align with the retention schedule nor the information provided by ICCM (Institute of Cemetery & Crematorium Management). In addition, there is no document destruction / disposal log in place.

5.2.2 Paper and electronic records are in place for every cremation, burial and interment carried out by bereavement services. Records include personal information in relation to next of kin. Management were unsure how long these records are / should be retained for.

5.2.3 Paper documentation is not always stored securely in locked cabinets. The key fob access to the building reduces the risk but does not totally mitigate against it. It would be good practice to ensure that there is a clear desk policy overnight to ensure that all personal data is kept securely out of hours.

5.2.4 A review of documentation identified that not all of the forms completed by members of the public accessing services include notification to the individual that their personal data will be shared with a third party. It was also noted that there are no data sharing agreements in place with any of the third party suppliers.

Recommendation 5 – The following should be completed to ensure compliance with GDPR legislation:

- **Both paper and electronic document retention should be reviewed by the service to ensure compliance with current regulations. The documentation retention schedule and privacy statement should be aligned to this. A document destruction / disposal log should be introduced.**
- **All documentation containing personal data should be stored securely.**
- **Due to LGR it is recommended that the service contacts Information Governance for guidance as to how best to cover the Council when sharing data with third parties to ensure compliance with GDPR legislation.**
- **A review of all forms used by the service should be undertaken to ensure that all documentation covers the Council in relation to GDPR and data sharing.**

5.2.5 The service uses the software 'BACAS' (Burial & Cremation Administration System) which is owned by ClearSkies and is a cloud based system. This system provides the facilities which are needed to manage and control the Crematoria and Cemeteries in line with legislative requirements.

5.2.6 Codes are used to ensure everything is in place to meet legislative requirements prior to completing a burial or cremation. Checks include ensuring all paperwork is in place, including death certificate (counter signed by a medical referee if a cremation) and ensuring music is in place. A second officer confirms the documentation is correct.

5.2.7 The Council pays ClearSkies for BACAS support, bookings & hosting support. Automatic updates are completed on the system, if the team have any system issues, they contact ClearSkies.

5.2.8 There is no data sharing agreement in place between the Council and ClearSkies and it was unclear whether the information recorded in the BACAS Support and Licence Agreements is adequate to comply with GDPR legislation. ***(See Recommendation 5)***

5.2.9 Failure of software is a risk on the operational risk register, historically there have been system downtime problems; however, the backup of data has been significantly improved since the last audit review. At the time of the audit, it had not been possible to establish where the ClearSkies datacentre is and where the data is stored (geo location).

Recommendation 6 – ICT Services should be advised of the location of the datacentre and where the data is stored (geo location) for the BACAS system.

5.2.10 The system access is controlled through user permissions and three members of the team have access to the system, each having their own individual user ID and password. At the time of the audit review the Bereavement Services Manager did not have access or knowledge of the system, so is unable to monitor and supervise work undertaken on the system.

Recommendation 7 – The Bereavement Services Manager should be set up with a user ID for BACAS and complete system training in order to be able to use the system efficiently to support the team when required.

5.2.11 Wesley Music is the music system that is used by the service. It also has the flexibility to provide virtual access (virtual attendance) to a service if this is required. Wesley also provides an online link to funeral directors and the service can be watched up to a week after the live service. The agreement with Wesley is out of date and audit was advised that this contract will need to be reviewed as part of LGR.

5.2.12 The five year memorial safety inspection contract for 2023 -27 is due to be reviewed and background for this has recently been started as it is site specific.

5.2.13 The team receive newsletters, information, and updates from ICCM. They also provide accredited education & training opportunities for members. The Bereavement Services Manager is enrolled to start the training. The ICCM develops and promotes best practice in cemeteries and crematoria and their aim is to raise standards for bereaved people through the promotion of above

5.2.14 The management team have had a meeting with an external training company to talk about a tailor made training course specifically for bereavement services officers.

5.2.15 A review of the teams' current training records showed that all of the team have undertaken the mandatory Skillgate GDPR training; however, not all of the team have received fire extinguisher training and the fire warden training has expired. The team would also benefit from training in dealing with difficult situations and emotional resilience.

Recommendation 8 – A review of the team's training should be completed to ensure that all relevant areas have been covered and that new team members received all the appropriate training to support them in their roles.

5.2.16 The health and safety risk assessments including lone working were out of date and in need of review as where the safe systems of working and the Premises Handbook.

Recommendation 9 – All health and safety risk assessments, safe systems of working and the Premises Handbook should be reviewed and brought up to date as appropriate.

5.2.17 A third party is contracted by the Council to ensure emissions from the cremators meet the specific standards set in the Council's Environmental Permit. Stack emission testing must be carried out on an annual basis and the findings reported to Environmental Health in order for cremations to be permitted. The last report was dated February 2022 and concluded that the emissions of all pollutants complied with the required standards.

5.2.18 All items are PAT tested accordingly and the lifting equipment is serviced regularly. Property Services team are involved in the PAT testing and ensuring that the relevant test is carried out within the legally required timescales.

5.2.19 It was noted during the audit review that some documentation was difficult for the team to locate therefore consideration should be given to setting up a SharePoint site to retain all the service documentation including risk assessments, equipment tests & services, procedures / guidance etc so that documents are readily available to the team and easily located.

5.3 Information – reliability and integrity of financial and operational information

5.3.1 Any complaints for Bereavement Services are dealt with via the Council's Corporate Complaints & Feedback Policy. Two recent complaints were reviewed and had been adequately resolved.

5.3.2 At the time of the audit there was no documented guidance / procedures for the process followed for handling informal complaints, such as a complaint about the grounds at the crematorium or in a cemetery. ***(See Recommendation 1)***

5.3.3 The Media & Communications Officer deals with all news stories and communications. There have been no recent issues.

5.3.4 The BACAS system allows officers to manage the day to day tasks for Bereavement Services. It allows 24hr access for bookings to be made for services by the Funeral directors through the remote booking system.

5.3.5 Access is restricted so each Funeral director can only see their case load and the vacant slots. This enables the Funeral directors to confirm arrangements with service users out of office hours.

5.4 Security – Safeguarding of Assets

5.4.1 CCTV cameras are in place for the protection of staff, the premises, and visitors. There is no Surveillance Camera Operating Procedure in place for the cameras at the Crematorium, the signage at the Crematorium is not in compliance with the policy as the signs are in black and white and do not have the Council's Logo or Privacy Notice details in place.

Recommendation 10 – The Surveillance Camera Operating Procedure should be completed. The signage should be updated in line with the new Cumberland Council's Surveillance Policy.

5.4.2 A Premises handbook is in place and covers the operation of the building, this is retained within Bereavement Services. A review of the handbook needs to be undertaken to ensure its completeness and that the correct processes are followed. ***(See Recommendation 9)***

5.4.3 The failure of the cremator equipment is a risk which is detailed in the operational Risk Register. To mitigate this risk equipment / machinery is tested and serviced appropriately

and the team complete daily checks to ensure that all the equipment / machinery is working.

5.4.4 Careline support is in place for lone working at the Crematorium. The lone working risk assessment needs to be reviewed and updated. ***(See Recommendation 9)***

5.4.5 The medical referees have access to the premises out of hours; however, the team are unaware if they have an adequate lone working procedure in place.

Recommendation 11 –The medical referees should provide assurances that appropriate lone working procedures are in place when they are visiting Council premises out of hours.

5.4.6 Cash & cheque payments are made at the site office for services provided by the Council including additions to the book of remembrance and the bronze plaques. These payments are securely retained. The Bereavement Services Administrator confirmed that Kalamazoo is used for issuing receipts for payments. Currently there are no facilities for clients to pay for services via payment cards. Management confirmed that a review of payment methods will be undertaken after LGR.

5.4.7 All Memorial Masons & Funeral Directors are invoiced through the debtors system and members of the public who don't use cheques or cash.

5.4.8 A copy of procedures for cash payments, depositing & recording was also provided. A review highlighted that these procedures do not contain the date or date of review. It was also noted that the procedures do not include cash bank pay in collection. In addition, cash carrying procedures / risk assessments should be reviewed and updated as appropriate. ***(See Recommendation 1 & 9)***

5.4.9 Audit testing confirmed that the cash payments received are minimal and infrequent. Cash is banked by Bereavement Services officers due to the low value. Cheques received are usually taken to the bank or Civic Centre to be banked. A secure collection service is available to the crematorium but has not been required for some time due to the low value of cash held on site.

5.4.10 Petty Cash is securely retained. The Bereavement Services Administrator manages the petty cash and completes the petty cash returns.

5.4.11 A review of the insurance levels and the cash held confirmed that the cash held is well within the limits.

5.4.12 At the time of the audit there was no record of any of the safes' contents. A record of all safe contents should be completed and maintained.

5.4.13 A signed key holder list is maintained and was up to date. A review of this highlighted a potential risk that could invalidate the Council's insurance/. However, this risk is minimal as no large volumes of cash are retained on site although management should closely monitor this.

5.4.14 The Crematorium has building security which includes an alarm system and fob access control. A review of this highlighted the following weaknesses:

- There is no procedures or guidance for opening and closing the premises. ***(See Recommendation 1)***
- Several individuals have fob access to the crematorium that is no longer required. ***(See Recommendation 12)***
- It was not possible to review the alarm users, this should be completed next time an alarm engineer is on site.

Recommendation 12 - The fob access report should be reviewed and anyone who no longer requires access should be removed.

5.5 Value – effectiveness and efficiency of operations and programmes

5.5.1 Annual benchmarking is undertaken across all the Crematoriums in the UK. The service is required to complete a self-assessment questionnaire for the government body for the industry, the ICCM. The Council has obtained the Gold standard award for both burials and cremations. Market comparison reviews have also been undertaken.

Appendix A – Management Action Plan

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 1: All procedures should be reviewed and brought up to date where appropriate. They should include version control, date, author, and a review date.	M	If procedures are not clearly documented, officers may be unsure of their roles and responsibilities and incorrect practices may occur this may lead to complaints and reputational damage to the Council.	Review and agree a list of service procedures. Completed documented procedures in place for Bereavement Services with appropriate version control, date, author and review dates.	Bereavement Services Manager & Head of Communities and Wellbeing Bereavement Services Manager	16/01/2023 30/09/2023
Recommendation 2: Risks should be regularly reviewed in line with the Corporate Risk Management and Assurance Framework.	M	If risks are not regularly monitored there is a risk that Council priorities are not achieved / supported.	Risks reviewed on a quarterly basis in line with the Corporate Risk Management and Assurance Framework.	Head of Communities and Wellbeing	31/01/2023

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 3: The 2022/23 fees and charges for Bereavement Services should be uploaded to the Council's Website.	M	There is a risk of reputational damage to the Council and customer complaints if fees and charges on the website are not up to date.	IT contacted to request access & guidance to upload 2022/23 fees & charges.	Bereavement Services Manager	16/12/2022
Recommendation 4: In light of the upcoming Local Government Reorganisation (LGR) it is recommended that an appropriate action plan be agreed by both service managers to cover how sensitive information will be securely shared if required.	M	Non-compliance with GDPR legislation resulting in service user details being shared without permission.	Data sharing agreement completed by both service managers to cover how sensitive information will be securely shared if required prior to 1/04/2023.	Bereavement Services Manager	16/12/2022

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 5: The following should be completed to ensure compliance with GDPR legislation: -Both paper and electronic document retention should be reviewed by the service to ensure compliance with current regulations. The documentation retention schedule and privacy statement should be aligned to this. A document destruction / disposal log should be introduced. -All documentation containing personal data should be stored securely.	M	Non-compliance with GDPR legislation and failure to control records management.	-Document retention is reviewed and aligned to legislation and the retention scheduled and privacy statement updated accordingly. -Implement a document storage procedure.	Bereavement Services Manager Bereavement Services Manager	31/01/2023 31/01/2023

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 5 continued: -Due to LGR it is recommended that the service contacts Information Governance for guidance as to how best to cover the Council when sharing data with third parties to ensure compliance with GDPR legislation. -A review of all forms used by the service should be undertaken to ensure that all documentation covers the Council in relation to GDPR and data sharing.	M	Non-compliance with GDPR legislation and failure to control records management.	Meeting to be set up with Data Protection / Information Governance for guidance and actioning of this recommendation. All forms to be reviewed and updated to cover the Council in relation to GDPR and data sharing.	Bereavement Services Manager Bereavement Services Manager	16/12/2022 31/01/2022
Recommendation 6: ITC Services should be advised of the location of the datacentre and where the data is stored (geo location) for the BACAS system.	M	Non-compliance with GDPR legislation and failure to control records management.	Request information from ClearSkies and advise ITC of outcome to ensure that this is satisfactory.	Bereavement Services Manager	31/12/2022

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 7: The Bereavement Services Manager should be set up with a user ID for BACAS and complete system training in order to be able to use the system efficiently to support the team when required.	M	Customer Service may be impacted in the event of staff absence / shortages.	User ID set up and training undertaken by BACAS.	Bereavement Services Manager	30/11/2022
Recommendation 8: A review of the team's training should be completed to ensure that all relevant areas have been covered and that new team members received all the appropriate training to support them in their roles.	M	Failure to identify and act upon ways to improve service delivery.	Team training reviewed and a team training plan agreed for 2023/24.	Bereavement Services Manager	31/03/2023
Recommendation 9: All health and safety risk assessments, safe systems of working and the Premises Handbook should be reviewed and brought up to date as appropriate.	M	Failure to meet Council's procedures / guidance on health & safety for the service which may lead to staff and members of the public being put at risk.	Review and update health and safety risk assessments and safe systems of work. Review and update the Premises Handbook in conjunction with Property Services to clearly define roles and responsibilities.	Bereavement Services Manager Bereavement Services Manager	28/02/2023 31/03/2023

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 10: The Surveillance Camera Operating Procedure should be completed. The signage should be updated in line with the new Cumberland Council's Surveillance Policy.	M	Non-compliance with council procedures and GDPR legislation.	The Surveillance Camera Operating Procedure completed, documented and signage updated.	Bereavement Services Manager	28/02/2023
Recommendation 11: The medical referees should provide assurances that appropriate lone working procedures are in place when they are visiting Council premises out of hours.	M	Non-compliance with Council procedures and failure to be aware of all factors affecting the facilities.	A copy of the medical referees lone working procedures provided.	Bereavement Services Manager	31/01/2023
Recommendation 12: The fob access report should be reviewed and anyone who no longer requires access should be removed.	M	Unauthorised access to the Council premises.	Fob access report reviewed, and access removed for all individuals who no longer require access.	Bereavement Services Manager	30/11/2022

Appendix B – Advisory Comments

Ref	Advisory Comment
5.2.19	Consideration should be given to setting up a SharePoint site to retain all the service documentation including risk assessments, equipment tests & services, procedures / guidance etc so that documents are readily available to the team and easily located.
5.4.12	A list of all safe contents should be completed and maintained.
5.4.13	Management should monitor the levels of cash retained on site to ensure that the Council's insurance is valid.
5.4.14	The users for the alarm system at the Crematorium should be checked / review on the next site visit by the alarm company and any users who no longer require access should be removed. It would also be good practice to retain a list of alarm users for future reference.

Appendix C - Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The control framework tested are suitable and complete are being consistently applied. Recommendations made relate to minor improvements or tightening of embedded control frameworks.
Reasonable	There is a reasonable system of internal control in place which should ensure system objectives are generally achieved. Some issues have been raised that may result in a degree of unacceptable risk exposure.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently embedded. Any high graded recommendations would only relate to a limited aspect of the control framework.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses that have been identified. The level of non-compliance and / or weaknesses in the system of internal control puts achievement of system objectives at risk.	There is an unsatisfactory level of internal control in place. Controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. High graded recommendations have been made that cover wide ranging aspects of the control environment.
Limited/None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-existence or non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist.

Appendix D

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are two levels of audit recommendations; high and medium, the definitions of which are explained below.

	Definition:
High	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	Some risk exposure identified from a weakness in the system of internal control

The implementation of agreed actions to Audit recommendations will be followed up at a later date (usually 6 months after the issue of the report).