OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 23 June 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 23 June 2020

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HEALTH AND SPORT COMMITTEE
18th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeane Freeman (Cabinet Secretary for Health and Sport)
Tansy Main (Scottish Government)
Dr Gregor Smith (Scottish Government)
Greig Walker (Scottish Government)
Humza Yousaf (Cabinet Secretary for Justice)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 23 June 2020

[The Convener opened the meeting at 09:00]

Subordinate Legislation

Health Protection (Coronavirus) (International Travel) (Scotland) Regulations 2020 (SSI 2020/169)

Health Protection (Coronavirus, Public Health Information for Passengers Travelling to Scotland) Regulations 2020 (SSI 2020/170)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment Regulations 2020 (SSI 2020/171)

The Convener (Lewis Macdonald): Good morning, and welcome to the 18th meeting in 2020 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton.

The first item on the agenda is consideration of affirmative instruments on emergency public health measures to prevent the spread of infection or contamination with coronavirus. The regulations impose requirements on people arriving in Scotland and on operational commercial services for international passengers who are travelling to Scotland, by sea or air, from outside the open borders area.

We will have an evidence session with the Cabinet Secretary for Justice and his officials on all three instruments, and then we will move directly to questions. Once we have concluded our questions, we will have the formal debates on the motion for each instrument.

I welcome to the committee Humza Yousaf, the Cabinet Secretary for Justice. He is accompanied by John Nicholson, from the community surveillance division for health, and Anita Popplestone, from the police division for enforcement, both of the Scottish Government; and Gary Cox, head of aviation at Transport Scotland. Welcome to all.

As with previous virtual meetings, we will take questions in an agreed order. I will begin, then I will invite members to ask other questions, and then I will come back with one or two more. I remind everyone to keep questions and answers succinct. Please give broadcasting staff a few moments to switch your microphone on before you begin to ask your question or provide an answer.

Cabinet secretary, can you start by telling us how many people are quarantined in Scotland under the regulations, and how many have arrived for whom exemptions to quarantine apply?

The Cabinet Secretary for Justice (Humza Yousaf): Good morning, and thanks for the opportunity to speak to the committee about the regulations.

As a direct answer to your question, the figures that I have this morning are that roughly 3,200 people have arrived since the beginning of the regulations. With regard to the figures for exemptions, you will be aware that Border Force does what we might colloquially term “spot checks”, as opposed to checking every single person who comes through, on whether they are exempt. Based on that spot-checking analysis by Border Force, approximately 18 per cent of those travellers have applied for some kind of exemption.

The Convener: Can you tell us how much monitoring and enforcement has taken place in relation to those who have already been subject to the regulations?

Humza Yousaf: As I expect that that will be a regular theme of questioning with regard to some of the regulations, let us bear in mind that two potential offences can be committed.

One offence is not providing information as per the regulations. That is enforced, and in some respects monitored, by Border Force. It does spot checks to see whether people have filled out a passenger locator form. According to the work that Border Force has done in Scotland so far, there has been no need to issue any fixed-penalty notices. That suggests a high level of compliance, and in fact Border Forces tells us that compliance levels among people who are coming off flights in Scotland has been very high, which is good to hear.

The other offence relates to breach of the self-isolation requirements, and Police Scotland would enforce that. As I have said from the beginning, Police Scotland will—very much in line with police forces across the United Kingdom—take a reactive approach. If Police Scotland has intelligence to suggest, or has been told by a third party, that somebody is not self-isolating, it will take action.

Again, the message from Police Scotland is that compliance with the self-isolation requirements has been very high, and it has not issued any fixed-penalty notices for any breach in that regard.

In addition to what I have described, public health officials are carrying out spot checks—"dip sampling" may be a better term. They are contacting approximately 20 per cent of travellers to give them public health guidance in relation to quarantine and self-isolation.

The Convener: It sounds from what you have said that the evidence so far shows that the arrangements in place are effective. Some other countries, and territories such as Hong Kong, have used tagging for those who are required to be in quarantine in order to ensure compliance. Is that an approach that you have considered, or would consider, in the current circumstances?

Humza Yousaf: If I heard you correctly—I might have misheard you; forgive me—I think that you asked about tagging.

The Convener: Yes, indeed.

Humza Yousaf: That is not something that I, or we, have considered here in Scotland. First, compliance is high, so I am not sure that there is a need to go there. Secondly, given the connotations of electronic monitoring in Scotland, I am not sure that people would take well to being tagged and monitored in that regard. It is not necessary or proportionate at this time. We obviously keep such measures under review, but we are certainly not currently looking at tagging.

Emma Harper (South Scotland) (SNP): According to our briefing papers, the regulations were brought into force without any consultation with carriers, who are required to ensure that travellers are made aware of quarantine on three occasions during their journey: when they book, when they check in and when they are in transit. I am interested to know what impact the regulations have had on carriers. To be clear, the term "carriers" include not just our planes but our seafaring vessels and ferries, such as the ones coming from Larne and Belfast to the port of Cairnryan.

Humza Yousaf: Emma Harper is right to make those points. On her latter point, I know that she has an interest in those ferry routes in particular. She will be aware of the exemptions that apply to the common travel area, which are important and provide a clear mechanism for those who wish to travel from the Republic of Ireland into Northern Ireland and to stay there or come over to the mainland UK.

The regulations also ensure that there are safeguards in place for those who use Dublin as a hub airport. They still require those people to self-isolate, minus the amount of time that they have spent in the Republic of Ireland. I want to be clear about the common travel area.

With regard to Emma Harper's more substantial point, I suppose that it depends on the definition of "consultation". We would love to undertake a three-month consultation, as per the usual Government guidelines, for any such policy. However, for emergency legislation or regulations, that is clearly not possible. Has there been a formal consultation in the way that we would normally undertake consultation? Of course that has not been possible, but we have had discussions and engaged with not only the carriers but the airports and—as Emma Harper rightly highlights—other transport providers.

We will need to continue that work. As the committee will be aware, there is a review every three weeks, and we are already considering the data to inform us on the next review. The feedback from carriers, transport providers, airports and hubs will be hugely important to that work.

Emma Harper: What role will the carriers have in the three-weekly review of the regulations? Will they be consulted on proposals and asked to provide data on use?

Humza Yousaf: I have touched on that briefly. Discussions and engagement with the carriers and other transport providers will of course be important. I must mention that, as Emma Harper said, we are not just talking about the carriers and aviation. There will be a conversation across the board with those that have been impacted as regards collecting some data.

When it comes to the review, we will always be driven by the public health imperative. We do not doubt that there has been an impact on the transport sector as a whole, particularly the aviation industry. That is not typically down to regulations such as those before you; there has been a worldwide impact on aviation due to coronavirus. The sector will clearly be part of the consideration when it comes to the three-week review. However, it will always be driven by the public health imperative and the data that comes before us.

The Convener: In light of your answers thus far, are you satisfied that the appropriate mechanisms are in place to ensure that all visitors to Scotland complete and submit the appropriate documentation and to ensure that carriers are indeed providing passengers with the required notification at each of the three stages that Emma Harper described?

Humza Yousaf: The short answer is yes. I am quite satisfied with the data that we have before us. There is ample opportunity for travellers to be reminded of the quarantine rules that exist, and they are directed to the UK Government's Home Office website in relation to the form. Hard copies can be made available if necessary. Based on

what has happened thus far, however, the short answer to your question is yes: I am satisfied.

The Convener: Should a fixed-penalty notice be required for a temporary visitor to the United Kingdom, how would that be enforced in Scotland?

Humza Yousaf: I think you have asked about enforcement for temporary visitors coming into Scotland. Remember that a fixed-penalty notice will only ever be the last resort when it comes to encouraging people to comply or to provide data. If such steps need to be taken, there are measures in place to ensure that the fixed-penalty notice is paid when the person concerned is in the country; if the matter has to be followed up when the person leaves the country, processes are in place for that. That would only be a last resort and, thus far, that has obviously not been needed.

The Convener: Thank you—that is understood and appreciated.

There are no further questions from other committee members, so we will now move on to agenda items 2, 3 and 4, which are the formal debates on the affirmative Scottish statutory instruments on which we have just taken evidence from the Cabinet Secretary for Justice.

I remind members that we are now in a debate process. I ask the cabinet secretary to speak to and move S5M-22031, in the name of his colleague Jeane Freeman.

Motion moved,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Regulations 2020 (SSI 2020/169) be approved.—[*Humza Yousaf*]

The Convener: Thank you. No member has indicated that they wish to debate the motion. The question is, therefore, that the motion be agreed to.

Motion agreed to.

The Convener: Under agenda item 3, we will debate the second affirmative instrument. I invite the cabinet secretary to speak to and move S5M-22017, in the name of Jeane Freeman.

Motion moved,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus, Public Health Information for Passengers Travelling to Scotland) Regulations 2020 (SSI 2020/170) be approved.—[*Humza Yousaf*]

The Convener: Thank you. No member has indicated that they wish to debate the motion. The question is, therefore, that the motion be agreed to.

Motion agreed to.

09:15

The Convener: Under agenda item 4, we come to the third and final affirmative instrument before us. The same rules and procedures apply. I invite the cabinet secretary to move S5M-22018, in the name of Jeane Freeman.

Motion moved,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment Regulations 2020 (SSI 2020/171) be approved.—[*Humza Yousaf*]

The Convener: Thank you. No member has indicated that they wish to debate the motion. The question is, therefore, that the motion be agreed to.

Motion agreed to.

The Convener: That concludes consideration of the affirmative instruments. I thank the cabinet secretary and his officials for their attendance.

09:16

Meeting suspended.

09:38

On resuming—

Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill: Stage 1

The Convener: The fifth item on our agenda is a final public evidence session on the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill, at stage 1. We have discussed a number of issues with witnesses in previous evidence sessions, and the committee has also received significant written evidence. This meeting is an opportunity to discuss the Scottish Government's position on the issues.

I welcome Jeane Freeman, the Cabinet Secretary for Health and Sport. She is accompanied by Dr Gregor Smith, who is the interim chief medical officer, Greig Walker, who is the bill team leader, and Tansy Main, who is the unit head in the CMO's rape and sexual assault task force. I thank you all for joining us.

We will ask questions in a prearranged order. I remind members and witnesses to keep questions and answers succinct and, please, to give broadcasting staff a few seconds to operate the microphones before you begin to ask a question or provide an answer. Members should, please, indicate when they are on their final question. I invite the cabinet secretary to make a short opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you, convener, and good morning to you and colleagues. I offer my apologies for the technical problems that we had at our end, which have held you up.

Thank you for continuing your scrutiny of the bill at what is a uniquely challenging time. The progress of the bill sends the important message that we are committed to improving the experience of victims of sexual crime in the health and justice systems.

I record my appreciation for all the staff who work in those services, notwithstanding the fact that they have also been addressing the challenge of the pandemic. I give my grateful thanks to Dr Gregor Smith, the interim chief medical officer for Scotland—who, as the convener said, has joined me this morning—for providing continued national leadership of the task force that is overseeing improvement of the relevant services across the country.

This is an important and focused bill that we, as a Government, have chosen to prioritise. It will underpin the work of the task force, which has firmly positioned forensic medical services first and foremost as a healthcare response. All health board chief executives have committed to delivery of sustainable trauma-informed services, in line with national Healthcare Improvement Scotland standards.

Transformation in the response to rape and sexual assault is already well under way through the work of the task force, and is supported by Government funding of £8.5 million over three years. Together, the work on the bill and the task force address recommendations in Her Majesty's Inspectorate of Constabulary in Scotland's report from 2017.

As I set out in my letter to the committee on 5 May, a comprehensive package of resources has been developed to ensure consistency in the approach to pathways of care, as well as to recording, collation and reporting of data in relation to services. Implementation of the clinical pathway, national documentation and national data sets for adults has been delayed due to Covid-19, but plans are now being developed to deliver virtual training for health boards to prepare them for implementation of a wider package of resources covering all age groups before the end of the calendar year.

Other important improvements are also being progressed over the next 12 months, including development of the role of nurse sexual offence examiners, implementation of a national clinical information technology system, and preparation of health boards for commencement of the bill.

I welcome the committee's having spoken to survivors of rape and sexual assault; the Government shares the committee's commitment to learning from people with lived experience. I was heartened that Sandy Brindley of Rape Crisis Scotland acknowledged in her oral evidence that improvements to victims' experiences resulting from the work of the task force are beginning to bed in, particularly in recent months.

The bill will enshrine in law an holistic healthcare and recovery focused model, and will provide access to self-referral consistently across Scotland. That will mean that when a person who has experienced rape or sexual assault does not want to tell the police straight away, or is undecided, the health board will be able to obtain certain forensic evidence and keep it safe. If the person decides not to tell the police, the evidence will be destroyed after a period, or on request. That choice being available to people after a significant trauma is vital to giving them control over what happens to them at a time when control has been taken away.

I emphasise, however, that the principles of trauma-informed and person-centred care will apply whether or not a police report is made. The

bill supports the delivery model of a co-ordinated multi-agency service to ensure a smooth pathway of care for the person. In that regard, I consider the bill to be barnahus ready.

A number of issues have been raised with the committee, and the committee will have a number of questions. I and my colleagues look forward to answering your questions.

The Convener: Thank you, cabinet secretary. As you said, the committee heard directly from survivors of rape and sexual assault. We heard from Sandy Brindley in person, as well as in writing. She put on the record that the single most important issue for survivors is access to a female doctor or examiner. How confident is the Scottish Government that, through the bill and the other changes that you have described, victims of rape and sexual assault will have a real choice about the gender of the examiner?

09:45

Jeane Freeman: I am confident about that, based on the following. I say first that I agree completely that people should have that choice; it is particularly important in circumstances such as we are discussing.

Now, some 61 per cent of sexual offence examiners are women, and 70 per cent of the doctors who have completed NHS Education for Scotland's essentials in sexual offences forensic examinations foundation training are women. In addition, introduction of the role of nurse sexual offence examiner improves availability of choice, and work to maximise choice across the country will continue.

There are clearly some restrictions to that. For example, where a team of sexual offence examiners is predominantly male, those individuals will be on contracts, so we have to find other ways to add to the number in order to offer choice. The task force has that work well in hand. The 61 per cent figure is, however, a significant improvement and illustrates the commitment to ensuring that choice is available.

The Convener: We heard from Dr Anne McLellan from NHS Lanarkshire about the work that is being done at regional level, with what are, in effect, recruitment networks. She spoke about the potential benefit of a national network for recruiting female examiners. Do you envisage recruitment causing a difficulty? Are there, for example, issues in recruitment of paediatricians for instances in which a paediatrician would be appropriate? What is your view of the mechanism for identifying and recruiting female examiners, and networking in that regard?

Jeane Freeman: There are two points to make in response to that. With your agreement, I will ask Dr Smith to contribute on this.

It would be foolish to deny that there are recruitment challenges in just about every area of our healthcare workforce at this point. Clearly, there are recruitment challenges when it comes to paediatricians. However, work is under way to ensure that the training and the pathway that I have described create a career. Dr Smith might say a bit more about that.

Dr Gregor Smith (Scottish Government): I thank you, first of all, for the opportunity to speak to you today about what is, for me, a very important bill on an area in which a tremendous amount of work has been done.

Recruitment and retention are incredibly important. The task force has, over the years since it has been in place, sought to make the role of forensic medical examiner much more attractive. That is not only to attract more people; the aim is also to ensure that we retain expertise in the role.

When I was first involved with forensic medical examiners, it was a very male-dominated profession, or specialty. Over the past decade, I have seen far more women coming forward and expressing a desire to develop a career in the area. The career-development aspect is important. We need to ensure that people are working within safe and effective pathways of care and that they get support, as part of a multidisciplinary team that provides that care. We also need to ensure that they work to quality-of-care standards that they can buy into. Those things together make the role much more attractive.

However, we need to make the practicalities of the role much easier to deal with. Many doctors who get into the line of work do so as part of a portfolio career. As has been mentioned, they might have a background as a paediatrician, a gynaecologist or a general practitioner. We need to ensure that the work that they do fits with their wider portfolio of work. An issue that was commonly raised in the past was the need to facilitate court appearances. People have enjoyed doing the work of a forensic medical examiner but have found the practicalities of shifting the rest of their portfolio of work to accommodate court appearances to be incredibly difficult. Our work with the justice system to facilitate that much better and more proportionately has made the role a more attractive career choice, and has made it much more likely that we retain expertise in the service.

The cabinet secretary touched on use of specialist trained nurses as sexual offence examiners. That is also very important, because it ensures that the basis of everything that we do, in

the care that we provide, is that the choices and preferences of people who experience sexual assault are catered for.

The Convener: This is my final question. Is it the Government's aspiration to have a 24/7 examination service throughout Scotland? If that is your ambition, how optimistic are you about progress towards it?

Jeane Freeman: The HIS standards set a time frame of three hours for someone who has experienced rape or sexual assault to be able to access forensic medical examination. That is the objective that we are working to. Each health board has made progress in building the capacity and capability of the workforce to achieve that aim.

However, as the convener will understand, there are undoubtedly challenges in remote and island communities in meeting that standard as easily as we might be able to do elsewhere. That said, it is still our intention to do so, and the task force is working with the relevant boards and colleagues on steps that we might take to overcome the particular challenges.

At this point, I am confident that we will be able to meet the aim in most of Scotland, and I am confident about our commitment to ensuring coverage of all Scotland, notwithstanding the fact that challenges exist that we need to find ways through.

David Stewart (Highlands and Islands) (Lab): Good morning. Why was it decided to restrict self-referral for forensic medical examination to people over the age of 16?

Jeane Freeman: There is some debate about that. It is only sensible to acknowledge that. Some argue for the age being 13 and others argue for 18, for example. Consensus was reached on its being 16. However, I am conscious that there is a debate; we have not closed our minds to further discussion of the age limit.

David Stewart: You might be aware of other evidence that the committee has had on that matter. Dr Anne McLellan from NHS Lanarkshire made two quick but powerful points when she said that

"we should encourage self-referral in 13 to 15-year-olds, because 40 per cent of last year's 13,000 sexual assaults were on under-18s"

and that

"One in four under-16s in Scotland is sexually active."—[*Official Report, Health and Sport Committee,* 12 May 2020; c 10.]

Do you share my view that the extremely low reporting and conviction rates for child sexual assault could be reversed if we were to encourage self-referral by under-16s?

Jeane Freeman: Again, I might ask the chief medical officer to comment, but I am cognisant of the debate, the different views on the issue and the many strongly held opinions and powerful points that have been made. I am open to discussion of whether there is a case to be made for us supporting a lower age. As I said, consensus was reached on the age of 16. As I have noted, other arguments favour an age limit of 18, but it seemed to us that 16 would fit in with the age of majority in other areas of life in Scotland. We are happy to have a further discussion on that aspect.

Gregor Smith might want to add something on the process that was undertaken to reach the position in the bill.

Dr Smith: The age threshold is an important area for discussion. As the proposals were developed, there was a great deal of discussion with stakeholders, in particular about whether, on balance, the age for self-referral should be 13, 16 or, as the cabinet secretary mentioned, perhaps even 18. The strongest view among the clinical community in particular, which balanced the aims that self-referral is intended to achieve with the need to ensure that we safeguard young people, was that 16 is the right cut-off point.

We have always adopted a position of being open to further discussion on the matter, but we should recognise that the current clinical consensus, which balances all the needs that relate to young people, sits with the age of 16.

David Stewart: I thank both witnesses for those helpful suggestions. I will suggest two possible ways forward. A sunset clause could be inserted in the bill so that we would keep the age limit at 16 but it would be reviewed within a certain time—for example, three years—and/or we could encourage post-legislative scrutiny of the legislation.

I understand that the committee would have a role in that regard, but a strong steer from Government that the legislation will be reviewed in the future to see whether the provision is fit for purpose would be a helpful way forward. I would welcome the cabinet secretary's views on that. It might be that she has not yet considered those points, but I would be happy if she could get back to the committee on my suggestions.

Jeane Freeman: I am grateful to Mr Stewart. Those suggestions are both very positive and they recognise that there is not necessarily a single right answer. I am happy to consider the matter further and to respond to the committee in due course.

David Stewart: The Scottish Children's Reporter Administration notes in its written evidence that the bill

"does not offer therapeutic supports beyond the forensic medical examination".

Do you agree with that view?

Jeane Freeman: The bill needs to be viewed alongside the work of the task force in the context of what we are trying to achieve. It provides a legislative underpinning where that is necessary. The approach is trauma informed, so it is, by its nature, multidisciplinary and therapeutic. I think that the SCRA's view is an unfair criticism of the bill, given that what it highlights is not the bill's purpose; rather, the bill sits alongside the overall work of the task force and the commitment to a trauma-informed and health-based service.

David Stewart: I move on to my final question. You said in your opening remarks that the bill is consistent with the principles of the barnahus model, which is—as our viewers might know—the name of the original Icelandic scheme. It means "children's house". It is about involving children in the justice system, and it is geared up to be more efficient and sensitive to children's trauma.

Will you say a bit more about that important principle, which has, as you will know, been picked up by many other European countries?

10:00

Jeane Freeman: It has indeed, and the Scottish Government is committed to pursuing that model across portfolios.

As I highlighted in my opening remarks, I believe that the approach in the bill, when set alongside the wider work of the task force and the overall approach that I have described, which involves an interagency multidisciplinary therapeutic model that is focused on both the physical and psychological needs of the individual, as well as the collection of appropriate and recognised forensic evidence, will contribute to the overarching barnahus principle. That is why I have said that I believe that the bill is barnahus ready.

In and of itself, the bill will not deliver in total what we seek in pursuing a barnahus model, but it will contribute to that work, and it certainly does not contradict that overall ambition.

Brian Whittle (South Scotland) (Con): Good morning, cabinet secretary and colleagues. I have a question on whether children and young people who are alleged to have perpetrated sexual assaults and abuse should be included in the bill. I think that it is fair to say that there is quite a bit of conflicting opinion in that regard. The National Society for the Prevention of Cruelty to Children seems to be favour of their inclusion whereas Rape Crisis Scotland is not. What consideration has the Scottish Government given to extending the bill's provisions to cover alleged child perpetrators?

Jeane Freeman: Mr Whittle is absolutely right: there are conflicting and often strongly held views in that area. The task force has undertaken, and continues to undertake, some work on the matter. I ask our chief medical officer to advise the committee what the task force is doing through its sub-group in considering the issue.

Dr Smith: It is important that that aspect be addressed, and it has certainly been picked up as part of the task force's work. A specific sub-group of the task force is examining the approach to children and young people who have been accused of being perpetrators of sexual assaults.

It is important that we understand that this is a very complex area. We are already starting to see some movement on the guidance with regard to how such young people should be examined and the type of interagency discussion that would be necessary in respect of those in older age groups—for example, those aged between 13 and 16—before any decision to examine, and a decision on the location of an examination, is made. That work is under way.

My view is that it is right that the issue is picked up as part of a pathway approach to this complex clinical area. Such young people might have experienced trauma themselves, and that needs to be carefully and sensitively explored. Rather than using the bill in a way that might complicate and delay its greater intent and focus, it is right that we pick up the issue appropriately by other means.

Brian Whittle: Has the Scottish Government considered allowing for examination and collection of forensic samples from alleged perpetrators in a healthcare setting rather than in police custody?

Jeane Freeman: There is no straightforward yes or no answer to that question. The starting point is probably to say, as Dr Smith has just said, that alleged perpetrators are oftentimes themselves victims of abuse. In that situation, one would want to collect the evidence in a way that is supportive, and certainly in a way that does not create more trauma or difficulty for the individual. However, there must be case-by-case consideration in consultation with Police Scotland to determine in each individual circumstance what is the right approach.

As I said, there is no straightforward yes or no answer. We would certainly not want healthcare facilities to bar individuals who are alleged perpetrators but, equally, I understand that there will be circumstances in which it would not necessarily be appropriate for such facilities to be used.

Brian Whittle: I will move on to a question about retention services and the retention periods for evidence that is collected from forensic medical examinations. I should probably declare an interest in that I have been working with a constituent over the past couple of years regarding historical sexual abuse. The case, which goes to trial tomorrow, is from 40 years ago. You will therefore understand my interest in this line of questioning.

We heard in oral evidence that there is a lack of consensus on the matter between organisations, and I can understand that. What progress has been made on seeking a consensus about the appropriate timescale for the retention of evidence?

Jeane Freeman: Quite a lot of work has been done on that, and my colleagues may wish to add to what I am about to say. A group that is part of the task force's self-referral sub-group is working to develop a national protocol under which the provisions of the bill would be implemented.

There is no consistency among self-referral services across the UK. Retention periods in England, Wales and Northern Ireland range from one to seven years. The Archway service at NHS Greater Glasgow and Clyde currently retains its evidence for 18 months. Having gathered information, the membership of the group, which includes the health service, Police Scotland, the Scottish Police Authority and the Crown Office, has reached a consensus that a period of two years and two months feels about right. However, further work needs to be undertaken before we can be confident in settling on a period.

I am mindful of what you have self-declared, with your parallel interest in the area. The question is not a straightforward one, but we will work through it. At this point, however, the consensus is around a period of two years and two months.

Brian Whittle: As has been mentioned, we heard some incredibly compelling evidence from victims of sexual crimes. Will you consider victims' views in making a decision of that nature?

Jeane Freeman: That is a very important point. With your agreement, convener, I will ask Tansy Main, who has been involved in the area, to say a little more about how we will make progress.

Tansy Main (Scottish Government): As the cabinet secretary highlighted, we have a sub-group under the remit of the CMO task force that is considering the implementation of the bill's provisions, and a task and finish group that sits beneath the sub-group is specifically considering the protocol for health boards for the retention and storage of evidence and the retention period, which will be set out in secondary legislation.

As the cabinet secretary said, that work involves the Crown Office, Rape Crisis Scotland, the police and health boards. Sandy Brindley, who is chief executive of Rape Crisis Scotland, plays a very important part in that group, helping to ensure that the voice of lived experience is fed into its considerations. Our proposal would be that, when we do some further work and analysis on what the appropriate retention period might be, we will take that to survivors through the survivor reference group that is linked to the task force and ask them for their views on it.

When survivors gave evidence to the committee in early March, they suggested that they would like the retention period to be as long as possible. That must of course be balanced with the need to provide an element of closure for survivors, and the period should not carry on for ever. The storage requirements on health boards are a further consideration.

On the point about historical abuse, it is worth noting that abuse often does not come to light until many months or years after it has taken place. In such cases, DNA evidence will not be obtained. DNA evidence in acute child sexual abuse cases is normally obtained within seven days. However, because the abuse in historical cases does not come to light within that timeframe, the retention period for such cases will be less relevant.

Brian Whittle: Given the lack of consensus between organisations on retention timescales, will they be subject to regular review? Will the bill contain a provision on that?

Jeane Freeman: That is a sensible and reasonable question. It goes back to Mr Stewart's line of questioning and our recognition that, although we will have to settle on particular matters as the bill progresses, there will nonetheless be no absolute right or wrong answers in some areas, so we should be willing to review provisions after a particular time.

As I said to Mr Stewart, I am happy to consider how we might do that and to come back to the committee on it in due course; and I will incorporate Mr Whittle's point in that consideration. Of course, if the committee has particular views, I will be grateful to hear them.

Sandra White (Glasgow Kelvin) (SNP): Good morning, cabinet secretary. I will follow on from Brian Whittle's questions on the type of evidence that health boards are expected to retain. Tansy Main mentioned a protocol. Can you clarify what type of evidence health boards would be required to store? Have you made a decision on that yet? Would it be part of the protocol that Tansy Main mentioned?

Jeane Freeman: For speed, it is probably best to go straight to Tansy Main and get her to clarify

what the protocol covers and the procedure on retention.

Tansy Main: At the moment, the sub-group that is developing the protocol is doing so on the basis that the evidence that will be retained will be, as it is now, in accordance with the guidance published by the Faculty of Forensic and Legal Medicine, which sets out what forensic examples should be obtained following a rape or sexual assault. That guidance applies in both police referral and self-referral cases.

At the moment, the sub-group considers that biological samples will be retained, which might also include images from a colposcope from an internal examination and, if relevant to the case, underwear, sanitary wear or condoms. The clinician will be able to judge what is required, on the basis of the information that the complainer has provided to them. In the rare circumstances where there is evidence of ejaculation on clothing, the clinician would make a decision about whether to retain that item. If they were in any doubt, they could contact the lead scientist at the Scottish Police Authority, who is on call 24/7, to check whether they think that retaining that item would provide an opportunity for a DNA analysis and have some evidential value.

The two health boards in Scotland that currently provide self-referral are of the view that when we have a national protocol, all health boards should take the same approach, which should be limited to the evidence that I have just set out: biological samples; underwear and so on, if required; and, in exceptional circumstances, another item of clothing. However, there is no proposal at the moment to retain large or bulky items, or anything that might be within the scene-of-crime remit, which is very much investigative territory that resides with Police Scotland.

Sandra White: You said that the clinician would decide on the evidence and whether to contact the police. However, what about the victim in all this? What would happen if the victim was insistent about a certain piece of clothing? Would they have a say on what evidence was being retained?

10:15

Tansy Main: It is important to emphasise that, in the process of the initial consultation when someone attends for a self-referral, information is provided to the person to explain what self-referral is and what it is not. It is explained that self-referral is not the same as a police investigation and that the retention of biological samples and other relevant evidence that might have evidential value from DNA testing does not mean that all evidence relating to the suspected crime will be obtained. The complainer therefore needs to decide whether self-referral is for them. If someone was insistent that something should be kept, a decision would have to be taken on whether DNA evidence could be found on that item. As I said, if there was any doubt, the expert advice of the forensic scientists at the Scottish Police Authority would be sought.

Sandra White: If there was a self-referral but the incident was not reported to the police, could the evidence from the medical examination be lost?

Tansy Main: No, the evidence would not be lost in that case. It would be stored securely by the health board according to the national protocol that is being developed, which will be agreed with Police Scotland, the Crown Office and Procurator Fiscal Service and the Lord Advocate. I am not quite sure what you mean by loss of evidence, though. Do you mean loss of evidence in terms of things that the police might be looking for?

Sandra White: Yes.

Tansy Main: The nature of self-referral is that the police are not involved, so if there is closed-circuit television evidence or fingerprints on glasses in a nightclub, for example, it is explained to the person that that kind of evidence will be lost if they do not report at that point in time. The person can then decide whether they wish to go ahead with the examination and just have the forensic evidence from that retained, and then consider whether to report to the police at a later date.

The Convener: Thank you. I remind members and witnesses that it is important not to talk over each other, because of the sound quality—[*Inaudible*.]

Sandra White: That is my fault, convener. Having just spoken to Tansy Main about evidence, my next question is for the cabinet secretary. Would there be advantages in allowing analysis of samples by the Scottish Police Authority prior to a case being reported to the police?

Jeane Freeman: We need to hold carefully in our heads the distinction between a report to the police that then triggers an investigation—Tansy Main covered what a police investigation would look at—and a self-referral, which is largely a healthcare-led service that focuses on the physical and psychological needs of the individual but has the capacity to retain forensic evidence that has evidential value. Part of the approach to the self-referring individual is ensuring that they understand the difference between self-referral and reporting to the police, and are therefore able to make a better-informed choice about how they want to progress and what they want to do.

On the SPA analysing samples in the way that Ms White described, I cannot see the value of that.

We should remember that we have properly trained sexual offence examiners, whose training includes not only how to secure samples with evidential value, but how to know where those samples might be and how to go about that exercise. I am therefore not entirely sure where the value might be in bringing in the SPA. Who would decide that and what would that add to the process? I could be wrong, and the committee might want to say more to us about that but, at this point, I do not see what the value of that might be.

Sandra White: I must admit that I agree with you. I think that that would go against the grain of the bill.

There has been talk about anonymous databases. Has the Government considered establishing an anonymous DNA database?

Jeane Freeman: The most recent written evidence from Police Scotland and the UK Information Commissioner's office cautions against any anonymous DNA databases, and the Crown Office has been clear that a proposal to do that would need how that would operate to be fully defined before it would comment on it.

I know that the issue has arisen in the stage 1 evidence, but it has not been consulted on. The existing national UK and Scottish DNA databases, which contain DNA profiles of people who are suspected or convicted of having committed a crime, are subject to pretty rigorous legal and governance controls. We have not considered the matter, but if the committee wants to make any points to us about it in its stage 1 report, I will, of course, consider them along with any other points that it makes.

Emma Harper: Good morning, cabinet secretary and witnesses. I thank you for the work that you have done so far.

I am interested in the process for raising public awareness of self-referral and signposting services. How do you envisage people being made aware of self-referral services?

Jeane Freeman: A workstream that is chaired by Rape Crisis Scotland is undertaking a feasibility study and an options appraisal to consider how individuals will access self-referral services—in other words, how they will be made aware of their existence—and is looking across to see what other partners might help in the delivery of that. A national awareness-raising campaign is being considered, and the group is consulting other stakeholders, including deafscotland, the Royal National Institute of Blind People, People First (Scotland) and Young Scot, as it progresses that work to try to ensure that it captures as many contributions as possible before it determines how we will raise public awareness and perhaps target specific groups of people to ensure that they know that the services exist.

Emma Harper: I am sure that there has been consideration of targeting the black, Asian and minority ethnic community in a national public awareness campaign. Can you touch on that a wee bit?

Jeane Freeman: I did not name that community, but it will, of course, be part of the range of stakeholders in the group of consultees in the workstream that is led by Rape Crisis Scotland. We want to be able to reach a range of groups, such as young people, the BAME community, of course, and the Traveller community. The messages that are conveyed should be consistent, but the means by which those messages are channelled will differ, depending on the group.

I am sure that the sub-group of the task force will come back with some key pieces of information that it wants to ensure that people receive and, I suspect, a range of methods by which that should be promulgated. That should be consistently followed up, because there is no point in just doing a big "Ta-dah!" moment at the point when a service becomes available—we want people to be consistently aware of it. Of course, we want to ensure that other important partners such as Police Scotland have information that they can pass on to individuals who might benefit from the service.

Emma Harper: I should have also mentioned that persons with additional support needs should be considered.

You said that £8.5 million of Scottish Government money has been utilised for the process. Who would be responsible for funding the public information or education campaign? Would there be additional funding for that?

Jeane Freeman: We would need to make sure of whether more funding was needed. It would be an NHS Scotland-led campaign, because it is a health service and because the NHS brand is well recognised and trusted. We would want to have that at the forefront and we would make sure that there was resourcing to support a consistent information campaign.

Emma Harper: Will Police Scotland have a role to play in informing people about self-referral services, so that they can make an informed decision about whether to report an incident to the police?

Jeane Freeman: Yes, it will. Police Scotland is an active and enthusiastic partner in all of the work and we have benefited from that input.

Miles Briggs (Lothian) (Con): How will the Scottish Government ensure that people who have

self-referred for a forensic medical examination have early access to advocacy?

Jeane Freeman: Advocacy is an important element. We are talking about a trauma-informed service that recognises the importance of the individual's psychological and mental health and their needs in that regard. That includes having support to express what they want in a situation in which they might, for understandable reasons, find that difficult.

We have had a lot of advice from Rape Crisis Scotland, which has a role. The CMO might want to say more about how the task force is looking at advocacy.

Dr Smith: Advocacy is becoming increasingly important in all aspects of healthcare, and the bill should be no different. The Rape Crisis Scotland advocacy project has been helpful in informing, through the task force, the approach that we should adopt.

It is important to make a distinction between the underpinning elements of the legislation and the work of the task force in ensuring that we have optimal care pathways that we can monitor to ensure that quality standards are as good as we can make them.

I see advocacy fitting into that latter part. It is about how the NHS in Scotland responds to the need for advocacy for the relevant group and how it works with our third sector partners in making sure that advocacy is accessible and available when it is required. The issue is not unique to this sphere of clinical practice; it is much broader.

Miles Briggs: What research has the Scottish Government undertaken into same-sex cases? Might the Government put in place bespoke support for those individuals?

Jeane Freeman: If Mr Briggs does not mind, perhaps he could explain what he is asking about a little bit more.

Miles Briggs: I am talking about individuals who have been involved in same-sex cases.

10:30

Jeane Freeman: Whether it is someone of the same sex or of the opposite sex who perpetrated sexual abuse on an individual, the individual's health and mental wellbeing, and their psychological needs, will by and large be comparable.

Part of the discussion is to look at and make sure that our proposals for the establishment of the service are equitable and accessible to all individuals, regardless of their sex or sexual orientation. I do not quite follow why there would be any difference in the trauma-informed approach and the service on offer as a result of the sex of the individual who perpetrated the abuse. I apologise if I am missing something, and it might be that the committee will want to say something about that issue to the Government in its report.

If either Tansy Main or Greig Walker wants to add to that, I am happy for them to do so.

Greig Walker (Scottish Government): The bill has been deliberately drafted in gender-neutral language. It talks about people; it does not talk about female victims. That approach is deliberate, and it follows on from the development of the equality impact assessment, which I think is included in members' papers this week. That means that all victims have the same legal entitlements under the bill, irrespective of sex, age, race or other distinguishing characteristics.

Following Detective Superintendent Filippo Capaldi's oral evidence to the committee, he provided interesting statistics that show that the predominant dynamic in sexual offending is male perpetrator and female victim. I have just used the phrase "drafted in gender-neutral language". That is carefully crafted, because we do not consider the bill to be gender neutral; it is informed by the gender dynamics that are in play in the "equally safe" portfolio.

Miles Briggs: My final question is about mental health assessment and support. What does the cabinet secretary consider should be available for people accessing services? How will that be provided? How will ministers ensure that the same level of support is put in place across Scotland?

Jeane Freeman: As I have said more than once, the service is a trauma-informed service. That is deliberate. It is also intended as a national service, hence the national standards and the overall national protocol and approach.

The Government's overall intention is that, regardless of where someone is in Scotland—notwithstanding the challenges that we talked about at the outset with delivery in remote and rural communities, for example—they will receive the same standard and quality of service and access to the services around that service. That includes psychological support, which may be continuing psychological support, depending on the individual's needs. Because the forensic medical service is a health service, the psychological support would come through the health service.

David Torrance (Kirkcaldy) (SNP): How will health boards be encouraged to co-operate with one another and share best practice? How will that be overseen and monitored?

Jeane Freeman: The CMO may want to add a few words to what I have said on the implementation of the national clinical pathway.

Our health boards are heavily involved in the work of the task force, and the bill will underpin that work. The national service, protocol and standards are designed to involve our health boards but not be open to local interpretation. It is a national service that boards are required to deliver and report on, according to various quality standards. Underpinning that is the clinical approach—the CMO may want to add a few words on that.

Dr Smith: I emphasise to the committee the degree of co-operation that has taken place, not just in the clinical community but between the clinical community and the wider group of stakeholders, in relation to the aims of the task force and what we are trying to achieve with the legislation.

There are various ways in which we can start to achieve consistency of approach across the country. The first of those is through the specialty organisations—the Faculty of Forensic and Legal Medicine, for example—that are associated with this area of work. There are also the clinical networks that have formed between forensic medical examiners throughout the country, which have broadened over time to include other disciplines and professions.

I could also point towards the co-operation that has occurred between boards to develop regional approaches to care, all with the aim of achieving much greater access, and quality and consistency of service. Underpinning all that are the national clinical pathways that are being developed and the national quality standards that were developed by Healthcare Improvement Scotland, which were launched first on an interim basis and then more fully in March 2020.

All that points towards different vehicles that we can use to maximise the enthusiasm and eagerness to continue to improve care, and to harness the broader clinical communities in a way that gives them something to wrap their approach around.

We continue to explore different ways that we might continue to enhance that in future, for instance through the emergence of a managed national clinical network. As I say, though, we have a variety of approaches to ensure that there is consistency in the quality of services across the country.

David Torrance: What plans does the Scottish Government have for monitoring and reporting of quality indicators? Will that information be made publicly available?

Jeane Freeman: As we have said, there are HIS quality indicators, and the service will be monitored against those. The results of that monitoring will be made public. I think that we would anticipate an annual report of performance against those quality indicators.

David Torrance: Will additional support be needed for smaller health boards to implement the legislation, and will the implementation of the legislation be evaluated in relation to the impact on people according to protected characteristics and socioeconomic disadvantage?

Jeane Freeman: The latter point from Mr Torrance is very important and I am grateful to him for raising it. No matter what we collectively agree on how the legislation should be evaluated, that evaluation should take account of its impact on protected characteristics and areas of socioeconomic disadvantage. I am sure that there will be other areas of evaluation.

On support for smaller health boards, there is a long-standing tradition in the NHS of inter-board support on a range of services. As we look to deliver the national service, we will instinctively begin by seeing where smaller boards can be assisted in what they are doing by larger boards. If further support is needed, we would look at that, because we are determined to ensure that a national service is delivered.

George Adam (Paisley) (SNP): I have a question on the financial implications of resourcing the bill. It is important that the bill delivers what it sets out to do. However, NHS Greater Glasgow and Clyde has made a number of claims, including that

"The estimated costs do not take into account changes to existing service ... Or the potential for increased provision leading to increased demand on existing service resulting from increased public confidence in the service."

I serve a constituency that is part of the NHS Greater Glasgow and Clyde area, and I know that a lot of things that the board says do not necessarily reflect what it does in reality. However, taking that into consideration, how would you respond to those claims?

Jeane Freeman: To start, I remind us all that health boards are already delivering a police referral service under the existing memorandum of understanding, and that there was a baseline transfer of £7.6 million for forensic medical services from the police to health in 2014, when health boards took over responsibility for delivery of those services. The modelling assumptions that we make in the financial memorandum predict an incremental 10 per cent increase in demand from self-referral, and each health board would incur a proportional share of that cost.

All that notwithstanding, we accept that there could be a revenue tail—as we would describe it—from the initial pump-priming funding of £8.5 million that I mentioned. Government finance officials continue to work through any additional financial pressures that may be expected to arise. However, at this point I am comfortable that, notwithstanding the fact that such services are already delivered by health boards to a degree and are therefore accommodated in boards' financial envelope, and that there has been a baseline transfer, the planning assumption in the financial memorandum is sensible. I have not yet seen any evidence from a health board or from anywhere else that a 10 per cent increase in demand as a planning assumption in the financial memorandum is in any way off kilter.

George Adam: As always, the cabinet secretary has given an impeccable answer, and she has already answered my supplementary question, so I have no further questions.

The Convener: In that case, we have time for a brief supplementary from Brian Whittle.

Brian Whittle: I apologise, cabinet secretary—I should have asked this with my initial questions. You will know of my interest in ensuring that we have the correct technology to deliver on Government policy. To go back to retention, do we have a digital platform that will allow for the digital retention of evidence for an extended period of time?

Jeane Freeman: I wondered why you had not asked me anything about technology, Mr Whittle—I thought that it might have been a first, but there we go. If you do not mind, I will ask Tansy Main to respond in detail to that question.

Tansy Main: The package of resources that the task force will introduce before the end of the current calendar year includes new national forms to ensure that information and data from forensic medical examinations are collated consistently across Scotland. The forms will initially be paper based, but we are already working on a national clinical information technology system for the whole of Scotland, which will mean that the forms will be online and the information can then be transferred to the analysts in Public Health Scotland, who will use the data to assess health board performance against the Healthcare Improvement Scotland quality indicators. Part of that clinical IT system will provide the functionality to enable things such as colposcope images to be retained securely on file.

I am not sure what Brian Whittle means when he asks about how long information will be kept. The clinical IT system will contain a mechanism to ensure that, when the end of the retention period is reached—whether or not that is determined to be two years and two months—the forensic information will be deleted from that record, and only health information will be retained.

The Convener: I thank the cabinet secretary and her officials for taking part in the meeting. That concludes our formal evidence session, and we now move into private session.

10:45

Meeting continued in private until 11:35.

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