OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health and Sport Committee

Tuesday 10 November 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 10 November 2020

CONTENTS

HEALTH AND SPORT COMMITTEE
29th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (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:

Joe FitzPatrick (Minister for Public Health, Sport and Wellbeing)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Isabel Hinds (Scottish Government)
Stuart McMillan (Greenock and Inverclyde) (SNP)
Margaret Mitchell (Central Scotland) (Con)
Andrew Mylne (Scottish Parliament)
Willie Rennie (North East Fife) (LD) (Committee Substitute)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 10 November 2020

[The Convener opened the meeting at 09:00]

Liability for NHS Charges (Treatment of Industrial Disease) (Scotland) Bill: Stage 1

The Convener (Lewis Macdonald): Good morning, and welcome to the 29th meeting in 2020 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton; I welcome Willie Rennie as his substitute.

I also welcome Stuart McMillan MSP, who joins us for stage 1 consideration of his member's bill, the Liability for NHS Charges (Treatment of Industrial Disease) (Scotland) Bill. We will hear evidence on the bill from two panels of witnesses. First, I welcome Joe FitzPatrick, the Minister for Public Health, Sport and Wellbeing, who is accompanied by officials from the Scottish Government directorate of health finance: Isabel Hinds, governance and finance accountant; and Julie McKinney, head of internal financial performance. I thank you all for joining us and invite the minister to make brief opening remarks.

Joe FitzPatrick (Scottish Government): Thank you for the opportunity to give evidence today. The Scottish Government is sympathetic to the intention behind the bill, which is to ensure that the costs of treating and caring for individuals who are affected by an industrial illness are recovered from the party that has compensated those individuals, rather than the taxpayer. We are keen to consider any proposal that would allow national health service resources to be used more effectively.

In saying that, we would be interested to see more evidence behind the detail of the bill, as a number of points require further clarity. The policy memorandum notes that there would be in the region of 500 cases per year but states that, ultimately, it is impossible to estimate the costs to the NHS of treating those people. We are keen to see further information about the number of cases and resulting costs.

As we set out in the memorandum that we submitted to the committee in September, it would also be helpful to have evidence on the anticipated level of revenue that the bill could recover and on the cost of administering the scheme. It is important that the scheme should not run at a loss due to the potentially low number of cases.

At present, the effect of the bill is that the Scottish ministers would administer the scheme. We note that the member says in the bill documents that his preference is for the United Kingdom Government to administer the scheme through the Department for Work and Pensions compensation recovery unit. It will be important to clarify details on scheme administration, as the bill might need to be amended to enable the scheme to be administered by a new statutory body, or to give new statutory functions to the existing body.

At this unprecedented time, we recognise the difficulty of gathering further evidence on costs to include in the financial memorandum. Nonetheless, if we are to come to a clearer position on the bill, we require further work to be done on the expected costs to be recouped, compared with the time and resources that would need to be spent on the proposed approach.

We look forward to the committee's report on the bill. I am happy to take questions.

The Convener: Thank you, minister. Given everything that you have just said, would it be fair to say that you are not averse to the general principles of the bill and indeed are sympathetic to them, but that, if the bill is to proceed to the next stage, you will need the questions that you have summarised to be addressed?

Joe FitzPatrick: That is an accurate summary of our position. Obviously, everyone has an interest in the NHS having additional resource, but we need to ensure that any scheme that we put in place meets its intended purpose and has that effect, rather than ending up as a drain on resource.

The Convener: In that case, is it your view that all the practical and implementation issues that you raised can be addressed through the Parliament's scope for taking proposed legislation to a conclusion?

Joe FitzPatrick: We would need more information about intention, and it looks like more work requires to be done. The Government would be keen to help the committee get more information if the decision is that the bill should proceed in this parliamentary session. Obviously, accessing some of that data in the current pandemic, particularly on issues around finances, is particularly difficult, and more difficult than it would be in normal times.

The Convener: Thank you very much. That is helpful.

Emma Harper (South Scotland) (SNP): The minister has raised the issue of finance, with one challenge being the need to find out about the cost of the scheme.

I am interested in the definition of "industrial disease". The bill defines that as a disease

"arising out of the employment of the injured person ... arising out of the employment of any person associated with the injured person, or ... which makes the person suffering from the disease eligible for employment-injury assistance under regulations made by the Scottish Ministers".

Might issues relating to the implementation of the new scheme arise from the definition of "industrial disease"? If there are challenges with the definition, what are the reasons for potentially implementing the new scheme?

Joe FitzPatrick: As the bill goes through the parliamentary process, it is really important that we ensure that we get robust definitions. It is clear that the existing scheme is a United-Kingdom-wide one and that the new scheme would be a divergence from that. It would have Scotland-specific aspects. There would be a balance between ensuring that the aspects of the scheme that remained aligned across the four nations would still be robust and ensuring that we have appropriate definitions for specific aspects.

David Stewart (Highlands and Islands) (Lab): [*Inaudible*.] I would like to talk about the administration of the scheme. Who should administer the new scheme? Should it be the Scottish Government or the compensation recovery unit at the Department for Work and Pensions?

Joe FitzPatrick: That is a very important question. The member in charge of the bill has suggested that it should be administered by the compensation recovery unit at the DWP. My officials have contacted the DWP to seek clarification on its position, and we are still waiting for a response. Obviously, we will provide that information to the committee when it is received.

The question is very important because the answer to it would determine to some extent where the burden of the costs would rest. It is clear that, if the costs rested on the NHS and those costs were higher than the recovered costs, we would have a scheme that was intended, in principle, to help the NHS but which would do exactly the opposite. It is really important that, in looking at the bill, the Parliament and the committee ensure that we do not inadvertently create a scheme that does exactly the opposite of what Mr McMillan and, I am sure, others hope that it would do.

David Stewart: My experience is that the Governments in the four nations tend to underestimate the costs of providing new services. As a generalisation, there are hidden costs in setting up any new organisation. The advantage of the compensation recovery unit administering the scheme is that there is an existing scheme and it knows which way is up. The issue is not a party-political one. I understand that the minister may wish to have a lot more powers in the Scottish Parliament, but that is not what we are talking about; this is about ensuring that the approach is cost effective and that we do not create another huge tier of bureaucracy.

Joe FitzPatrick: I am sorry if I gave the impression that I have a preference one way or the other; I do not. What I am saying is that in the bill as drafted those powers rest with the Scottish ministers, although I understand that the preference of Mr Stewart and Mr McMillan is that the scheme would be administered by the compensation recovery unit.

Sandra White (Glasgow Kelvin) (SNP): You said in your opening remarks that you are sympathetic to the scheme, but that there are a number of issues and that more evidence is needed on finance. My question follows on from David Stewart's question. What consideration has the Scottish Government given to the potential costs of administering the new scheme? I note that the DWP charged £215,000 to administer the current scheme on our behalf. Will you elaborate on that? Have you looked seriously at whether you would continue with that scheme while having to set up a unit under the Scottish ministers, would you have a Scotland-only scheme?

Joe FitzPatrick: The member is absolutely right about what the DWP charges—the figure is £215,600. This is not a Scottish Government bill. If the committee decides that the bill should move to the next stage, we would do as much work as is required around it. Just now, huge resources are going into the Covid response. As I said in my opening remarks, some of the costings might be more difficult to estimate under current circumstances than in normal times.

Sandra White: I have a short follow-up question. I thank you for the correspondence that the committee has received from the Scottish Government. Point 10 in that correspondence says that if the Scottish Government wished to set up its own scheme, it would need to speak to the DWP about whether it would

"have the capacity to provide the service"

or whether it would be happy to work with you to set up a separate service. How difficult would setting that up be?

Joe FitzPatrick: As I said, Scottish Government officials have contacted the DWP to seek clarification on its position, but we have not yet had a response. I guess that it is suffering the extra pressures that we are suffering, and which the committee is suffering, in terms of the work that it is doing around the Covid response. We will

make sure that the committee sees any DWP response.

Sandra White: Thank you.

The Convener: That is very helpful, minister.

Brian Whittle (South Scotland) (Con): Good morning, minister. Your opening statement and the Scottish Government's written evidence alluded to the fact that further explanation is needed as to whether setting up the scheme would be worthwhile and would not incur costs. Has the Scottish Government made any assessment of the potential financial benefit to the NHS of the scheme as set out in the bill?

Joe FitzPatrick: As I say, this is not our bill and we will take it forward as the committee suggests. The point I made in my opening statement is that some additional evidence would be required to enable that assessment to be made. There are two sides to that: one is the cost of administration, and the other is what might be recovered. Both figures would be difficult to estimate at any time. Parliament and the Government are used to making estimates for which it is difficult to access the information, but it is especially difficult just now, given the pressures that we are all facing.

Brian Whittle: What process will be required to get that information, and what is the timescale for that?

Joe FitzPatrick: This is not a Scottish Government bill, so the member and the committee would need to satisfy themselves that they have robust figures. If there is a role for the Scottish Government, we will put in the required resource. However, that resource will have to come from somewhere. The health directorate, in particular, is working very hard across the board, and we have already had to put aside a number of the Government's priorities in health and other areas in order to focus on the work that is required to respond to the virus.

09:15

Willie Rennie (North East Fife) (LD): I am not detecting a great deal of enthusiasm from you, minister.

Have you looked at the work on the issue by the occupational and environmental health research group at the University of Stirling, which has said that the money that would be brought in from the proposed scheme would easily cover the cost of running it? Do you agree with that assessment?

Joe FitzPatrick: I have not looked specifically at the University of Stirling's work in this area. Isabel Hinds might be able to comment on that.

Isabel Hinds (Scottish Government): I thank the committee for having me.

I have not seen the piece of work in question, but I can certainly have a look at it and submit any views to the committee, should that be required.

Willie Rennie: That is fine.

The Convener: I invite Stuart McMillan, who is the member in charge of the bill, to ask any questions that he may have for the minister. I ask any other committee members who have questions for the minister to indicate that in the chat box and I will try to bring them in.

Stuart McMillan (Greenock and Inverclyde) (SNP): A question has been asked about the definition of "industrial disease". Do you believe that the definition in the bill is robust? I realise that the issue of whether it is robust has already been touched on.

Joe FitzPatrick: The definition that is used in the bill does not give us huge concern. If the bill were to proceed to the next stage, we would consider whether any amendments were necessary. The definition of "industrial disease" is not an area that we have huge concern about, unless Isabel Hinds has evidence to the contrary.

Isabel Hinds: I agree with that assessment. We have no concerns about the definition at the moment. It would be at stage 2 that we would look to make further assessments.

Stuart McMillan: With regard to the financial memorandum, Willie Rennie asked about the work that has been done by the University of Stirling, which you said you have not seen. At last week's meeting of the committee, the witness from the University of Stirling indicated that they believed that, if the proposed scheme was introduced, the measures in the bill would cover its costs and the additional resource could go into the NHS.

I recommend that, once the meeting is over, you have a look at the evidence from the University of Stirling. I am aware that you are waiting to receive a reply from the DWP.

Joe FitzPatrick: We will look at that evidence. However, it is important that the financial memorandum is as robust as possible, and if the University of Stirling can provide more data that can go into the estimates in the financial memorandum, that will help with their robustness.

As I said, I have not seen what the witness from the University of Stirling said, so I do not know what assumptions they made about who would administer the scheme, what the costs of administering it would be and how many cases they assessed. It sounds as though the work that has been done at the University of Stirling, on which evidence was presented last week, is an interesting piece of work. Neither I nor my officials have seen it as yet, but it is important that that information is looked at.

Stuart McMillan: I have one final question, which is on the administration of the proposal. I am sure that we will also address that issue when I am asked questions shortly. The suggestion that the CRU should undertake the administration was made to ensure that costs are reduced, instead of establishing something new in Scotland. With that consideration in mind, does the minister think that that would be the most appropriate way forward, even in the short to medium term, to ensure that the proposal could be introduced until such time as constitutional arrangements are altered?

Joe FitzPatrick: It is important that we understand who would administer such a scheme in the short term and in the longer term. As I said, my officials have contacted the DWP to assess its take on the matter, but we have not yet had a response. I do not know whether there is an opportunity for the DWP's CRU to carry out the work; the DWP might say that it does not have the information. My officials will chase the DWP for a response about administration. If we receive a response, we will ensure that the committee gets sight of it.

The Convener: That is very helpful. As there are no further questions for the minister and his officials, I thank them for their attendance. I ask that the further evidence that the minister has offered to provide to the committee is with us by 20 November at the latest. That will allow us to proceed on the schedule that we have set.

Joe FitzPatrick: We will provide the information by then if we receive it. As I said, it is not ours.

The Convener: Indeed. However, if it is possible, that would be welcome and would assist the committee with its work.

We move to the second evidence session on the bill. I welcome back the poacher turned gamekeeper, or the gamekeeper turned poacher—I am not sure which it is—Stuart McMillan, who is the member in charge of the bill. As a witness, he is accompanied by Andrew Mylne, who is the head of the non-Government bills unit of the Scottish Parliament; Kenny Htet-Khin, who is a solicitor; and Seonaid Knox, who is a researcher for Stuart McMillan. I welcome all the witnesses to the evidence session.

I ask Stuart McMillan, who will no doubt be considering the evidence that he has just heard and elicited, to make a short opening statement before we move to questions.

Stuart McMillan: Thank you, convener. At the outset, I would like to thank a few people and organisations for their assistance in getting the bill to this point. First, I thank Phyllis Craig MBE from Action on Asbestos, which was formerly Clydeside Action on Asbestos, and Laura Blane from Thompsons Solicitors. Phyllis and Laura have been the genesis of the bill and have been consulted at every part of the process. This is the second attempt to bring such a bill to Parliament, and I believe that this bill is more tightly drawn and focused than my proposal in the previous parliamentary session.

Staff in the NGBU have worked tremendously hard to get the bill in shape to allow it to be introduced, and I offer my thanks to them. Finally, I thank my former staff members Shaun Kavanagh and Jenifer Johnston, as well as my present staff member Seonaid Knox, all of whom played their part in helping to shape the bill that is in front of the committee.

The bill's purpose is to help to bring additional financial resource into NHS Scotland when there is a successful personal injury claim relating to industrial injuries. The claimant would not need to do anything extra, but the additional sum to the NHS would be consequential on a successful claim for damages. The liability to repay NHS costs would fall on the responsible organisation—that is, the organisation that was already required to pay the damages. That organisation might be an employer or its insurance company. The bill is not retrospective, so it would cover only harmful events that occurred after the bill came into force.

The bill will deliver two main things. First, after a period of time, it will introduce additional finances into NHS Scotland. Secondly, it will encourage employers to introduce better health and safety measures. As a result of that, I would expect a long-term reduction in insurance premiums. It would be unavoidable that premiums would rise in the short term, particularly as soon as the act came into force; employers would be liable for a new category of cost and sensible employers would extend their insurance to cover that risk. However, in the longer term, costs would certainly reduce.

Finally, as touched on, I would prefer the administration of the system that the bill would put in place to be done by the CRU. It already exists, so asking it to take on a new task would be easier and cheaper than establishing something new. Nonetheless, the bill would still be worth while if a Scottish equivalent of the CRU had to be established. I am sure that I will get some questions about the financial memorandum, which was touched on this morning. I am happy to take questions.

The Convener: As you just said very clearly, we are talking about future events; nonetheless, on the basis of past events, you will have in mind some idea of how many cases that are not currently covered might end up being covered by the bill. How many cases might be involved annually?

Stuart McMillan: One of the challenges in bringing forward the bill has been the financial memorandum, which has been touched on, and trying to get a figure for the number of cases to put forward has been difficult. In the financial memorandum, we used the figure of 514 cases, which is based on information that was provided by Thompsons Solicitors. I am also aware of the additional information that was presented to the committee by the Forum of Scottish Claims Managers and Alan Rogerson. I believe that 514 is a rough estimate; as time goes on, the real figure will clearly differ from that, including in relation to industrial diseases that we do not yet know about.

The Convener: That is a helpful starting place nonetheless.

Emma Harper: Good morning to Stuart McMillan. You talked a little bit about other industrial diseases, the definition of which I am interested in. Last week, we heard evidence that the term "industrial disease" might be a bit out of date and that we should perhaps use the words "disease or long-term injury from employment". I am interested in the emergence of industrial diseases, injuries or illness caused by Covid, and mental health has also been mentioned. Last week, Thompsons Solicitors reminded the committee that liability would already have to have been established for a person to become liable for NHS charges; nonetheless, mental health conditions and emerging conditions such as Covid and long Covid might be issues to consider. Obviously, those are new issues. Might they be covered by the provisions in the bill?

Stuart McMillan: That is a valid question, and my answer to it is yes. When we consider the information in the policy memorandum and the financial memorandum, "industrial disease" is defined broadly to include any diseases arising out of a person's employment but also a disease arising out of another person's employment—so long as there is a causal connection between the disease and the employment. However, the definition also includes diseases that confer eligibility for employment injury assistance, as defined by regulations under the Social Security (Scotland) Act 2018. Your point regarding Covid is worth considering, and I will do that but, ultimately, the short answer to your question is yes.

09:30

Emma Harper: Obviously, you have done fantastic work to prepare the bill and get it this far. I am interested in the fact that the Covid pandemic might have added complexity when it comes to considering financial implications.

Stuart McMillan: That is a fair assessment. When the bill was being produced and worked on, Covid was not on the horizon. Things are a lot different now.

I will bring in Andrew Mylne, if that is okay, convener.

Andrew Mylne (Scottish Parliament): Just to add to what Mr McMillan has said, it is important to bear in mind that, because of the way the bill sets up the definition of "industrial disease", the provisions will apply only in cases where there is already a compensator. In other words, it will apply only where an employer—it usually is an employer—has accepted liability in the first place for what would become a damages claim, and the NHS cost recovery will flow from that. Therefore, in a case where someone contracts Covid, the employer would have to be liable and would have to pay damages for the circumstances in which the employee contracted Covid. The bill certainly would not apply automatically just because someone contracted Covid while they were at work. There would have to be that extra element.

However, subject to that, the definition is drawn fairly broadly. Obviously, there would be capacity to adjust that according to policy that the Government wished to impose on it in future.

I hope that that helps.

The Convener: Emma, are you happy with those answers?

Emma Harper: Yes.

The Convener: In that case, I call Donald Cameron.

Donald Cameron (Highlands and Islands) (Con): Could Stuart McMillan provide more information on the estimates of the amounts that the new scheme is expected to recover? I ask that in the context of supplementary evidence that Alan Rogerson has provided to the committee in which he estimates that, over 12 years, there would be a shortfall of approximately £0.5 million between the costs of administering the scheme and the amounts recovered.

Stuart McMillan: I saw that information. I must say that I am very much aware of the scepticism of the insurance industry towards any type of proposed damages legislation, although, of course, the bill is not that. However, that certainly was the case with the 2009 legislation relating to pleural plaques.

I saw the figures, and I can see why the insurance industry has suggested them, but I would point to data from the compensation recovery unit that shows that £66.8 million was recovered from employers from 90,219 settlements. That means that, on average, £740.80 was recovered per case. If that figure was applied to the estimated 514 industrial disease

cases, that could generate more than £380,000 for NHS Scotland.

It has been difficult to get accurate information to nail down the financial memorandum. If the committee decides to move the bill forward, the minister's earlier comments will be helpful and will potentially assist with getting more accurate data. However, I suggest that it is impossible to determine how many cases will come forward, due to the nature of the proposal.

Donald Cameron: I entirely agree with your last comment—it is very difficult to predict.

The current cap is set at £54,566 for 2020. Do you have a view on whether the cap should be increased or even removed?

Stuart McMillan: I am quite flexible on whether the cap should remain as is, or be amended. I do not have a fixed position on that and am keen to find out what the committee would suggest.

David Torrance (Kirkcaldy) (SNP): In evidence, the Forum of Scottish Claims Managers, the Association of Personal Injury Lawyers Scotland and Thompsons Solicitors Scotland believed that the compensation recovery unit would be best placed to administer the new scheme. What discussions have you had with the compensation recovery unit on the possibility of its undertaking the administration of the new scheme, and what is its view?

Stuart McMillan: In October 2018, I wrote to the DWP, and I got a reply. The DWP indicated that it had previously been approached by the Welsh Government about the CRU administering its proposed legislation to enable the recovery of NHS costs relating to industrial diseases. The DWP explained that it was willing to discuss the proposals in order to understand the feasibility of the request. Scottish Government representatives were to approach the appropriate DWP officials to discuss any proposal to use the DWP CRU. Therefore, the DWP did not say that it would not do it; it said that it would have the dialogue to decide whether it would happen.

David Torrance: I have no further questions, convener.

George Adam (Paisley) (SNP): I can see the challenges that you have faced in trying to get this worthy bill together. The whole point of the bill is to ensure that the claimants have a positive outcome. A number of issues have been brought up such as appeals and reviews and how the process would take longer and clog up the system. BLM commented that

"In our view, the complexities of disease cases are likely to mean that the administrative burden placed on NHS Boards is greater than that with which they are presently accustomed."

That is an issue that would worry me. Is it anticipated that there would be an increased proportion of appeals and reviews under the new scheme for industrial disease claims compared with the existing scheme?

Stuart McMillan: Obviously, the appeals process already exists. As is set out in paragraph 22 of the policy memorandum,

"Compensators must make the payments required by a certificate before appealing against it, unless this requirement is waived by Ministers; but a decision by Ministers not to waive this requirement may also be appealed to the First-tier Tribunal".

In effect, appeals could still happen, but the payment must happen first, before any appeal.

George Adam: In that case, there are likely to be more claims and therefore it would be more difficult, would it not?

Stuart McMillan: It is hard to determine whether there would be more claims. I know that that was suggested in evidence last week, but it is genuinely hard to determine whether there would be more or fewer appeals. The key point is that the compensators must make the payments before appealing.

George Adam: Have you taken into account the difficulty and complexity in assessing the cost of administering the scheme? That is also a concern.

Stuart McMillan: I accept that there is a complexity to the proposal. However, at the same time, the proposal is to use the CRU process, to try to make it easier, in comparison with setting up something new.

I also accept that there are complexities in calculating the cost of NHS treatment in individual personal injury claims. However, the CRU operates a tariff system, with a cap that sets the maximum amount that could be claimed from any compensator. Therefore, although there are complexities, a process is already in place that would make it easier to progress and deliver my proposal.

George Adam: Finally, I will ask about an issue that I want to get right in my own head. At this stage, none of us have heard anything from the CRU, have we?

Stuart McMillan: No. The DWP is the United Kingdom Government agency that operates the CRU. In its reply to me, the DWP did not say that it would not operate such a scheme. It said that it would have to have a dialogue with the Scottish Government and then come to an agreement as to whether it would undertake what is set out in the bill.

Brian Whittle: Last week, I raised the difference between the abilities of small and medium-sized

businesses and multinational companies to implement health and safety measures—that can be more difficult for the former. What considerations have been given to how the changes to liability resulting from the bill would be publicised?

Stuart McMillan: No consideration has been given to that so far. However, I imagine that a few things would certainly need to happen. First of all, there would need to be a media campaign by the Scottish Government. Secondly, it would be extremely useful if organisations such as the Federation of Small Businesses, the Scottish Chambers of Commerce and trade associations helped to publicise information on the changes through the business community, particularly the small business community. I am sure that all the organisations that I have mentioned will have been involved in publicity campaigns on a wide variety of issues in the past, so I do not see there being any issue in that respect.

Brian Whittle: This is my final question. Will you clarify who you think would be responsible for getting out the information about the changes in respect of the liability for NHS charges to SMEs? As I said, I think that it can be a little bit more difficult for SMEs to implement legislation of this type. Who would be responsible for informing them?

09:45

Stuart McMillan: The Scottish Government would be the main body for sharing the correct information, but industry bodies would also play a pivotal role—it would not be just one organisation that undertook the task. I accept Brian Whittle's point about smaller businesses and microbusinesses. However, in many aspects of public policy and policy changes, it tends not to be just one organisation, such as the Scottish Government, that puts information in the public domain. The Scottish Government might be the lead organisation, but other relevant organisations would also play their part in helping to get information out.

Willie Rennie: I think that Stuart McMillan has answered this question, but I will ask it for clarity. Would his bill result in any delays in compensation payments for people with industrial diseases? I understand his point that payments must be made before appealing, but would the bill have knock-on consequences for the rest of the process by adding complexity?

Stuart McMillan: Mr Rennie is right that I touched on that. I do not see how the bill could lead to compensators delaying making payments in industrial disease cases any more than they do in accidental injury cases. I see no effect on that from the outcome that we want the bill to deliver.

Willie Rennie: You commented on liaising with the DWP. Have you had any political engagement? Have you spoken to the Secretary of State for Work and Pensions about whether she supports the DWP collecting such payments?

Stuart McMillan: I have not spoken to the DWP; I wrote to it and, as I said, the reply gave the example of a discussion with the Welsh Government and said that the DWP would want to have such dialogue with the Scottish Government.

David Stewart: I support the bill in general, but my experience of dealing with bills has been that there are always issues in relation to unintended consequences. Have you analysed the bill's potential impact on insurance premiums for Scottish businesses in comparison with those in the rest of the UK?

Stuart McMillan: We looked at that. A fair assessment, which I touched on in opening, is that insurance premiums would inevitably increase in the short term or that additional insurance cover would be sought as a result of the bill. However, as employers took further precautions over time to protect their staff, premiums would reduce. Scotland could then become the safest part of the UK for employment. As we heard last week, if the bill were passed, it would bring health and safety benefits.

David Stewart: Staying on that issue, do you have specific evidence about when those costs would change? Clearly, no one on the committee would want to see businesses in Scotland incurring higher costs, which would make them uncompetitive compared with those in the rest of the UK.

Stuart McMillan: I accept Mr Stewart's point. However, although competitiveness might be an issue, I go back to my earlier comment that Scotland would also then be the safest place in the UK in which to work.

In the short term, premiums would no doubt increase—I am not running away from that fact, and I have to be up front about it. However, as I have indicated previously, if the bill were to progress and it could be seen that Scotland was a safe place in which to work, I suggest that the next step would be for premiums to reduce for those businesses that were doing the right thing and working to protect their employees. That could also have a beneficial effect on employees' output, because they would feel safe in the knowledge that when they were going to work they would be able to come home again.

Therefore, although insurance costs would be higher in the short term, I expect that in the

medium to longer term they would reduce because Scotland would also become the safest part of the UK in which to work.

David Stewart: I have a final question. Mr McMillan might have touched on the subject already, but I will ask it, just for the record. Do you consider that the bill would have a preventative impact that would result in there being fewer industrial disease claims in the future?

Stuart McMillan: Yes, I do. However, I repeat the caveat that I made in a comment a few moments ago. We do not know what new industrial diseases will emerge in the future. Therefore my answer is yes in relation to the list of existing industrial diseases that we already know about. However, in relation to new cases I will have to say that I do not know, because we do not yet know what they might be.

The Convener: I thank Stuart McMillan and our other witnesses for their attendance this morning. We have had a thorough examination of the issues affecting the bill, and the committee will proceed to have a further discussion on those in due course.

We will now move on. Agenda item 2 relates to the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill at stage 2, which will clearly involve our hearing from a number of people besides members of the committee. As we will not be able to proceed to consider the bill until 10:45, I propose now to suspend the public part of the meeting briefly.

We will resume on a different platform just before 10 o'clock, in private session, which will allow us to deal with agenda items 3 and 4 in advance of agenda item 2. That is simply to accommodate the participants in the stage 2 proceedings, who are not with us at the moment. I ask members to follow the advice of our broadcasting team. The BlueJeans platform will remain live. However, in a few moments we will send out a request for a separate meeting on Microsoft Teams, which will give the committee an opportunity to deal with those other agenda items ahead of our public session on the bill.

09:54

Meeting continued in private.

10:45

Meeting continued in public.

Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill: Stage 2

The Convener: We resume the meeting in public session. The next agenda item is the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill at stage 2. Members should have a copy of the bill as introduced, the marshalled list of amendments that was published on Thursday, and the groupings of amendments, which set out the amendments in the order in which they will be debated.

It might be helpful to explain the procedure briefly. There will be one debate on each group of amendments. I will call the member who lodged the first amendment in the group to speak to and move that amendment and speak to all the other amendments in the group. I will then call any other members who have lodged amendments in that group.

Members who have not lodged amendments in the group but who wish to speak should indicate that by placing an "R" in the chat box.

If she has not already spoken on the group, I will invite the cabinet secretary to contribute to the debate just before I move to the winding-up speech. The debate on the group will be concluded by me inviting the member who moved the first amendment in the group to wind up.

Following the debate on each group, I will check whether the member who moved the first amendment in the group wishes to press it to a vote or to seek to withdraw it. If they wish to press ahead, I will put the question on that amendment. If a member wishes to withdraw their amendment after it has been moved, they must seek the agreement of other members to do so. If any member present objects, the committee immediately moves to the vote on the amendment.

If any member does not want to move their amendment when called, they should say, "Not moved." Please note that any other member present may move such an amendment. If no one moves the amendment, I will immediately call the next amendment.

When I put the question on an amendment, members should immediately type "N" in the chat box if they do not agree to it. There will then be a division. Of course, only committee members are allowed to vote. Voting in any division will be done using the chat box function, as previously agreed by members.

The committee is required to indicate formally that it has considered and agreed each section of the bill, so I will put a question on each section at the appropriate point. The aim is to complete stage 2 today.

We move directly to amendments.

Section 1—Provision of certain forensic medical services

The Convener: Amendment 1, in the name of the cabinet secretary, is grouped with amendments 2, 3, 25 and 26.

The Cabinet Secretary for Health and Sport (Jeane Freeman): I am very pleased to open the debate on the first group of amendments to the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill at stage 2. It is a technical group of amendments that, first, clarifies the policy on private sector involvement in the provision of forensic medical services in the context of rape and sexual assault. Government policy is that responsibility for such services should rest with health boards. That is how they are currently being provided and how preparations for self-referral are being advanced.

The original wording of sections 1(1)(a), 1(2) and 1(3) was intended to allow, where necessary, locum cover for out-of-hours forensic medical examination. That can continue to be provided as needed under the existing National Health Service (Scotland) Act 1978 and its legal framework. Therefore, the inclusion in section 1(1)(a) of the words

"or secure the provision of"

might go too far. That wording, along with subsections (2) and (3), is unnecessary. The removal of those words by amendments 1 and 2 will better deliver the policy that I have described, which is that boards should provide in-house the examination service and the retention service that are set out in the bill, and that, where appropriate, limited private sector involvement in the form of locum cover can be arranged under the principal legislation for the NHS in Scotland. Amendment 2 is consequential on amendment 1.

The second main clarification that the technical amendments in this group provide is that sexual assault response co-ordination services under the bill are available to victims irrespective of their place of residence. A victim may be ordinarily resident in another health board area, in another part of the United Kingdom or indeed abroad. To deliver that policy, amendment 3 amends section 1, while amendments 25 and 26 consequentially amend the Functions of Health Boards (Scotland) Order 1991 via the schedule to the bill.

I move amendment 1.

The Convener: No other members have indicated that they wish to speak on this group of amendments. The question is, that amendment 1 be agreed to. I remind members that, on this occasion, anyone who does not agree should type "N" in their chat box.

Sandra White has indicated—

Sandra White: I apologise, convener: I thought that you said to type "M" if we agreed.

The Convener: I apologise. Another member has also put "M" for "mother" in the chat box. That was not my intention, and clearly my pronunciation needs to be sharpened. I will repeat this for the sake of clarity and to avoid any confusion: if you wish not to agree to amendment 1, please place an "N" for "Norway" in the chat box.

Sandra White: Thank you for the clarification, convener.

The Convener: I see no "Ns" for "Norway". I therefore take it that we are all agreed on the amendment.

Amendment 1 agreed to.

Amendments 2 and 3 moved—[Jeane Freeman]—and agreed to.

Section 1, as amended, agreed to.

Section 2—The examination service

The Convener: Amendment 30, in the name of Margaret Mitchell, is grouped with amendments 5, 31 and 32.

Margaret Mitchell (Central Scotland) (Con): Thank you, convener, and my thanks to the committee for giving me the opportunity to speak to my amendments in this group.

The bill seeks to strike a balance between the health and justice aspects of a forensic medical examination following a sexual offence. Under the bill, the age of self-referral is 16, and that is ostensibly based on three factors. First, it reflects existing services provided by NHS Greater Glasgow and Clyde and NHS Tayside; secondly, it aligns with the age of consent under the Sexual Offences (Scotland) Act 2009; and thirdly, it recognises that child protection measures apply to those under the age of 16.

However, under the Age of Legal Capacity (Scotland) Act 1991, anyone

"under the age of 16 years shall have legal capacity to consent on"

their

"own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner",

they are

"capable of understanding the nature and possible consequences of the procedure or treatment."

Amendment 30 therefore reduces the age of self-referral from 16 to 13. That helps to give effect to the views of Dr Anne McLellan, who is a consultant in sexual and reproductive health at NHS Lanarkshire, who gave evidence to the committee at stage 1, stating:

"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."—[*Official Report, Health and Sport Committee*, 12 May 2020; c 10.]

Here is the challenge. At present, we actively encourage children and young people to attend local young persons' clinics to ensure that they are able to make healthy decisions about their sexual relationships and access care for sexually transmitted diseases and pregnancy. In fact, we reassure children and young people that they can engage confidentially with sexual health services, while confirming that those under 16 years of age who might share information will, if a member of staff considers the child or someone else to be in danger, have that information passed on and disclosed to other agencies.

However, as has been stated, providing confidentiality in relation to the disclosure of child sexual abuse or exploitation is problematic, as protection service procedures will automatically apply. Consequently, that deters many young victims from coming forward to disclose such abuse and to seek the medical treatment that they need.

Amendment 32 seeks to address that problem. It states that

"Ministers must issue guidance to health boards about … child protection … and confidentiality"

so that boards can best support children to access forensic medical examinations. That should include ensuring that professionals are informed about the child protection process and how to talk to children about what happens next, thereby helping to ensure that those children feel that they are part of the process.

Ultimately, however, it will be for ministers to determine what the guidance will say. I hope that, in doing so, they will consider the getting it right for every child principles that are set out in the "National Guidance for Child Protection in Scotland 2014" document. The guidance states that the GIRFEC approach

"puts children's needs first; ensures that children are listened to and understand decisions that affect them; and … that they get the appropriate co-ordinated support needed to promote, support and safeguard their wellbeing, health and development."

Research has confirmed that, if staff who provide childcare are allowed a degree of confidentiality in relation to anything else that children aged between 13 and 15 who self-refer for a forensic medical examination may disclose, that creates the safe space that is necessary to enable the child to feel more in control.

Such an approach would result in three important and potentially positive outcomes. First, children and young people would be encouraged, and would be more likely, to present for a self-referral forensic examination. Secondly, the best evidence from that examination would be captured as early as possible and retained as necessary in due course. Thirdly, and most importantly, a child who may at present be deterred from coming forward would have access to the physical medical healthcare, as well as the mental health support, that they need.

As members of the cross-party group on adult survivors of childhood sexual abuse have come to understand from listening to many brave survivors of such abuse, children need to be assured that, if they disclose sexual abuse, they will still retain some degree of control over the situation and that will not be totally taken away from them when child protection services come in.

I turn to amendment 31. As it stands, the bill makes no special provision for children and young people and their distinct needs have not been addressed. Amendment 31 defines a "relevant child" as someone aged between 13 and 15 who refers for a forensic medical examination, and that includes a child who is referred for an examination by the police. The amendment provides that they receive the individual age-appropriate support that they require, and that

"the forensic medical examination"

must take

"place in a setting that is appropriate for the … child having regard to"

their

"age and maturity".

11:00

In her evidence to the committee, the cabinet secretary stated that she considered the bill to be barnahus ready. That is hopefully where Scotland is heading, and the absence of a physical building to provide the appropriate wraparound services under one roof does not mean that we cannot aspire to achieve the barnahus principles.

Amendment 31 therefore also provides for an appropriate adult to be assigned to the child who will be responsible for co-ordinating the necessary support and the assistance that is required as a result of the incident that gave rise to the need for the forensic examination. That adult would also be

responsible for explaining to the child what further steps, from both the health and justice perspectives, will take place; meeting the child as soon as is reasonably practicable after the forensic medical examination is requested and before the medical examination can begin; co-ordinating any process that follows from the incident; and, crucially, explaining any child protection procedures that follow from the examination.

In an article to *The Scotsman* last month, Dr Sarah Nelson OBE explained that one of the reasons that adult survivors of childhood sexual abuse give for waiting until they are 16 to report the abuse is that they are afraid of control being taken away from them due to the rigid and inflexible child protection procedures, which can often see authorities rush into a situation before it has been properly assessed.

To recap, the intention of amendment 30 is to ensure that children feel that they have that crucial control over what is happening through the support that they receive, and that they have their fears addressed. That will, in turn, help to ensure that, rather than being deterred from accessing vital healthcare, such children are instead encouraged to access it.

I turn to the cabinet secretary's amendment 5. Although I acknowledge and welcome the fact that the Scottish Government has taken on board the committee's recommendation that the bill be amended to allow ministers to amend in the future the age of self-referral, I firmly believe that there is an opportunity now, in the bill, if amendments 30 to 32 gain the committee's support, to address the confidentiality issue and allow 13 to 15-year-olds to self-refer, thus providing another opportunity to encourage those children who have experienced child sexual abuse or child sexual exploitation to come forward. That must surely be a good thing.

I move amendment 30.

The Convener: I call the cabinet secretary to speak to amendment 5 and the other amendments in the group.

Jeane Freeman: There has, rightly, been strong interest shown in children and young people issues in the bill's progress. Important context for the current group of amendments was provided in the children's rights and wellbeing impact assessment for the bill, which noted that forensic medical examination is not relevant to many victims of child sexual abuse because offending is often not disclosed within the seven-day DNA capture window. Access to healthcare and support for recovery are, of course, vital—irrespective of when child sexual abuse is disclosed.

I listened very carefully to what Ms Mitchell said on what she seeks to achieve with her amendments, and I have sympathy with what she said. I will address those issues in a moment. First, however, I will speak to amendment 5, which is lodged in my name.

The committee recommended in its stage 1 report that the minimum age of 16 for accessing self-referral should become the subject of a delegated power, which would allow it to be varied in the future, should that become appropriate. That was a sensible recommendation from the committee, and one that I welcomed and was happy to accept. Amendment 5 delivers on that commitment.

Amendment 5 proposes that the age must be no lower than 13 and no higher than 18. Thirteen is the age under which the Sexual Offences (Scotland) Act 2009 rightly says any sex with a child is rape, which means that a child of that age is taken to lack any capacity to consent to sexual activity. Maturity among children of the same age varies, of course, but it is reasonable to think that, in general, children under 13 would not have sufficient capacity to self-refer.

At the other end of the age range, 18 is the age at which the United Nations Convention on the Rights of the Child says a child becomes an adult. I look forward to the Delegated Powers and Law Reform Committee's scrutiny of the new power, should amendment 5 be agreed to.

I confirm that for the purposes of initial implementation of the bill next year—should the Parliament pass it—the Government intends that the minimum age for self-referral will remain at 16, as is provided for in the bill, in line with current self-referral practice in Scotland. The arrangement is referenced in the revised national child protection guidance that the Government has recently issued for consultation, which I highlighted to the committee in my letter last week.

I hope that there is consensus to support amendment 5. I encourage members and stakeholders, who strongly hold the view that a lower or higher age than 16 should be prescribed, to review and respond to the child protection consultation that I mentioned, so that a full range of voices can inform finalisation of the new national child protection guidance.

I turn to Ms Mitchell's amendments. I welcomed her contribution in the October stage 1 debate, and know from her work as convener of the Justice Committee that she has a long-standing interest in children's rights in the justice system. That interest includes, but is not limited to, support for the barnahus concept, which the Government also supports.

I understand the positive objectives that Ms Mitchell's amendments aim to achieve. We all want to ensure that victims of child sexual abuse

have access to age-appropriate and trauma-informed healthcare and recovery. I am conscious that the committee expressed in its stage 1 report the view that no specific amendments are required to support the Barnahus concept, or otherwise to make special provision for children and young people. I have consistently made clear the Government's position that the bill, although it is not a barnahus bill, is in all respects barnahus ready.

Amendment 30 goes against the grain of the committee's recommendation in paragraph 49 of its stage 1 report. The function of the proposed new delegated power is to allow a change, in the future, of the minimum age for access to self-referral from any age below the age of 16—from 13 to 15 years old—and any age above the age of 16 up to 80, but only following endorsement through affirmative regulations. Such regulations would, naturally, be consulted on widely, and a further children's rights and wellbeing impact assessment would inform them. I am grateful for the support of the NSPCC, which has written to me and the committee to oppose amendment 30, arguing that it could put services under strain and even, potentially, put children at risk.

I am afraid that against that background I cannot support amendment 30, although nothing in my amendment 5 would prevent a reduction to 13 of the minimum age for access to self-referral, following consultation on regulations, should they ever be appropriate.

Existing health, social work and Police Scotland practices already deliver much of what amendment 31 seeks to achieve. To be of assistance to the committee, I have written to provide an advance copy of Scotland's first-ever clinical pathway for children and young people who have experienced sexual abuse, which will be implemented in our health boards on 24 November, in advance of the formal launch in early December. As is set out in more detail in my letter, the chief medical officer's task force developed the pathway in close collaboration with a broad range of key stakeholders, including the three regional child protection managed clinical networks across Scotland, paediatricians, Police Scotland, Social Work Scotland and, of course, our third sector partners.

The aim of the pathway is to ensure a consistent national approach to provision of child-centred and trauma-informed healthcare, following a disclosure of sexual abuse. The pathway describes the requirement for close working across all key agencies to ensure an holistic healthcare response at every step.

In that regard, the pathway, like the bill, is in keeping with the barnahus principles. I consider it to be unnecessary to legislate for work that is already in hand or which is covered by the existing child protection responsibilities of public bodies and professionals. The provisions of the bill deliberately leave the details of health board practice to guidance and the professional judgment of skilled and experienced healthcare professionals. I am grateful for the support of the NSPCC, whose view is that amendment 31 is not necessary.

Although I would never object to an amendment wholly based on technical issues, I should flag up to the committee that the proposed role of the appropriate adult, in the sense of the professionals who support the processes, would be unprecedented in the healthcare system. That could have unpredictable practical and financial effects.

The Rape Crisis Scotland national advocacy project, which is fully funded by the Scottish Government, exists to provide appropriate advocacy support to children over 13. In its briefing for the stage 1 debate, Rape Crisis Scotland acknowledged that the approach does not require a statutory underpinning. I emphasise the Government's strong support for Rape Crisis Scotland and the advocacy project.

Nonetheless, amendment 31 has prompted me to reflect on what more the Government might do to support child victims to access services under the bill. Although I cannot support amendment 31, I undertake to give thought to how we can further support the NHS to implement the clinical pathway for children and young people, including through provision of on-going care and support for children and families, to aid recovery.

Amendment 32 proposes statutory guidance on matters that are outwith the remit of the chief medical officer's task force. I mentioned the live consultation on the national child protection guidance, which contains specific guidance on child protection and forensic medical examinations. Guidance on confidentiality is most appropriately provided by employers and professional bodies such as the General Medical Council and the Nursing and Midwifery Council, so it would be inappropriate to give the Scottish Government a statutory role that would cut across that.

Moreover, the committee rightly sought views from the Information Commissioner's Office on data protection matters; I fear that the proposal in amendment 32 also risks cutting across the ICO's role. Therefore, I cannot support amendment 32.

In summary, I reiterate that I agree with the sentiments that inspired Ms Mitchell's three amendments in the group, but I invite the committee to reject the amendments, for the reasons that I have given. I look forward to hearing

comments, but I ask Ms Mitchell not to press amendment 30 and not to move amendments 31 and 32. If the amendments are pressed, I ask the committee to reject them and to support amendment 5, which specifically addresses the committee's stage 1 recommendation.

The CMO task force is advancing preparations to implement the bill next year, should the Parliament pass it at stage 3, and I am concerned that Ms Mitchell's amendments could have the unintended consequence of delaying commencement of the bill and of the time when the advantages of self-referral for victims can be realised.

The Convener: A number of members want to contribute to the debate on the group.

David Stewart: I congratulate Margaret Mitchell on her comprehensive amendments and on her speech. As the convener knows, I have a background in child protection management, from many years ago. I agree with Margaret Mitchell, in that I have always been concerned about the low level of reporting by victims of abuse.

Having said that, I note that I read with interest the recent reports by Children 1st and the NSPCC, which oppose amendment 30 on the basis that children under 16 will automatically be considered under the child protection pathway, to which the cabinet secretary referred.

There is also a wider picture; we need to be aware that incorporation of the UNCRC into Scots law is on the horizon. That will be significant for the rights of children, and will increase reporting by victims who are under 16. The child protection guidance that is currently out for consultation is very important, so I encourage organisations to take part in that consultation.

11:15

At stage 1, I looked sympathetically at the change, and I understand many of the arguments for it. However, having read the cabinet secretary's amendment 5, on the change to delegated powers, I think that the Government is keeping the door open for a possible change in the future. That is the right way to go. There is a lot of common ground between Margaret Mitchell, the cabinet secretary and me: we all share the same objectives. However, given the reports that I mentioned from Children 1st and the NSPCC, I am not confident that we should support amendment 30. On that basis, I urge Margaret Mitchell not to press amendment 30, and not to move amendments 31 and 32. I support amendment 5 in the name of the cabinet secretary, which makes sense and reflects the arguments at stage 1.

I am very sympathetic to Margaret Mitchell's objectives and I know that she has a lot of expertise in the subject. My concern is primarily about timing. I hope that her sentiments will be followed through when the bill is changed in the future, under delegated powers.

Brian Whittle: As you know, convener, I have a specific interest in the matter. I should also declare that I am working with a constituent who was in the relevant age bracket when an offence happened some 44 years ago, and is only just now getting to court. That process has given me more information than most people might want to have on such a crime. I have been very struck by the fact that the individual had nowhere to turn because the appropriate adult was one of the people who allegedly committed the crime.

I am also struck by the fact that the NSPCC now runs, in all primary schools, abuse courses that include sexual abuse. Our children are much better informed about what constitutes abuse. For that reason, the NSPCC says that they should speak to an appropriate adult.

I listened carefully to what the cabinet secretary had to say. I know that she is thinking along those lines by leaving the door open for a future change. That is much appreciated. It strikes me, however, that there is still a gap that we can fill with the bill. I do not accept the argument for not including 13 to 15-year-olds in the self-referral provision. Margaret Mitchell makes a strong case for including them. I am disquieted by my experiences with my constituent and by the fact that there is a gap. What happens if the appropriate adult is the one who has committed the crime? Where does the child go, then?

I will support amendments 30, 31 and 32. If they fall, I will lend support to the cabinet secretary's amendment 5, which intends to leave the door open. I ask the committee to consider what happens to someone who is between 13 and 15 years old, who in all likelihood knows the abuser who might be the appropriate adult that we are asking them to go to. I hope that the committee will consider that point in deciding on Margaret Mitchell's amendments.

Donald Cameron: I, too, express my support for Margaret Mitchell's amendments. I do not have much to add at all, given how eloquently and persuasively she made the arguments.

I also acknowledge the constructive way in which the cabinet secretary has responded to the amendments. I do not think that there are huge divergences of opinion, but I was persuaded by Margaret Mitchell's argument about age, particularly in relation to legal capacity in Scotland. The Age of Legal Capacity (Scotland) Act 1991 says that anyone under the age of 16 has the

"legal capacity to consent" to any medical or surgical procedure.

I think that Margaret Mitchell's points about needing to encourage children under 16 are important, too. Through amendment 5, the Government acknowledges that "no lower than 13" is the age at which a person could self-refer. Therefore, it seems to me that this is a question of timing, as David Stewart put it. The Government appears to accept that such a change might happen in the future. Given that the Government has conceded that, the question is why that should not happen now. If one accepts that 13 to 16 is a potential age range, not making the change now would be incorrect.

I will deal briefly with amendments 31 and 32. It strikes me as eminently sensible for guidance to be issued to health boards on matters of confidentiality. Those are difficult legal questions, so it would be a wise move for the Government to issue guidance to health boards and I support amendment 32.

Amendment 31 would allow control by the individual involved, by giving them a supportive figure who would be trained and supported by the Government. That would truly implement the barnahus concept through the legislation.

For those reasons, I will support the three amendments in the name of Margaret Mitchell.

George Adam: David Stewart's argument was powerful and persuasive, as always, and I find myself agreeing with him on the issue. Let us consider NSPCC Scotland's comments about amendment 30 and lowering the age of self-referral. In its written submission, NSPCC Scotland said:

"We do not support this amendment. Given the sheer level of complexity in the lives of many children who experience sexual abuse, any change to the age of referral which potentially separates the forensic medical response from statutory child protection response, must be underpinned at the very least by comprehensive research into need, whole systems review and substantial resourcing for services, to allow them to cope with increased demand."

I read that out because I consider it to be important. We get information constantly from third sector organisations and those who work in the sector. To not listen to what they have to say would not be the place that we would all want to be in. I understand where Margaret Mitchell is coming from, but I find NSPCC Scotland's argument persuasive.

On amendment 31, NSPCC Scotland admits that the

"intention of this amendment is welcome. It clearly recognises that a lack of co-ordination and support for a child in their journey through complex and at times disparate systems ... However, the scope of the amendment ... clearly illustrates the critical need to radically reform the response to children who experience sexual abuse."

NSPCC Scotland more or less wants to work to find a way forward. I think that we are on that road, given what the cabinet secretary has produced. Furthermore, we mentioned in our stage 1 report that we want to go down that route. For those reasons, I will not vote for amendment 31.

Emma Harper: I understand why Margaret Mitchell has introduced the amendments. However, I have listened to the cabinet secretary and considered the information that has been presented to us about the CMO's task force and the children and young people's clinical pathway. Those are the best ways for us to approach the issue, because the door might be open for further amendments.

I would like the work of the children and young people's clinical pathway to be delivered in a timely way. Professionals from multiple disciplines have worked together to produce a pathway that applies to the care of children and young people up to the age of 16 and even, if a young person is vulnerable, up to 18.

The cabinet secretary's letter says:

"The aim of the pathway is to ensure a consistent, national approach to the provision of child centred and trauma informed healthcare and forensic medical examination following a concern raised or disclosure of sexual abuse."

The committee took evidence on the barnahus model being implemented. I support a wider holistic and child-centred approach. I do not support amendments 30 to 32, but I support the cabinet secretary's amendment 5, so that we can implement the child-centred principles through the clinical pathway that has just been developed, which will be rolled out and monitored. That is how I would prefer to proceed.

Sandra White: For the sake of brevity, I will not go through everything, but I concur with what my colleague Emma Harper said about the clinical pathway and the number of professionals, including those from the third sector, who have been involved in developing it. The cabinet secretary's amendment 5 supports a stage 1 commitment to the committee that the door would be left open, which is the proper way to proceed. I support amendment 5, but I do not support amendment 30.

On amendment 31, I have worked with Margaret Mitchell many times and I know that she is passionate about the subject, which I thank her for giving us the opportunity to debate. The cabinet secretary said—she can clarify this if I picked her up wrongly—that she is sympathetic to the amendment and will perhaps look at further

support. I will go with her words; I do not support the amendment.

Amendment 32 would cut across the work of professionals whose job is to look at the situation, which is tragic for everyone involved and particularly the kids—as Brian Whittle said, that can apply in later years. I am sure that we are all sympathetic to that.

I support amendment 5; I do not support amendments 30 to 32.

Willie Rennie: I am persuaded by what the cabinet secretary said about lowering the specified age, but I will press her on a couple of points. She referred to demand for services. I understand the point about having a joined-up system that is not in conflict with child protection measures, but I do not understand why the proposals would increase demand for services. In some ways, surely an increase would be good, if it meant that more people were coming forward. Perhaps I have misunderstood, so more clarity would help.

If the cabinet secretary is open to lowering the specified age below 16, I press her on the timescale for that. When does she envisage that happening? Does she have an idea from the services of when they would be ready for the age to be lowered? When could such work commence?

The Convener: I exercise my discretion to invite the cabinet secretary to comment briefly on those points, if she so wishes, before we return to Margaret Mitchell, who moved the lead amendment in the group.

Jeane Freeman: Convener, as you have invited me to make a few points in response, I will do so. Before I say anything further, I repeat that I am very sympathetic to the intention behind Ms Mitchell's amendments. However, I urge the committee not to support them.

11:30

Mr Stewart has summarised large parts of what would have been my argument more eloquently than I could have done.

I also completely understand Mr Whittle's point, and have addressed such issues with my own constituents. However, in my experience—from the great number of years that I spent as a member of the Parole Board for Scotland, which considered such matters from the other side; from seeing the consequences for perpetrators of sexual abuse and other crimes of early sexual abuse; and from listening to victims—the long-term, almost irreparable damage that such abuse does to children is just as important.

I say to Mr Whittle that the Rape Crisis Scotland advocacy project fills the gap that he mentioned—and does so with the significant experience, compassion and real learning that it has acquired over many years. That is one of the reasons why the Scottish Government supports it so strongly; it is also why Rape Crisis Scotland itself has taken the view that it has.

As for the amendment on guidance, Ms White is absolutely right. I have made the point that the requirement for confidentiality means that the responsibility for guidance on such matters is properly given to the professionals involved by the General Medical Council and the Nursing and Midwifery Council, which are not only professional but regulatory bodies. It would be wrong for the Government to cut across that and in any way to attempt to superimpose additional guidance on professionals. As Ms Harper will know, and as I know from my experience many years ago, the views of the Nursing and Midwifery Council are absolutely to be followed through by those whom it regulates.

However, the substantive point in all this is the one that is being made on age. If I understand the arguments that are being made about self-referral at an age lower than 16, the question that is being asked is: why not do that now? I strongly encourage members to refer to the view of the NSPCC, which Mr Adam referenced earlier and which has expressed the point much more eloquently than I could have done. It says that

"the sheer level of complexity in the lives of many children who experience sexual abuse"

means that any

"change to the age of referral, with potentially separate forensic medical responses from statutory child protection response must be underpinned at the very least by comprehensive research into need, whole systems review and substantial resourcing for services to allow them to cope with increased demand."

In answer to Mr Rennie's questions about when changes could be made, I think that the two aspects, which are the implementation of the clinical pathway—I wrote to members about it, enclosing a copy—and the conclusions, go hand in hand. The national child protection guidance consultation will provide us with significant further information and data so that, should it make the case strongly for a younger age, we will already have provided in the bill the opportunity to make such a change. Without research, underpinning and wider work having taken place, particularly with our key professionals and those in our stakeholder groups, this is not the time to make that change. However, it is right to have the door open. Perhaps it will happen in the very near future—but it is certainly a matter for the future.

The Convener: I invite Margaret Mitchell to wind up and to press or withdraw amendment 30.

Margaret Mitchell: I thank committee members for their comments.

In order to put my amendments into context, it is important for us to remember that the vast majority of child abuse is committed not by strangers, but by family members and those who are in positions of power and trust. Worse still, we know from charities and agencies that support children who have been abused, that during lockdown incidents of child abuse have rocketed and spiralled. There is a pressing need to address the issue now.

I understand that people, including the cabinet secretary at stage 1, have referred to the complexity of how to do that, given that child protection obviously kicks in and there is the question of how we would involve clinicians—whether they would be obliged to report sexual assault on young people in that age group. However, the way forward that I suggest in amendment 32 is based on what already exists in the health service in the context of young people in the same age group: 13 to 15-year-olds have access to medical health services in respect of sexually transmitted disease and pregnancy.

We know that a key factor preventing young people who are abused and exploited from coming forward is the loss of control and the breach of their confidentiality. Therefore, what amendment 32 proposes would give them that safe space of a little bit of time to come to terms with and understand what will happen before it does. If there is a risk that they will continue to be abused, that will most certainly be reported and acted upon. Crucially, amendment 32 puts in place a provision that gets over the complexity and encourages those young people who are presently falling through a gap and not getting the medical and mental health support that they need to access that support.

Turning to amendment 31, I have noted what members said about the clinical pathway and what the cabinet secretary said, but Children 1st's concern was that we should have a barnahus model and not create within the bill a separate, parallel approach for children. I rather fear from the comments that that is exactly what we are en route to doing. Amendment 31, were it agreed to, would clearly set out the wraparound support for victims of childhood sexual abuse—the trauma-informed, multidisciplinary approach for children who have been sexually assaulted—and ensure that someone will take the lead in looking at a 13 to 15-year-old's case so that they do not have to repeat their story, time and again, to different health professionals.

For all those reasons, I hope sincerely that the committee will think again and agree to the amendment for 13 to 15-year-olds now. If it may happen sometime in the future, I do not think that it is sufficient to say that it is all too difficult now, especially given my comments about the escalating incidence of child abuse during lockdown.

Therefore, I press amendment 30 and hope that there is the political will to support it.

The Convener: The question is that amendment 30 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Cameron, Donald (Highlands and Islands) (Con)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Macdonald, Lewis (North East Scotland) (Lab)
Rennie, Willie (North East Fife) (LD)
Stewart, David (Highlands and Islands) (Lab)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 2, Against 7, Abstentions 0.

Amendment 30 disagreed to.

The Convener: Amendment 4, in the name of the cabinet secretary, is grouped with amendments 20 and 29.

Jeane Freeman: At stage 1, there was a debate as to whether the definition of "evidence" in the bill was appropriate, and I committed the Government to developing a revised data protection impact assessment on the bill, which was duly prepared by my officials in consultation with the Information Commissioner's Office. I sent the impact assessment in its final form to the committee last week, and it was published on the Government's website this morning for wider scrutiny by stakeholders.

As highlighted in the revised impact assessment, the Government became persuaded that the definition of "evidence" in the bill should be refined. Amendment 20 will therefore insert an improved and more detailed definition of "evidence" into the bill. Subsection (1) of what will become new section 12A gives a non-exhaustive list of the types of things that may be considered to be evidence. In particular, the description of "notes or other records" now makes it clear that such notes can record matters that concern matters beyond the victim's physical condition, such as their psychological state.

Subsection (2) in the proposed new section will ensure that evidence that is collected may transfer to the police only when it is needed for the purposes of investigation or prosecution of the incident, which means that records that contain notes of wholly unconnected health information will not be considered as evidence and will not be subject to transfer or destruction.

Subsection (3) is included in order to allow evidence to be stored even in the event that a victim does not decide to proceed with a full physical examination, thus allowing the health board to store initial non-intimate samples such as blood and urine that may be taken before a full physical examination is performed.

Amendment 29 is consequential and removes the existing definition of "evidence".

Amendment 4 is a technical amendment that concerns the definition of "forensic medical examination" in the specific context of the bill. Although this point was not raised in stage 1 scrutiny, the definition of "forensic medical examination" is of equal importance to the definition of "evidence". Amendment 4 clarifies that a forensic medical examination in the particular context of the bill is predominantly a physical medical examination. That distinguishes the subject matter of the bill from wider types of forensic medical examination, such as forensic mental health capacity assessments.

I move amendment 4.

Amendment 4 agreed to.

Amendment 5 moved—[Jeane Freeman]—and agreed to.

11:45

The Convener: Amendment 6, in the name of the cabinet secretary, is grouped with amendments 7 to 9.

Jeane Freeman: The amendments in this group clarify that sexual assault response co-ordination services are available to victims under the bill irrespective of whether the incident took place in Scotland. Legislating to clarify the position in relation to incidents occurring outside Scotland will ensure that people who wish to access a sexual assault response co-ordination service can do so, regardless of where the incident took place.

Police Scotland already has well-established links with other police forces to transfer or receive evidence, when appropriate, under existing cross-border arrangements. In order to deliver the policy that I have mentioned, amendments 6 and 7 amend the definition of "sexual offence" in section 2(4) of the bill to clarify that it includes acts committed outside Scotland that would count as offences in Scots law if they were committed here.

Amendment 8 makes an equivalent amendment to the definition of "harmful sexual behaviour" in that section. Amendment 9 is consequential on amendment 8 and clarifies that the age of criminal responsibility in Scotland is the relevant one for the purpose of establishing whether an incident amounts to "harmful sexual behaviour". That ensures that all behaviour elsewhere is caught according to whether it would be an offence of harmful sexual behaviour in Scotland, regardless of how it would be treated in the jurisdiction where the incident took place.

I move amendment 6.

Amendment 6 agreed to.

Amendments 7 to 9 moved—[Jeane Freeman]—and agreed to.

Section 2, as amended, agreed to.

After section 2

The Convener: Amendment 31, in the name of Margaret Mitchell, has already been debated with amendment 30. I ask Margaret Mitchell whether she wishes to move or not move amendment 31.

Margaret Mitchell: [*Inaudible*.]

The Convener: We will try again. I see that Donald Cameron wishes to move the amendment instead.

Amendment 31 moved—[Donald Cameron].

The Convener: The question is, that amendment 31 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Cameron, Donald (Highlands and Islands) (Con)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Macdonald, Lewis (North East Scotland) (Lab)
Rennie, Willie (North East Fife) (LD)
Stewart, David (Highlands and Islands) (Lab)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 2, Against 7, Abstentions 0.

Amendment 31 disagreed to.

Sections 3 to 5 agreed to.

After section 5

Amendment 32 moved—[Donald Cameron].

The Convener: The question is, that amendment 32 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Cameron, Donald (Highlands and Islands) (Con)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Macdonald, Lewis (North East Scotland) (Lab)
Rennie, Willie (North East Fife) (LD)
Stewart, David (Highlands and Islands) (Lab)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 2, Against 7, Abstentions 0.

Amendment 32 disagreed to.

Section 6 agreed to.

Section 7—Return of certain items of evidence

The Convener: Amendment 10, in the name of the cabinet secretary, is grouped with amendments 11 to 17.

Jeane Freeman: This group of technical amendments deals with the return, destruction and transfer of evidence that is stored following self-referral examinations.

Amendment 14 proposes what members might recognise as a cooling-off period. In its written evidence at stage 1, the Faculty of Advocates suggested that, when a self-referring victim requests destruction of evidence that has been collected as a result of their forensic medical examination, there should be a period of reflection and the request should be withdrawn if the victim so wishes. I thought that that suggestion was sensitive, positive and fully in line with the bill's policy of giving victims control over what happens to them at a time when that control has been taken away. Therefore, amendments 13 and 14 provide that, following a request for destruction of evidence, the health board should not act on that request for a period of 30 days. Amendment 15 is consequential on amendments 13 and 14 being made.

New subsection (1A)(a), which amendment 16 proposes be added to section 8, allows a victim to withdraw their request for that evidence to be destroyed during the 30-day cooling-off period. If the request is withdrawn, the evidence will continue to be held until the end of the retention period that is specified in regulations that are made under section 8(1)(b), unless a further request for earlier destruction is made and not withdrawn. If the 30-day cooling-off period goes beyond the period that is specified under section 8(1)(b), destruction will take place at the end of the section 8(1)(b) period. Therefore, it will not be possible to withdraw a request for destruction made under section 8(1)(a) after that point.

Proposed subsections (1A)(b) and (1B) to (1C), which amendment 16 also proposes to add to section 8, deal with situations in which the victim requests the destruction of evidence or the evidence is due to be destroyed at the end of the period specified under section 8(1)(b), but a police request for the evidence to be transferred to it is made at around the same time. The request for transfer of the evidence to the police takes precedence unless it is not possible to stop the destruction of the evidence.

Amendment 12 is the other main amendment in the group, and it addresses the rare or exceptional situation in which a self-referring victim requests the return of their property but it is not in the public interest for the item to be returned to them. The amendment makes provision to ensure that the health board is not under a duty to make that return in those circumstances. Proposed subsection 2A(a), which would be added to section 7 along with proposed subsection 2B, allows a health board to refuse to return an item that is stored as evidence if, at the time that the victim requests the return of the item, the health board has some doubt about whether the item belongs to the victim. Amendments 10 and 11 are consequential.

Current CMO task force policy is that, apart from samples, only underwear and relevant outerwear would be stored as evidence. I therefore expect questions of ownership to be an extremely rare occurrence, but amendment 12 may become more relevant if there are any future changes to forensic science guidance about what items should or could be retained in a forensic examination.

Proposed subsection 2A(b), along with proposed subsection 2B, allows the health board to refuse to return an item that is stored as evidence if there is a safety reason why that item should not be returned to the victim. There could be exceptional circumstances in which an item has become biologically hazardous and it would be unsafe for it to be returned to the victim—for example, if there were remnants or traces of a date rape drug on the item. In both the above scenarios, the victim may be unsure why they cannot have the item returned to them, so provision is included in proposed subsection 2B(b) to ensure that the health board explains the reason.

Finally, proposed subsection 2A(c), along with proposed subsection 2B, provides that the health board must refuse to return an item that is stored

as evidence if the victim has made a police report. That will have initiated a police investigation, and the items will be awaiting collection by the police. Health boards require clarity about what to do should the victim appear to request the return of items that have become the primary responsibility of the police. However, I must emphasise that the victim's right to the return of property under the Victims and Witnesses (Scotland) Act 2014 is unaffected; the nuance is that they must request the return of the property from the police and not from the health board.

Amendment 17 amends section 9 to make it clearer that the police cannot request a transfer of evidence that has already been destroyed or returned to the victim. Although that is implicit, the greater focus on those issues introduced by the other amendments in the group means that the point being made more explicit will assist.

I move amendment 10.

Amendment 10 agreed to.

Amendments 11 and 12 moved—[Jeane Freeman]—and agreed to.

Section 7, as amended, agreed to.

Section 8—Destruction of evidence

Amendments 13 to 16 moved—[Jeane Freeman]—and agreed to.

Section 8, as amended, agreed to.

Section 9—Transfer of evidence to police

Amendment 17 moved—[Jeane Freeman]—and agreed to.

Section 9, as amended, agreed to.

After section 9

The Convener: Amendment 18, in the name of the cabinet secretary, is grouped with amendment 28.

12:00

Jeane Freeman: The principle of trauma-informed care runs through the bill and drives the work of the chief medical officer's task force. In that context, the bill enshrines the principle of trauma-informed care, writing it into the law for the first time in Scotland.

The existing wording on trauma-informed care appears in the schedule to the bill. However, given the principle's importance, I am minded to give it more prominence. Amendment 18 therefore inserts improved wording on trauma-informed care in the main body of the bill. I am grateful to NHS Education Scotland colleagues for their support to help to expand and improve the wording on trauma-informed care in the amendment.

There are a number of different interpretations of what is meant by "trauma informed". Without any reference in the bill to what is meant by "trauma informed" or "retraumatisation", many may feel that they are already providing trauma-informed care without having an understanding of retraumatisation or of the importance of identifying and avoiding it.

Amendment 28 is consequential on amendment 18 and simply deletes the existing wording on trauma-informed care from the schedule.

I move amendment 18.

Sandra White: [*Inaudible*.]—who worked on this particular issue, which is one of the most important issues that we need to consider.

The trauma that had been experienced by the women whom the committee met and spoke to was horrific, and it was very moving to hear from them. I am pleased that the amendment will put the wording on trauma-informed care in the main body of the bill.

I have one question for the cabinet secretary. Page 24 of the policy memorandum, which sets out the Scottish Government's policy intent behind the bill, lists five asks. The second of the bullet points under ask 2 refers to the need to ensure that

"A female doctor and nurse chaperone are available 24/7 ... where a victim"

so

"requests."

Progress on that is marked as "ongoing". Will that element be included in amendment 18? Is it to be part of the approach to ensuring a lack of trauma for, and retraumatisation of, victims? I would like clarification on that.

The Convener: As no other member has indicated that they wish to speak, I call the cabinet secretary to wind up.

Jeane Freeman: I have nothing further to add, except to respond to Sandra White's question. The content of amendment 18 is clearly set out, and that is what it will say. I agree completely with Ms White that it is important that we have moved the wording on trauma-informed care from the schedule to the main body of the bill. With regard to the linked aspect of her question, the two areas—trauma-informed care and the provision of a female examiner or nurse chaperone—go hand in hand.

Ms White will be aware of the new course for forensic nurse examiners that has commenced at Queen Margaret University. That is an important

step along the road, in addition to what we have already done, to ensure that we provide 24/7 access to female examiners should that be what an individual wants.

Amendment 18 agreed to.

Sections 10 and 11 agreed to.

After section 11

The Convener: Amendment 19, in the name of the cabinet secretary, is in a group on its own.

Jeane Freeman: The committee recommended in its stage 1 report that there should be a statutory annual reporting requirement, and the Government accepted that recommendation. Amendment 19 requires Public Health Scotland to produce annual reports on the implementation of the legislation should it be passed by Parliament.

Public Health Scotland is the body that is best placed to discharge that new statutory duty, as it had already agreed with the CMO task force the report on health board performance against the March 2020 Healthcare Improvement Scotland quality indicators. I am grateful to Public Health Scotland for agreeing that its work should have a statutory underpinning and for its approval of amendment 19 in draft form.

I do not believe that an indefinite statutory reporting requirement is proportionate, so the amendment provides for a long stop that—[*Inaudible*.]—reports must be produced on a statutory basis. I should emphasise that nothing in the policy prevents further non-statutory reports or post-legislative review by the Government, the Public Audit and Post-legislative Scrutiny Committee, the media, academia, or any other person.

I move amendment 19.

Amendment 19 agreed to.

Section 12 agreed to.

After section 12

Amendment 20 moved—[Jeane Freeman]—and agreed to.

Schedule

The Convener: Amendment 21, in the name of the cabinet secretary, is grouped with amendments 22 to 24 and 27.

Jeane Freeman: Paragraph 1 of part 1 of the schedule makes important consequential amendments to the National Health Service (Scotland) Act 1978. That is to ensure that the pre-existing NHS Scotland legislation and the bill will dovetail and interoperate properly.

Amendment 22 adds to the consequential amendments to the 1978 act so that ministerial intervention powers in sections 76, 77, 78 and 78A of the 1978 act are available, should they ever be needed. I emphasise that those powers are not new and ministers have always treated them as powers of last resort. Nevertheless, to enshrine the principle that forensic medical services under the bill are mainstream board functions, it is appropriate that all relevant 1978 act measures are applied to them just as they are to other health board services.

Amendments 21, 23 and 24 are purely consequential on amendment 22.

Amendment 27 concerns the clinical negligence and other risk indemnity scheme, which is established by regulations; the scheme is sometimes known as CNORIS, although I think that it is best known by its full title. Amendment 27 updates the wording of the regulations to cover forensic medical services that are provided under the bill. The regulations already cover forensic medical services under the memorandum of understanding between Police Scotland and health boards by virtue of wording that was inserted by amendment regulations in 2014. Amendment 27 reflects the new statutory basis for the delivery of services.

I should highlight, as I did in my recent letter to the committee, that further technical consequential amendments might be made at stage 3. It is too early to confirm that that will be the case or what those amendments might be, but I do not envisage that any consequential amendments that the Government lodges at stage 3 will contain any substantive policy; they will be purely technical and consequential so that existing legislation dovetails with the bill's provisions.

I move amendment 21

Amendment 21 agreed to.

Amendments 22 to 28 moved—[Jeane Freeman]—and agreed to.

Schedule, as amended, agreed to.

Section 13—Interpretation

Amendment 29 moved—[Jeane Freeman]—and agreed to.

Section 13, as amended, agreed to.

Sections 14 to 16 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill. I thank Margaret Mitchell, the cabinet secretary, members and all those who have assisted in the proceedings.

Meeting closed at 12:11.

Official Report
Room T2.20
Scottish Parliament
Edinburgh
EH99 1SP

Email: official.report@parliament.scot
Telephone: 0131 348 5447
Fax: 0131 348 5423

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba