OFFICIAL REPORT
AITHISG OIFIGEIL

Citizen Participation and Public Petitions Committee

Wednesday 29 October 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 29 October 2025

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CITIZEN PARTICIPATION AND PUBLIC PETITIONS COMMITTEE

16th Meeting 2025, Session 6

CONVENER

*Jackson Carlaw (Eastwood) (Con)

DEPUTY CONVENER

*David Torrance (Kirkcaldy) (SNP)

COMMITTEE MEMBERS

*Fergus Ewing (Inverness and Nairn) (Ind)
*Maurice Golden (North East Scotland) (Con)
*Davy Russell (Hamilton, Larkhall and Stonehouse) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Kym Kestell (British Heart Foundation Scotland)
Kirsty Morrison (Chest Heart & Stroke Scotland)
Edward Mountain (Highlands and Islands) (Con)
Steven Short (Scottish Ambulance Service)

CLERK TO THE COMMITTEE

Jyoti Chandola

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Citizen Participation and Public Petitions Committee

Wednesday 29 October 2025

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Jackson Carlaw): Good morning, and welcome to the 16th meeting of the Citizen Participation and Public Petitions Committee in 2025.

Under agenda item 1, we simply have to decide whether to consider in private item 5, which covers a discussion on the evidence that we will hear this morning. Are colleagues content?

Members *indicated agreement.*

Emergency Cardiac Care

09:30

The Convener: The next item is a thematic evidence session on emergency cardiac care issues that have been raised in various petitions. The first is PE1989, to increase defibrillators in public spaces and workplaces, which was lodged by Mary Montague. I always make a point of noting that Mary is the provost of my local authority in East Renfrewshire. The petition was tabled prior to her appointment in that position. The next petition is PE2067, to improve data on young people affected by conditions causing sudden cardiac death, which was lodged by Sharon Duncan, who is the mother of David Hill, who was a Parliamentary colleague who died while playing rugby for the Scottish parliamentary team in Ireland. The other is PE2101, to provide defibrillators for all primary and secondary schools in Scotland, which was submitted by Peter Earl on behalf of Troqueer primary school.

We have used the evidence that has been raised in our consideration of the three petitions to date to draw up a series of themes to allow us to explore the issues. In due course, we will hear from the minister but, this morning, I am delighted to say that we are joined by Kym Kestell, policy and public affairs officer at the British Heart Foundation Scotland; Kirsty Morrison, policy and campaigns officer at Chest Heart & Stroke Scotland; and Steven Short, programme lead for out-of-hospital cardiac arrest with the Scottish Ambulance Service. A very warm welcome to you all.

There are five themes. Each of us is going to lead on one of them, and other colleagues will jump in with questions. Please indicate if you would like to answer a question. For the *Official Report,* it will be helpful if the leader of each section says their name as they come in, otherwise it might not be entirely clear who is contributing.

The five themes that we have identified to look at are data, research and guidance; public awareness; the provision of life-saving equipment and emergency preparedness; preventative actions and protection of vulnerable populations—it is striking that the survival rate is a lot lower in deprived areas—and cross-sectoral policy, which means how those things bounce across different areas of responsibility.

The first of the themes is data, research and guidance. Fergus Ewing will lead on that.

Fergus Ewing (Inverness and Nairn) (Ind): Plainly, any medical treatment or process must be based on the best evidence and data. That is

pretty obvious. One of the several petitions before us asks to improve data on young people who are affected by conditions that cause sudden cardiac death. I want to ask each of you about your views on data, research and guidance. First, what data currently exists on sudden cardiac death in young people in Scotland? Is there enough data? Are there gaps? If so, how should they be filled?

I appreciate that it is quite a broad theme but, given the importance of evidence-based practices in medicine as the sound way to proceed, it is perhaps a good starting point. What data exists, and what are your views about what more might or should be done?

Steven Short (Scottish Ambulance Service): I am happy to kick off on that. Data underpins all of our programmes, not least on out-of-hospital cardiac arrest. We have a data-rich system for out-of-hospital cardiac arrest. The Scottish Ambulance Service publishes a report every year on behalf of the whole strategy partnership in Scotland. As has been alluded to, the report breaks down data by Scottish index of multiple deprivation scores, age and whether people are male or female, so we know the demographic and the age range of the patients who are having cardiac arrest.

Of course, cardiac arrest is caused by multiple things. It is not just caused by the heart; there can be many other causes, and that impacts on the types of treatments that we deliver. The causes are perhaps the elements in the data that are not as well defined or understood. We can give broad themes for the causes, but that much more granular data is not necessarily as available as it is for other elements. It probably could be but, at this point, we tend to report on slightly higher-level data.

Kirsty Morrison (Chest Heart & Stroke Scotland): Data is essential. The work that we do at Chest Heart & Stroke Scotland is always evidence and data driven. I think that everyone round the table and my colleagues here would agree with that. Our focus as an organisation is on helping people to live well after an event. When it comes to cardiac arrest, we invest about 10 per cent of our work and resources into prevention, but we are more focused on the other end of the chain of survival.

We believe that greater amounts of data would increase the ability to support movement on the issue that is raised in petition PE2067. On the data that is available at the moment, I do not have more than you have, but it is clear that there are data gaps and some disputes. Sudden cardiac death seems to be a tricky area. I know that the petitioner highlighted death certificates, for example. Those will not always be the best way to understand the full extent of the issue, as information is not always reported on them. It is a tricky area, but we agree that more data would be incredibly helpful. We are grateful for the Scottish cardiac audit programme and other sources of data starting to come through, because that allows us to create more effective strategies and it allows the health sector as a whole to understand the issue.

Kym Kestell (British Heart Foundation Scotland): I agree with my colleagues, and the BHF is really supportive of improving data collection and better research. I want to highlight a bit of work that the BHF is funding at the moment.

You might be aware that the Scottish Government funded a pilot in the west of Scotland on inherited cardiac conditions, and the BHF has funded two clinical co-ordinators to roll out that programme to the rest of Scotland. In short, the pilot is a service to contact the families of those who have, sadly, passed away from a sudden cardiac death, where that has been indicated in their post-mortem. The service is there to give the family support and signpost them to genetic testing; to gather better data and research; to understand a bit better the risk factors; and to understand better the genetic relationships and who might be more at risk. That is being rolled out across Scotland, and it has been quite successful so far. We are funding those positions for two years, and we are at the beginning of the two years.

The programme is working closely with the Scottish cardiac audit programme to ensure that data is collected and that the programme is monitored. We are also working with colleagues in Denmark, which has a registry for sudden cardiac death and out-of-hospital cardiac arrest. Denmark's population is equivalent in size to that of Scotland, and data collection there is really good, so we are working with international colleagues to improve ours. The work is highlighting the fact that better research is needed, which the BHF is committed to.

The BHF has funded £30 million-worth of research in the CureHeart programme, which is the biggest-ever research grant through our big beat challenge. The programme is about potentially finding a cure for genetic cardiomyopathy, which is a leading cause of and risk factor in sudden cardiac death. As you can see, we are committed to the work in that space.

I have a couple of quotes from people who are involved in the inherited cardiac conditions pilot on how their families have been supported through the programme. A family member said:

"Whoever had the gene"—

the gene related to the greater risk of sudden cardiac death—

"regardless of how scared we were, I knew we'd be looked after."

That shows that having the clinical co-ordinator positions funded, and the work by the Scottish Government and the BHF is having a major impact on people's families. This is, understandably, a really emotional and important topic. It is great that there is support on the ground for people who are going through bereavement. They are going through grief, but they are being supported through the whole process and not being left to signpost themselves to services.

Fergus Ewing: My second and only further question is: what do you believe would improve data collection and analysis to inform screening and prevention strategies? Two of you have referred to gaps. Are there any particular steps that you would advocate for or areas where you feel that gaps need to be filled in order to improve data collection to inform screening? I am thinking particularly of young people, who are the topic of one of the petitions.

Steven Short: Joining up the data is one of the challenges. Many agencies become involved in dealing with such tragic cases. Where patients survive, there is almost a pathway for providing follow-up. Where, tragically, the patient dies, it is a question of how we pull together all the agencies to make sure that we get that data. We can then fill the gaps to ensure that, for example, we make all the extra testing for other family members available to everyone. Through the work that is happening in the west of Scotland, we are learning a lot about data gathering and joining up data between agencies to help fill the gaps.

Kym Kestell: I agree. The continuation of work and pilots such as the one that Steven Short mentioned, and rolling them out Scotland-wide will, I hope, fill some of those data gaps. Through the work with colleagues in Denmark and the Scottish cardiac audit programme, we hope that, as the pilot is rolled out across Scotland, we will only get better data and evidence around that particular issue. We hope that that work will continue and that the data that we get from it will inform our policy.

The Convener: I have a couple of follow-up questions. You talked about the roll-out of the pilot. What is its status currently? Is it still just a pilot, or has the roll-out started?

Kym Kestell: The roll-out has started. It has been rolled out across Scotland through the two clinical co-ordinators that the BHF funded. It is being rolled out as we speak.

The Convener: Is there a timeline? When do you expect it to have rolled out?

Kym Kestell: I do not have an exact answer for that at the moment, but we are very happy to write to the committee clerks after this meeting.

The Convener: My second question is on the issue of data and the Government's "Out of hospital cardiac arrest: strategy 2021 to 2026" document. A paragraph in that says that the strategy

"does not address cardiac arrests in children, or those caused by external physical injury".

It goes on:

"Both of these types of cardiac arrest are far less common than those caused by medical conditions in adults, and require a different approach to their management."

Given that the strategy document was written at a certain point and that data is emerging and being collected, does the data continue to support the view that there is still not a necessity to look at children per se or cardiac arrests as a result of physical injury, which was potentially one of the issues underlying one of the petitions that we are considering?

Steven Short: We report on children as part of the annual report, using available data, and through all the other measures in the report, but work on child death happens separately and is run by Healthcare Improvement Scotland. There is a multi-agency review into every death of a child in Scotland. We learn from those deaths and from that piece of work that is co-ordinated by Healthcare Improvement Scotland. Therefore, it is not that we do not do any work to improve cardiac arrests in children and young people. Lots of work is going on, but the way the data is reported and the processes for such cardiac arrests are slightly different. That is often because those cardiac arrests have different causes and different treatment options. There are themes within children's deaths, which can be picked up through Healthcare Improvement Scotland for public awareness, for example.

The Convener: Therefore, in essence, the data gathering is not ignored—

Steven Short: Far from it—

The Convener: It is just that data is gathered through a different mechanism.

Steven Short: Yes.

09:45

David Torrance (Kirkcaldy) (SNP): Good morning. Petition PE2067 highlighted issues around public awareness and education in relation to cardiac arrest, sudden cardiac death and inherited cardiac conditions. How can the public's understanding and awareness of cardiac emergency be improved? Who is going to go first?

Steven Short: I am happy to jump in first. It is a really important topic, and, in some respects, it is a good news story in Scotland. Over the past decade, we have made massive improvements in terms of survival from cardiac arrest. A huge part of that is as a result of the public awareness raising and training that has been provided through the Save a Life for Scotland partnership. A decade ago, in the region of 45 per cent of all cardiac arrests had bystander CPR, which is poor and low. The improvement work has seen that figure get closer to 70 per cent, and the rate for 30-day survival from out-of-hospital cardiac arrest has doubled.

However, there is still work to be done. Denmark has already been mentioned in that regard. On the basis of some of the examples from Denmark, we know that we can probably improve further. Large swathes of the population still do not have awareness, whether of cardiac conditions or of how to perform bystander CPR or use a publicly available defibrillator.

On what more can be done, that is exactly the work that the Save a Life for Scotland partnership is doing. As well as its, for want of a better expression, business-as-usual activities—all the work that it has done over the past decade—we are now, and have been for some time, proactively looking for and reaching out to more difficult-to-reach communities, so that there is an equitable response to cardiac arrest across the country. The best care happens in the community before the Ambulance Service arrives. For these individuals, it is an immediately life-threatening emergency, and they need the public to intervene to help to save their life. It is through that partnership work and the Save a Life for Scotland partnership that the vast amount of that work is being done. We have seen improvements, but there is more to do.

Kym Kestell: I agree. The Save a Life for Scotland partnership is doing incredible work on this. The BHF works a lot on CPR training. We have RevivR, which is a free and accessible online tool to teach as many people as possible CPR. It takes only 15 minutes. The idea behind all these different ways of learning CPR is to make it accessible and to normalise it. We have just rolled out classroom RevivR. The idea is to socialise the idea of being aware of and doing CPR, knowing how to use a defibrillator and knowing where your nearest defibrillator is—knowing whether your community has one. I know that mine is on my road, but people need to know whether it is at their local church, the school or a few streets over, for example.

We are encouraging people to be aware of their communities and their environments but also to recognise that there are places in Scotland that are underserved, with regard to defibrillator access and CPR training, and that there is more work to do to ensure that those communities are CPR-ready and ready to support anybody who experiences a cardiac arrest.

The Convener: Maurice Golden will explore those themes further shortly.

Kirsty Morrison: I agree with my colleagues. We have made advances in Scotland through the Save a Life for Scotland partnership and the out-of-hospital cardiac arrest action plan—the data shows that—but we need to go further. Chest Heart & Stroke Scotland has been discussing that with our colleagues internationally.

We are one of the leading partners on the CPR bystander support service that is part of the OHCA plan. The support service provides aftercare for people who witness or provide CPR to someone in a cardiac arrest. It is a traumatic event, as I think that we can all recognise, and part of the challenge is ensuring that people know about the full chain of support that they can have. People need to know how to do CPR, and they also need to know that they are going to be supported afterwards.

Earlier this year, we held a symposium on recovering after a cardiac event with colleagues from Scandinavian and other countries that are doing work on after-are. We are going to make that an annual event in order to explore that aspect. One of the outcomes of the symposium was the understanding that we need to look at how we spread awareness of the good offering that we have in Scotland.

So far, more than 200 people have come through our bystander support service, which they can call and get on-going support from. For something that has been running for two years, that is good—we are happy and it is picking up pace—but we know that more people can benefit from that, so we hope that the next iteration of the strategy in Scotland will not only continue to look at what we are doing well, but consider how we communicate that throughout the population.

Steven Short: The other group that it is incredibly important for us to target in raising awareness is our amazing young people in Scotland. It is well recognised that CPR training in schools has a lot of benefits, not least because kids do not forget stuff. Twenty years down the line, guidelines may have changed, but children and young people will still remember what they were trained to do in school 20 years ago.

There is also a huge multiplier effect with kids. The committee may be aware that we held an amazing “Restart a Heart” live event just a couple of weeks ago, where we spent 12 hours livestreaming training to whoever wanted to see it. It was targeted at schools and young people, and

132,000 people, albeit from all across the UK, tuned into the event, which was amazing. When kids do things like that, they do not just learn themselves. They go home and grab their teddies off the bed or stick a coat in a pillowcase and show everyone else around them how to do chest compressions and make people more aware of defibrillators. That is a hugely important piece of the jigsaw when it comes to awareness raising.

Kym Kestell: I will jump in here—please stop me if I am jumping ahead. On the issue of CPR training in schools, I highlight that Scotland is the only nation across the UK where CPR is not mandated in the curriculum and is not reportable. There is some anecdotal evidence that leans in the direction that we need to make it mandatory for schools to train every child in CPR skills.

We need to normalise it in the same way that using a fire extinguisher or knowing where the nearest fire exit have been normalised. Kids need to be socialised to see knowing how to do CPR and being confident in it as a normal part of growing up.

At the moment, the picture in Scotland is quite unclear; it is really hard to gather data on how many kids in Scotland are being trained in CPR skills and when and how that is happening. We think that there may be a bit of inequality there. We do not know what is going on. If CPR training were to be made mandatory and reportable, it would be a lot easier for organisations such as ours to monitor how many people in Scotland have those skills. We would hope that that would be quite strongly reflected in the bystander CPR rate, and in more people being socialised to see knowledge of CPR as a norm in our society. That is something to consider.

The Convener: I will come back to that shortly in the questions that I have, because it follows on from one of those.

David Torrance: I run a scout group, and I am just thinking about how effective the scouts are at doing CPR, first aid and things like that. I agree that those skills stay with kids for the rest of their life.

We touched on this earlier. How effective are the Scottish Government's campaigns in reaching people, and how inclusive are they in reaching diverse communities?

Steven Short: I do not know the answer to that directly in terms of how effective we are. The campaigns help to raise awareness not just among the whole population, but among those people who are trying to do work within those campaigns. That is important, because it gives validity and support to what we are trying to achieve.

We are trying to reach out to people in the homeless communities in Scotland so that they are as likely as those in any other community to get bystander CPR if they need it, so having Scottish Government buy-in on out-of-hospital cardiac arrest is hugely valuable and very welcome for the whole Save a Life for Scotland partnership.

Kirsty Morrison: I do not have the answer either—it would be interesting to know whether there has been any evaluation of that so far. We know that certain groups are less likely to receive CPR training at work and through voluntary schemes; I have received it at work. People who are no longer working may not be keeping those skills live.

As Kym Kestell said, we do not know what is happening in schools. We have the commitment, but a few weeks ago, the Parliament heard a very moving speech from a young man, Cameron McGerr, who lost both his parents and did not know CPR, so we know that there is an issue.

There is more to be done, and that includes looking at the communities where people can be socialised well on CPR, and at those who may not receive training elsewhere, which is key.

A key message that has come out of some of the discussions that we have had is that people are scared of doing something wrong, but doing something is better than doing nothing. That is a really easy message to get behind, but we are not seeing it out there as much. I do think that we in the sector can collectively agree that that it would be worth while getting behind that—-the question is how we do so.

David Torrance: I have no further questions, convener.

The Convener: Thank you very much. We will move on to the provision of life-saving equipment and emergency preparedness, and Maurice Golden will take us through this section of questions.

Maurice Golden (North East Scotland) (Con): PE1989 and PE2101 both call for increased availability of defibrillators. I will park funding for the moment—that will be my final question—but on the issue of availability, can you provide some information on how defibs are mapped and how access can be improved?

The question of speed versus effectiveness is, I suppose, a bit of a conundrum. An obvious quick way of rolling out defibs would be to, say, put them outside every school, but I think—and I would be interested to hear your thoughts on this—that that might mean doubling up in a community. Moreover, a school might not be located in the right area. In Dundee, for example, Grove

academy is right in the centre, with lots of houses nearby and having a defib there would be useful. The new Greenfield academy, on the other hand, is right on the outskirts of a community; it might take someone a 10-minute round trip to get there and one would hope that the ambulance would be there by that stage.

When it comes to thinking about a more effective and perhaps longer-term way of rolling out defibs, how would you map that? Where would you look at? What would be the priorities with regard to ensuring the most access, and how might that affect rural communities?

Kym Kestell: I am happy to start. It is a really important question, and I should say that we have never had better data on where defibs are or should be.

As to where defibs are, the BHF created the circuit—the United Kingdom's national defibrillator network. Those defibs are mapped out geographically across the UK, and you can go online and look at where your nearest defib is. The Ambulance Service has all that information, too, so when you call 999, it can point you to the nearest defibrillator.

However, the circuit can hold only registered defibs and that is still a problem. We cannot put a figure on it, unfortunately, because we do not know how many defibs are not registered, but we believe that the number in Scotland is in the thousands. Therefore, the first thing is to ensure that we have every available defib registered on the circuit, and, if we are to expand provision of PADs, to ensure that all of them are registered, too.

The circuit has been around for quite a while now, and it has matured, so we are getting an incredible amount of data from it. For example, we have statistics on areas of Scotland that we know do not have enough defibrillators. Moreover, this year, we have a new tool in Scotland called PADmap, which has been funded by the Scottish Government with involvement from the BHF, the Scottish Ambulance Service and St John Scotland. We have never had a better tool for telling us where defibs need to be, because it brings together the information on historical cardiac arrest incident rates and the information on existing defibrillators that we get from the circuit and manages to mathematically optimise defib placement.

PADmap is a free online tool. You can google it on your phone; it will show you a number of green dots, and you can break things down by local authority or postcode. It will show you, for example, the best places in those communities to place a PAD, how many times the PAD is expected to be deployed and how many shocks are expected to be delivered, and it will even give you an estimate of how many lives it could save.

With PADmap and the circuit data that we have, the BHF has identified 12 areas across Scotland that have really long retrieval times for defibrillators. In Saltcoats in North Ayrshire, for example, you are looking at a retrieval time of 17 minutes, which is way too long. One would really hope that an ambulance would have got there before then.

However, the data also shows that we have really good coverage in some areas. We have other really successful schemes, too; the BHF has funded a community defibrillator scheme and provided more than 400 defibs in Scotland over the past 10 years. There is still a way to go, but the good news is that we know where they should be.

I will also say that, although all this data is amazing, it needs to be coupled with community support. We need boots on the ground to ensure that communities are engaged. Sometimes, we have problems with getting guardians for defibrillators so that they are emergency ready. We need members of the community to ensure that there are replacement PADs if batteries need to be replaced, check on the equipment and report back to the circuit. There are barriers and obstacles, but SALFS is doing great work to understand what they are and how to get around them.

In relation to where we put defibs, they are most needed in more deprived communities. We know where we need to put them, so, if there is a commitment to a roll-out, we have never been in a better position to do that.

10:00

David Torrance: I have seen how PADmap works.

The majority of defibrillators are bought by community organisations, youth groups and so on, but, as you said, they are often not in the right place. How can we ensure that such organisations know where defibrillators should be? How can we advertise, when defibrillators are bought, where they should be placed?

Kym Kestell: There should be better socialisation of PADmap, the circuit and the tools that are available, and there should be robust signposting to those resources, because there are a lot of schemes and funds that community groups can apply for. As a sector, with the Scottish Government and the Parliament, we need to ensure that there is good awareness of those tools and maps.

We also need to ensure that community support is available for people. If people have questions about defibrillators, it can be quite difficult to know who to ask, so we need to ensure that things are joined up and that the system is robust. We are getting there. Amazing work is being done by partners across the sector to address that, so we are definitely moving in a positive direction.

Steven Short: We should not shy away from involving the industry. Ultimately, someone has to sell defibrillators to individuals. It is right that we have good, positive relationships with those in the industry, because they can be incredibly powerful in signposting people to PADmap when communities ask to buy a defibrillator from them. They are an important part of the jigsaw in many ways.

Everyone in the SALFS partnership, which includes some big organisations, does a phenomenal amount of work to support communities in always using PADmap to place defibrillators.

Kirsty Morrison: I echo the comments about Scotland being in a unique and positive position in relation to PADmap, which was launched only in the summer—that shows how cutting edge the technology is. A pilot has been done in Falkirk, where 104 defibs have been fitted. About 41 were fitted using PADmap, and those have been deployed twice as often, with a 66 per cent increase in the number of shocks that have been delivered.

I really welcome the question. It is about not just how many defibs there are, but where they are, and having the data to support that. We are now at the point of thinking how we roll that out. The sector is in a really good position, with support from the Scottish Government, to have those conversations. As has been said, there needs to be community buy-in and guardianship of defibs, so we need to utilise the data and have conversations with people about how the system will work in their communities.

Maurice Golden: I will follow up on what has been said and bring in Steven Short.

After almost a decade in the Scottish Parliament, I have seen the Scottish Government on many occasions want to create a headline rather than tackle a problem. You can see how appealing it would be for the Government to provide public funding for defibs in every school in Scotland—that sounds great—but I want to press you a little on whether you think that a more sophisticated approach is required. Schools might be part of that, but it might be appropriate for defibs to also be in other public buildings or community areas. If the Scottish Government made public funding available, how should an effective approach be rolled out to prioritise the areas that are most in need of that piece of kit?

Steven Short: When people think about public access defibrillators, they picture them in a cabinet on a wall somewhere. A lot of the time, that is the case, but that does not always work, depending on the community.

The two things in your questions that jumped out were about defibrillators near housing estates and in rural areas. If a member of the public attaches a defibrillator to you and delivers a shock before the ambulance service gets there, there is no question that you are much more likely to survive. Remember that not every cardiac arrest needs a shock. In Scotland, a defibrillator will only work on about a quarter of cardiac arrests.

Eighty per cent of cardiac arrests happen in the home, and often the only person with the victim of the cardiac arrest is the caller, so they are unable to leave to get the PAD off the wall that is 200 yards down the road, because they have to stay there and do chest compressions, which are guided by our call handlers. In more remote and rural parts, it is difficult to find places to put defibrillators where they will provide coverage.

There are two things here. We have the data on where PADs would be effective when more of them are put into the public space, and we can support that through PADmap. However, the other piece of support that we would welcome would be help to look at other ways to get defibrillators to people, such as community cardiac responders, community first responders or other types of co-response, such as with emergency service partners. When we know that ambulance response times are slower because of the rurality of the area, we need to work out how we can get people to the patient quicker.

We have had some success in that, and I will use Grampian as an obvious example. It has the Sandpiper wildcat project, which has a couple of hundred community cardiac responders all over the region and, on average, they get there six minutes quicker than we do. They are trained and equipped by the Scottish Ambulance Service. We know that they do excellent CPR because we have been able to download the metrics from the defibrillators that they use and analyse it. That is one example.

You might have seen on the BBC last week that we have now rolled out a community cardiac responder scheme in the Dumfries and Galloway area and, within a few days of going live, a responder was successfully deployed and saved a life. That was in a particularly rural region, so we send the PAD with someone who can use it, rather than expecting a member of the public to retrieve it from a fixed place.

The answer to the question about improving survival through the use of PADs is not necessarily to flood the place with more public access defibrillators because that does not equate to extra survival. It means thinking about different ways of getting public access to defibrillators in areas that need a different way of doing it, and how we can roll that out.

Kym Kestell: A lot of those communities need a nuanced approach. We have a very rural nation so we need to ask how we can best serve those communities.

I want to highlight some new data on PADs in schools that the BHF has produced using the circuit. We modelled what would happen to the average retrieval time for a defibrillator across the local authorities in Scotland if we put a registered PAD in every school. The results are just indicative, because the model covers a large area. In some cases, the results show a positive reduction in retrieval time. For example, the average retrieval time for a defibrillator in the Glasgow City Council area, which is a densely populated area, drops from 5 minutes 12 seconds to 3 minutes 48 seconds if a PAD is put in every school and registered on the circuit. That is a marked reduction in retrieval time and the reductions are most significant in the most deprived areas. The reduction in retrieval time is about 25 per cent in the most deprived communities. We would need to run that data at a local and more granular level, but putting a PAD into schools could be a good solution. However, as Steven Short said, there are other examples, and that solution might not work so well in rural communities.

We want to put more PADs in residential areas, and schools can be good for that. There is some research that shows that one third of out-of-hospital cardiac arrests can happen within 300m of a school. Locating registered defibrillators within residential areas could increase their number from just under 10,000 to 11,730. That is a big increase in the availability of defibrillators across Scotland, but the big thing to say is that that benefit is not seen equally across all local authorities.

For example, Aberdeen City Council already has defibrillators in a lot of its schools. However, in certain areas, such as North Ayrshire and Renfrewshire, we saw the retrieval time reduce by only a few seconds. So, there are reasons why it could be a good idea to put PADs on schools, but the more nuanced approach is to say that schools in certain areas, such as Glasgow city, might be good places to put PADs but that we should use tools such as PADmap and the learning from the Sandpiper wildcat project to make those decisions. We need to pull that information together to ensure that we are not leaving certain communities behind; that we are not doubling up defibs by, for example, putting one on a school that is next to a building that already has a defibrillator; and that all the unregistered defibs are registered, because that might change the picture. We could rerun all that data in six months' time and find that we have quite a different picture. We need a nuanced approach to ensure that, in relation to the communities that need defibrillators the most, we look at the combination of all that information.

Maurice Golden: My final question is to cover off the matter of funding, although witnesses have touched on that. There are a number of options for Scottish Government funding. It might be a case of taking a bird's-eye view and targeting the funding directly or it could be done via councils or a community fund. The risk with a community fund is that it is generally the most established community groups that will apply. If it were done through a community fund, the Isle of Eigg would definitely have a defibrillator, if it does not already, because it does a fantastic job of applying for funding. Do you have any thoughts on public sector funding but also any examples that could be spread out, by linking to public funding of excellent third sector work in this area or even to private sector work?

Steven Short: There is excellent work going on, not least from the third sector, which does some phenomenal work in communities right across Scotland. Any targeting of funding comes with the nuanced approach that we have been speaking about, and we can definitely identify areas that would benefit from having a greater increase in those public access defibs in the traditional way that we think of them.

The most deprived areas of Scotland are where we are most likely to see the types of cardiac arrest that are most likely to respond to defibrillation. We see survival across all the indexes of deprivation in Scotland, but the gap is getting wider. Survival rates are not climbing as quickly in the more deprived areas, which is often because, although individuals who live in areas of high deprivation are now probably just as likely to get bystander CPR as people in other areas, they are not as likely to be defibrillated. Looking at those types of areas in those types of communities and funding defibrillators is a win, but that needs to come with the resource that is required to raise community awareness. That is the key aspect of PADs. You cannot just stick one on a wall. Any of my colleagues will tell you that they have been at a cardiac arrest within sight of a PAD that has not been used and is still sitting in its case. That is soul destroying. It is the community engagement that comes with the placement of the PAD that is important. Funding to support that kind of stuff is just as important as funding for PADs in areas of need.

If you look at examples of taking the PAD to the patient, you will see that it is quite a resource-heavy operation to set up, provide training for and equip a cardiac responder scheme, for example. That takes resource, so funding for that would be beneficial, and it would help more remote and rural communities, too.

Kirsty Morrison: We have two quite nuanced approaches that we can take to the two issues that my colleagues have identified in relation to areas of deprivation and rural areas. Studies have shown that, in Scotland, if you are in a most deprived area, you are more than 300 metres further from a 24/7 access defib than you are in the least deprived area. In England, the difference between the most and least deprived areas is only 90 metres, so we have a huge issue in Scotland. However, we know that, and we know the areas that we need to look at, now that we have the data. We need a cross-sector approach. The third sector can play a role in bridging the gap between the communities that need defibrillators but might not apply for funds, as you said, and in raising awareness of the use of defibrillators, as Steven Short said.

We have used the model—BHF has got its funds—and we see success in that regard, but we need something additional, along with looking at the areas that might need a different approach. I commend the work of the Sandpiper wildcat project that Steven just described, and the data is showing that, in Dumfries and Galloway and in Grampian, we are seeing things change because of that work. Public funding needs to take a strategic approach, and partners want to be round the table, as you can see today, to be part of the solution. People have bought into that already.

10:15

Kym Kestell: I agree with my colleagues. Scotland is the only UK nation that has not committed investment for defibs. In England, Northern Ireland and Wales, they have been placed in schools, but we have an opportunity in Scotland to invest effectively and strategically. They could be placed in schools but, as we have heard, there are many other ways to do it. We welcome the investment, which we think is needed. We have an opportunity to reduce the marked inequalities that we see in this space and have a real impact on survival, particularly in areas of deprivation and the communities of greatest need. This year, the BHF has taken a more targeted approach with our funded defib scheme, using data to ensure that we are actively targeting areas in the communities that are in the greatest need, and aiming to encourage targeted investment to those communities. The good news is that we now know where those areas are.

The Convener: Interestingly, just before the October recess I was able to raise the issues arising from these petitions directly with the First Minister at the most recent convener's group meeting. Two or three points were raised on the subject of our current conversation, which I will refer back to. The First Minister paid tribute to the work that has been done on roll-out, and he was keen to explore whether there is anything more that the Scottish Government can do to give impetus to the partnership—he has asked for feedback about that. However, he does not see a role for the public sector in the roll-out of defibrillators, which is where there is a distinction between other parts of the United Kingdom and Scotland. That also arose in the response that we received earlier from Jenni Minto, the Minister for Public Health and Women's Health.

The public access map shows serious clusters of non-availability, particularly in Glasgow and the west of Scotland. The First Minister says that he has asked for proposals to be submitted to him, because the Scottish Government has taken an interest in addressing that, as has the First Minister.

I have listened carefully to everything that has been said. The most recent figure, from 2023-24—I imagine that it will have increased a bit since then—shows that there are 8,723 PADs, so the number has tripled since 2019, which is excellent. However, Stephen Short said that it is sad to see them unused in a nice shiny case on the wall, having not been deployed. I suppose that it goes back to Maurice Golden's question: are we confident that the defibrillators are going to the right places? Are we confident that people are being trained in how to use them following their supply and installation?

Steven Short: There has been a graded approach to the work over the past decade. In the first out-of-hospital cardiac arrest strategy, there was a conscious decision to focus more on bystander CPR than on CPR and defibrillation, because our bystander CPR rates were so poor. For the first five years of the strategy, we decided not to focus as much on defibs, because, first and foremost, we needed to get people pressing up and down on cardiac arrest victims' chests. However, in the past five years, the situation has changed completely and we now have a much greater push for CPR and the use of defibrillators.

Are we confident that the defibs are in the right places? I think that we can say that some of them are, but, as we have highlighted, we still have work to do. You mentioned Glasgow and the west of Scotland, and the highest rates of shockable cardiac arrests, which are the types of cardiac arrests that the defibrillators work on, are in our deprived urban areas. They occur most commonly

in our service industry workforce, predominantly among males in their 50s, yet they are the people who are not close enough to the defibrillators, as Kym Kestell has described. So, I think that we can be confident in saying that the defibs are not always in the right places yet, despite the amazing work that is being done. We need to find the right areas and put them there.

The Convener: Other parts of the United Kingdom have Government-led initiatives to provide defibs, whereas, in Scotland, we are still largely relying on charitable organisations and voluntary community initiatives. Is that work going to plug the gaps in the access map in Glasgow, in the west of Scotland or in other areas where, I imagine, fundraising initiatives to address the deficiencies are going to materialise?

Steven Short: Finding the funding to provide PADs to plug those gaps is the easy part. The challenging part is finding the guardians in the community who can maintain and check the defibrillators, be responsible for changing batteries when they run out after several years and all those kinds of things. Funding and placement are relatively easy to achieve; it is the community part of it that is difficult to achieve, in terms of both guardianship and raising awareness in the community, which is a key part of having the PADs.

The Convener: I am just exploring some of the themes from the fourth question, which is the one on leading preventative actions and the protection of vulnerable populations.

I was struck by something that you said earlier, which, at my own expense, I want to understand. You have done a terrific job with children in schools. You teach them those skills and, 20 years later, they still know what they are doing. MSPs were all sent for training in CPR. I remember it happening upstairs in Queensberry house, but I cannot remember a blessed thing about it. Is that a reflection of my impending senility? Is it that the older you are, the less you can deploy a skill? We were all quite good at it by the time we left the room, but, five or six years later, I have never been in a situation where I have had to deploy it, so I have forgotten how to do it, unlike the children you were talking about, who were taught the skill at school and who, 20 years later, can still walk right into doing the correct actions. Is it just me, or is it the case that those skills are best absorbed at an early age, because they will last longer, and it is harder to retain those skills in an older age group?

Steven Short: This suddenly feels like the first question where I am under pressure. In adult learning, we know that we forget stuff. There is decay of any skill, and, if you do not keep performing it, your memory of a skill will decay relatively quickly. However, while acknowledging that you do not remember it—and you probably do not—you have had training and you are aware of it, so, when our call handler who supports you through telephone CPR advice says to you, “Kneel next to the patient,” something in your head will go, “Oh, I need to kneel next to the patient’s chest, and I need to put my hands in the centre of their chest—that’s right.”

The Convener: There are prompts.

Steven Short: Yes. It is almost a multimodal approach. You have had awareness and, although you may feel like you have forgotten it, those prompts will trigger your memory when you are speaking to the call handler.

The Convener: In essence, it is okay to have those prompts in a situation where CPR might have to be deployed, rather than a continuous programme of refreshment.

Steven Short: We expect our clinicians to refresh the skills that they use, and that goes for any skill. Take our colleagues in the fire service—if you drive past any fire station, you will see firefighters out training all the time. They are practising the skills that they need to know, so that, when they have to use them in reality, it is much more automatic.

That is difficult to achieve in an entire population, because you cannot expect communities to train all the time, but the more that people get exposed to those skills—God forbid that they have to use them—the more confident they will feel. That is the important word for members of the public when it comes to performing CPR. It is not about competence; it is about having the confidence to have a go. We have spoken about the fear of doing harm, which is often the biggest fear, but training and awareness can allay some of the anxieties that people may have.

The Convener: I want to touch on an issue that came from Sharon Duncan, David Hill’s mother, in relation to evidence that we were able to obtain from the consulate general of Italy. For a very long time, Italy has had a screening programme for young people who are actively engaged in sport up to the age of 35, and evidence suggests that there has been an 89 per cent reduction in sudden cardiac death as a consequence of that. That brings me to the generic question about preventative care versus reactionary care. The simple prejudice that I sometimes feel lies above all of this is that preventative care has a cost up front, which you do not see the benefit of, and that people would rather deploy things that the accountants can see the return from. That statistic in the evidence for the reduction in sudden cardiac

deaths is particularly poignant for the Hill family following David's death.

Is there more that we should be learning or that we should be prepared to embrace when it comes to preventative initiatives? I know that my colleague Brian Whittle raises that issue in the chamber in relation to almost all areas of health. Would preventative action and being willing to be more open minded about the potential issues that arise from all of this make a difference, especially given that the Government does not have a particular strategy to tackle this area?

Kirsty Morrison: Chest, Heart and Stroke Scotland has been calling for prevention. We have had conversations with Brian Whittle and many of your other colleagues about it, and it has been nice recently to see a shift in understanding that we cannot continue just to plug the gaps and focus on the key metrics that we all see in the media about waiting times and hospital beds. Those are important, but studies show that, even if we ignore the tragic human impact of not focusing on prevention, economically we cannot sustain the direction that we are going in. The state of healthy life expectancy in Scotland is scary for us all.

We need a nuanced approach to what is prevention and the different stages of prevention. The study of the Italian screening programme is compelling, and I would love to know more about what the stages are once they have done that screening. We saw from the work of the national screening committee that we need pathways for people.

There are different levels of prevention. At the population level, there is eating well and looking after yourself. However, a lot of the cases of sudden cardiac death in young people that we are talking about have a genetic element—they cannot be prevented from occurring—so the question is about when they are detected and what the next steps of the pathway are. It is a compelling issue, and it would be good to have more conversations about pathway development for those cases.

The Convener: Kym, you touched on schools and the fact that the requirement to learn CPR is not an integral part of the curriculum. When evidence was submitted to us about that, some local authorities did not contribute, so we are not altogether clear what is happening. Can you talk further about what difference such a requirement would make? How could learning CPR be made slightly more compulsory, and in what age group would it be done? Is there a best practice model to articulate how it could become a more established compulsory requirement?

Could you and others expand on the standards and guidance in workplace settings? Is there a national standard for workplace training and understanding of the issues? Is there a best practice guide, or should more action be taken in relation to that as well?

Kym Kestell: On the schools issue, it is difficult to create a best practice model without having the data available to us to model what the provision looks like at the moment. All the local authorities in Scotland have committed to teaching CPR to all secondary school students, but, as you say, we do not know what the landscape of that is like at the moment.

If we want to make that teaching mandatory and reportable on, we and our partners in that space are committed to finding out, in collaboration with colleagues in education, how to design it so that it is as effective as possible. It might be taught in one school year, with a refresher course a couple of years down the line. I do not have any specifics about what the roll-out of that would look like, but we are committed to working across the sector to ensure that, if it were put in place, it would be really robust. It is on the curriculum in England, and we have colleagues in England who are looking at what a monitoring system looks like, what it could look like, what information we would get from it and what we could learn from it.

10:30

I think that this is a really important issue. As Steven Short said, when you learn these skills as a young person, they become a lot more normalised. You carry them with you for the rest of your life, and it means that you are probably more likely to do a refresher course. It is a case of "I've done first aid training at work, and we get a refresher course every year." It just becomes a normal part of life, and that is really important in breaking down the barriers and addressing people's unwillingness to perform CPR, especially on older or frail people, because they think that they are going to do harm. There are also misconceptions about, for example, needing to be trained to use a defibrillator. People do not need any training; in fact, defibrillators speak to you and tell you how to use the equipment.

There is still work to be done, but I think that there is a real opportunity here. There are also examples to look at. From memory, I think that CPR training is mandatory and reportable in schools in Denmark, and the Danes have higher survival rates. It is an interesting question that we really want to dig into a bit more. At the moment, we do not understand the landscape of CPR training in schools.

The Convener: Does anybody have any thoughts on workplace standards?

Steven Short: I do not know what those standards, or the legislation, would say—I have

never run a business. However, I do know that there is a first aid at work programme, and there are initiatives to encourage workplaces to take up CPR and defibrillator training. SALFS has recently collaborated in a partnership with the Resuscitation Council UK and its "ResusReady" campaign. It is almost like a rubber stamp; your business is "ResusReady" if you have trained a certain number of individuals in your workplace.

There are things out there to encourage such activity. However, on your question about what workplaces have to do, I have to say that I do not know the answer.

The Convener: Thank you. We move to our final theme and questions from Davy Russell.

Davy Russell (Hamilton, Larkhall and Stonehouse) (Lab): My first question is on cross-sectoral policy involving health, education and other stakeholders. What are the key barriers to cross-sectoral collaboration between health and education in Scotland, and how might they be addressed through initiatives such as the Scottish Government's population health framework?

Steven Short: That is an important and interesting question. I was having this very discussion at a meeting last Monday.

When it comes to CPR training, I think that, through some great working with SG colleagues, we have come to realise what work is imagined in health and what is achievable in education. We have probably not understood each other as well as we could or should have done over the years, and we are looking to break down some of the barriers by having some joined-up thinking between health and education to say, from a health point of view, "This is what we think needs to be done," and to ask, from an education point of view, "How can we achieve that and ensure that it is done?"

There are other partners to consider, too. With education, it comes back to the local authority, and, as we know, what works in one local authority is not necessarily going to work in another. We are doing a little feasibility study with Dumfries and Galloway in which we are trying to join up a lot of this work, and we are looking at different levers at a local level through a sort of assets-based approach. Where we know that assets exist already, how can we join things up, say, to improve CPR awareness in schools and communities; to optimise PAD placement, which we have talked about already; and to find better ways of getting PADs to people through cardiac responders or people signing up to the GoodSAM app? We are proactively doing work in that space to join up different parts of the system in a better way.

Kirsty Morrison: Ahead of the next election, we have been calling for different public bodies—and, I guess, different policy areas—to see what role they can play in health creation. The population health framework that you mentioned is a starting point for making it clear that it is not just the health policy sector or health charities that play that role when it comes to prevention—we all do. That represents a shift, and it is a conversation that we need to have. We have all heard the stories about teachers' workload, so we need to move away from that simple view and have that conversation. We need to include different sectors, too. The third sector definitely has a role to play, because it is often able to bring different policy angles together.

Kym Kestell: I agree with my colleagues. They have covered the points wonderfully.

I would just add that we welcome collaboration between health and education colleagues, especially on the issue of CPR training in schools. There needs to be collaboration on that and co-design of it, to ensure that it works for everyone. We are very committed to working in that space.

Davy Russell: How do community planning partnerships contribute to aligning health and educational priorities locally? What opportunities exist to strengthen collaboration across health, education and community sectors?

Steven Short: That is exactly what we are exploring just now in the Dumfries and Galloway care zones feasibility study. Health boards might know lots about the health metrics of their communities, but the local authority actually knows those communities. Steven Short from the Ambulance Service might say, "You need a defibrillator there"—that would be a really simple thing for him to say—but it is the local authority that, with all its community partnerships, knows who to tap into in its communities and say, "Look, we think that you need this there. Who in the community can support it?" That is one of the big pieces of learning that we are taking from the pilot that we are right in the middle of, but that joined-up collaboration and thinking are hugely important when it comes to what is happening locally on the ground.

Davy Russell: My next question links in with that idea of collaboration. The funding seems to be going fine, you have the right places, and you have the data and info. You are working hard on all of that, and community and public awareness and training are all going hand in hand, too. You touched on this vaguely at the start, but what about the maintenance and replacement of faulty equipment? Inspection and maintenance seem to be a bit haphazard. You are putting a lot of effort into all the big parts of this, but the fact is that equipment gets older and, even if only 1 per cent of these things fail, that is still quite a significant

amount. Where is the co-ordination in that respect?

Steven Short: It is a huge, and real, challenge. Ultimately, a guardian owns, or is responsible for, that defibrillator—however you want to put it—and the responsibility lies with them to ensure that the piece of kit is rescue ready. They buy the kit in good faith and register it on the circuit so that our call handlers can signpost people to go and get it when someone is having a cardiac arrest. However, when that happens, the pads need to be replaced, and they are expensive—and by "pads" I mean the pads that you stick to the chest, not the public access defibs themselves. It is not that the guardians in the communities forget about that; it is just that they do not necessarily factor it in, because it is not in their thought process at that point. Again, there is awareness raising to be done there.

Although the defibs are designed to be left alone—they do their own self-checks and so on—their batteries have a finite life, with anything between three and five years being pretty much standard. Therefore, the batteries will decay over time, even they are not used, and will need to be replaced, which is another cost.

There is also a time commitment. For the defibs to stay in the circuit, someone needs to go around periodically and confirm that they are still rescue ready. After all, the last thing that we want to do is to send a bystander to a defib cabinet only for them to find the defib or its pads missing or not working.

So, yes, this is a real challenge for us. I guess that, as we are not the owners of the defibrillator, our responsibility in the Ambulance Service is to continue to raise awareness of some of the challenges.

Davy Russell: It just seems to be a weak part of the system—

Steven Short: For sure.

Davy Russell: —because, after all, you are working really hard on this.

Steven Short: We have some amazing partners out there who are doing brilliant work in this space, and there are some fairly large guardians managing multiple public access defibrillators in their areas. Indeed, they have come together as a group. You might have heard or be aware of the work of PAD Scotland, which is a bit of an offshoot of SALFS. Those involved are all partners in SALFS but they have their own working group to explore some of these challenges.

Davy Russell: Just to help you, I was thinking along the lines of what happens with fire extinguishers. A company comes around every year—or two years, depending on where it is—and gives them a wee check.

Steven Short: Absolutely.

Davy Russell: As I say, though, the issue is how you tie that in.

Kym Kestell: I would just add that, if there is to be investment in increasing PAD access across Scotland, it should also take into consideration maintenance costs over, say, 10 years. We have figures for how much those costs would be, and we think that it is a really important part of ensuring the longevity of any PADs that they are funded and that we have the guardians, the community buy-in and the community engagement in place to ensure that those PADs are used and are known to the local community.

We have heard from community groups and fundraisers that they have been left out of pocket when they have had to replace the pads or the batteries. Steven Short is right to say that it is not a cost that everybody knows about, so we need to ensure that there is really good communication as well as really good expectations of how those maintenance costs will be met. I hope that that will be considered in any investment that is made in PAD access.

Davy Russell: Thank you.

The Convener: We have run over our scheduled time quite a bit, but the discussion has been fascinating and productive. The issues arising from these petitions have been ones that the committee has been quite actively engaged with over the course of the Parliament, for a variety of reasons. They are very important, and I am very grateful for everything that you have been able to contribute this morning.

I will suspend the meeting briefly before we move on to the next item. Thank you again.

10:41

Meeting suspended.

10:42

On resuming—

Continued Petitions

Education Scotland (Staff Roles) (PE1953)

The Convener: The next item is consideration of continued petitions. I highlight to those who are joining us this morning or watching online that we have a very considerable number of open petitions but not long remaining in which to consider them. We have only eight meetings of the committee remaining before the dissolution of the Parliament. Our focus for the rest of the parliamentary session, in the limited time that remains to us, is therefore on identifying areas in which we believe that we can make real progress in relation to petitions.

The first petition that we will consider again this morning is PE1953, lodged by Roisin Taylor-Young, which calls on the Scottish Parliament to urge the Scottish Government to review education support staff roles in order to consider urgently raising wages for ESS across the primary and secondary sectors to £26,000 per annum; increasing the working hours for ESS from 27.5 to 35 hours a week; allowing ESS to work on personal learning plans with teachers and take part in multi-agency meetings; requiring ESS to register with the Scottish Social Services Council; and paying ESS monthly.

When we previously considered the petition in March, we agreed to write to the Cabinet Secretary for Education and Skills. Her response highlights the guidance on supporting children and young people with healthcare needs in schools, which states:

"NHS boards and education authorities should work collaboratively to ensure that all staff receive ... appropriate ... training".

The cabinet secretary states that the Scottish Government has no formal role in setting the pay or terms and conditions of non-teaching school staff. The submission highlights the Scottish Government funding to support pupils with complex additional support needs, which includes an allocation for local and national programmes to support the recruitment and retention of the ASN workforce.

In view of the response that we have received from the cabinet secretary, do colleagues have any suggestions as to how we might proceed?

10:45

David Torrance: Considering the cabinet secretary's response, I suggest that we close the petition under rule 15.7 of standing orders on the basis that the Public Audit Committee recently undertook scrutiny of additional support for learning in the context of the Auditor General for Scotland's report. We have explored the issue that is raised in the petition, and there is limited time remaining in the current session of Parliament to progress the issues further. In closing the petition, we could suggest to the petitioner that she raises the issues with one of her local MSPs and advise her that a new petition could be submitted in the next parliamentary session.

The Convener: That advice might be generally applied on a number of different occasions. Are there any alternative suggestions to those of Mr Torrance?

Members: No.

The Convener: Are we content to close the petition on that basis?

Members *indicated agreement.*

The Convener: We thank the petitioner very much for raising the issue, but there is clearly no time for us to adequately pursue the petition in the balance of the parliamentary session.

United Nations Convention on the Rights of Persons with Disabilities (PE1999)

The Convener: PE1999, which was lodged by William Hunter Watson, is on full implementation of the United Nations Convention on the Rights of Persons with Disabilities. I am afraid that, through a slight undermining of our normal procedures, we have not considered the petition in committee since 20 December 2023. At that time, we agreed to write to the Scottish Government. The then Minister for Social Care, Mental Wellbeing and Sport, Maree Todd, stated in her response that the Scottish Government was prioritising work to consider possible reform to the Adults with Incapacity (Scotland) Act 2000, and she highlighted the intention to introduce a new human rights bill.

The committee has received a written submission from Barry Gale, who states that, although the minister's response outlined a broad vision for change, the level of impact would depend on the details of how that vision was implemented. His submission emphasises the importance of reforming the law to put people unequivocally in control of decision making about their lives.

The petitioner's written submission makes a specific point about care for elderly people. He states that the minister failed to indicate whether the programme of reform would end the giving of sedatives to elderly care home residents. He also states that mental health law in Scotland cannot be compatible with international human rights if it

permits potentially harmful drugs being given to care home residents for the convenience of staff.

We have a recent update from the Scottish Government, which states its intention, subject to the outcome of the election, to introduce an adults with incapacity bill and a new human rights bill in the next parliamentary session. The human rights bill would give domestic legal effect to a range of internationally recognised human rights including the International Covenant on Economic, Social and Cultural Rights and the UN Convention on the Rights of Persons with Disabilities. The bill would aim to support rights holders, including disabled people, to access remedy where their rights are not upheld and to establish a multi-institutional model of human rights accountability in Scotland.

The submission highlights that the Scottish Government has now progressed or completed the majority of the actions and milestones that were set out in the initial delivery plan for the mental health and capacity reform programme. The Scottish Government also notes that the adults with incapacity expert working group continues to meet monthly and is taking forward the detailed development work that is required to modernise the legislation. In fact, a quite comprehensive series of commitments and actions are under way.

Do colleagues have any comments?

David Torrance: In the light of the response from the Scottish Government and the actions that it is taking, will the committee consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government intends to introduce a human rights bill in the next parliamentary session, which will give domestic legal effect to the UN Convention on the Rights of Persons with Disabilities? In addition, as the convener said, work on the mental health and capacity reform programme has begun, with the majority of actions being progressed or completed, and the adults with incapacity expert working group meets monthly and is taking forward detailed development work to modernise existing legislation.

The Convener: Thank you, Mr Torrance. We have identified those three points.

Fergus Ewing: There is no alternative but to close the petition. I say so because it is plain that we will not see any further specific action by the Scottish Government before dissolution. That is crystal clear. However, I want to say a few things.

First, I pick up on the fact that, as the convener said, Mr Gale—I think—noted that there is a particular concern about sedatives being given to people in old folks' homes to make them easier to deal with. That point has not been answered at all—I thought it only fair to Mr Gale and the petitioner to point that out—and nor, really, has the petitioner's ask ever been directly responded to. The petition was lodged on 5 January 2023, and its aim was that treatment for mental disorders without consent should not be permitted.

Looking back at Maree Todd's first response, on 29 January 2024, I see that she did not answer that point at all—not in the slightest. She said that the Scottish Government would introduce the human rights bill later that year. That has not happened. I think that it is only fair to the petitioner to point that out and get it on the record that that promise has plainly been broken.

We are not going to get any further, but it is symptomatic of the Government's approach, which is that, where it is not willing to do something that it is asked to do, instead of just saying, "We're not going to do that" and giving a reason—I suspect that that is the case here—we get huge amounts of written material in response that does not bear directly on the point. Personally, I feel that that does the Government no good at all, because petitioners understandably get completely hacked off that the thing that they are asking for has not been answered at all.

I just wanted to put that on the record, but I agree with Mr Torrance—perhaps from a slightly different perspective—that nothing further is going to take place. I note that the petitioner has been pursuing the issue for two decades now and he must feel pretty aggrieved and disappointed. I reflect on the fact that the committee tries very hard to extract answers from the Government but, very often, for whatever reason, that does not happen. This is one of those cases.

The Convener: Yes—that is a very fair summation of the position. I think that there is absolutely frustration and disappointment—well, probably more than disappointment now. The petitioner looks to the process that exists, which is the petitions system, yet our system is frustrated by our not engaging directly with the issue of the petition when we do not get the responses that would allow us to do so.

If legislation is introduced in the next session of Parliament, there will be an opportunity to directly address the issues that the petition raises in the context of the debate that will take place as that legislation progresses through Parliament. The issue is sufficiently serious that I hope that that will happen.

On that basis, given Mr Fergus Ewing's comments, are we minded to close the petition?

Members *indicated agreement.*

Property Factors (PE2006)

The Convener: PE2006, lodged by Ewan Miller, calls on the Scottish Parliament to urge the Scottish Government to amend the Property Factors (Scotland) Act 2011 to cover dismissal of property factors or bring forward other regulations that would achieve the same aim. That could include giving the First-tier Tribunal powers to resolve disputes related to the dismissal of property factors. We last considered the petition in March, when we agreed to write to the Minister for Victims and Community Safety and the Law Society of Scotland.

In providing her response, the minister has consulted the Scottish Courts and Tribunals Service. It suggests that the proposal to give small claims courts powers to dismiss property factors could add a layer of complexity that may not be suitable for simple procedure. An alternative may be to consider the summary application procedure that is available in the sheriff courts as a possible route to removing property factors. However, the SCTS believes that that would not be readily accessible to unrepresented parties and it may involve awards of expenses on a par with the ordinary cause procedure. The Government therefore concludes that it would not be a viable option. I think that it might have been Mr Ewing who floated some of those ideas.

The Law Society of Scotland observes that, if reforms are to be taken forward in this area, consideration would need to be given to what an "excessive charge" means in practice. It considers that proper mediation between residents and factors is essential and may avoid recourse to litigation.

Since we last considered the petition, the Parliament has scrutinised and passed the Housing (Scotland) Bill. Various colleagues lodged final-stage amendments that were directly relevant to the petition's ask. During the stage 3 proceedings, the Cabinet Secretary for Housing indicated that most of the issues that were raised in those amendments will be addressed in an updated code of conduct for registered property factors that will set out minimum standards of practice. As a result, those amendments were either withdrawn, not moved or disagreed to at stage 3. The cabinet secretary's amendment, which changed the proportion of owners that is required to remove a property factor from two thirds to a simple majority, was agreed to.

Do members have any comments or suggestions for action?

David Torrance: In light of that information, I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders on the basis that the changes that the petitioner asked for have been considered and voted on by the Scottish Parliament as part of the recently passed Housing (Scotland) Bill.

The Convener: If we agree to that, we will need to point to the code of conduct that is going to be developed that is supposedly going to address those issues. Expectations that the bill might have been amended to accommodate the petitioner's points have not been fulfilled. Do we have any other options or is the committee content to proceed on that basis?

Fergus Ewing: I agree with Mr Torrance's recommendation. I suggested that the summary cause procedure be used but, to be fair to the minister, she has responded directly to the point and given her reasons. I understand that the reasons might well be valid and my suggestion has been answered by the minister so, in the interest of balance, I should thank the minister for her response. It does mean, however, that there is no real resolution to the petitioner's request, although I suspect that, in many cases, no real resolution is ever possible when certain differences arise. That is my experience, anyway.

The Convener: Are we content to close the petition?

Members *indicated agreement*.

Disposable Vapes (PE2033)

The Convener: PE2033, lodged by Jordon Anderson, calls on the Scottish Parliament to urge the Scottish Government to legislate for a full or partial ban on disposable vapes in Scotland and to recognise the dangers that those devices pose to the environment and the health of young people.

When we considered the petition in March, we agreed to write to the Scottish Grocers Federation to ask for its views on whether the ban would go far enough to address the issue. Its response suggests that a number of organisations might need to be provided with significant extra resource to tackle the rise in illicit goods that could result from the ban.

On the environmental aspect, it expresses concerns about sufficient public commitment to educating vapers about returning used vapes and about retailers potentially being expected to accept used illegal vapes for recycling in their stores as part of their provision of vape take-back.

Finally, the SGF suggests that, alongside any further restrictions on affordable vaping products, the ban could risk an increase in cigarette consumption, and it calls for a nuanced debate on the topic of voting—I mean vaping. [*Laughter*.]

Since we last considered the petition, a UK-wide ban has indeed been introduced, which means

that, as of 1 June 2025, single-use vapes are no longer stocked or sold in Scotland.

Do colleagues have any comments or suggestions for action?

David Torrance: The committee should consider closing the petition under rule 15.7 of standing orders on the basis that a ban on single-use vapes is now in force.

Maurice Golden: I agree with Mr Torrance. However, in the next parliamentary session, it might be helpful for the petitioner to look at the effectiveness of the ban. I note that the petition called for a full or partial ban. I would agree that, in practical terms, the current ban is a partial ban and there are, unfortunately, numerous shops in Scotland where people can still buy disposable vapes.

The Convener: Thank you for that. Do members agree to close the petition?

Members *indicated agreement.*

The Convener: Maybe we will get a petition in the next parliamentary session for a nuanced debate on the topic of voting—we will see.

Court Summons (Accurate Information) (PE2073)

10:58

The Convener: PE2073, which was lodged by Robert Macdonald, calls on the Scottish Parliament to urge the Scottish Government to require the police and court services to check that address information is up to date when issuing court summons and to allow those who are being summoned the chance to receive a summons if their address has changed, rather than the current system of proceeding to issue a warrant for arrest. When we first considered the petition, we heard a detailed example of the impact of that practice.

We considered the petition in March, and the Lord Advocate has responded by echoing a previous submission from the Scottish Courts and Tribunals Service and highlighting the point that, if the person referred to in the background for the petition was an accused person, the responsibility to update the court on a change of address would rest with that person.

The response also confirms that the processes for obtaining a warrant for accused persons and witnesses, as set out in a past submission from the Crown Office and Procurator Fiscal Service, still stand.

Additionally, the Lord Advocate points members to a statement that she made before Parliament last October, in which she referenced her specific instruction that pre-conviction warrants should normally be obtained by prosecutors and executed by the police only if there is no immediate alternative to securing the accused's attendance, or when the accused represents an immediate risk to others.

11:00

Finally, the response highlights that His Majesty's Inspectorate of Prosecution in Scotland and HM Inspectorate of Constabulary in Scotland have initiated a joint inspection of processes for witness citation and of ways in which the processes could be modernised. The inspection is to be undertaken during the course of this year, 2025.

Do colleagues have any suggestions as to how we might proceed?

David Torrance: Will the committee consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government's position is that the core ask of the petition is an operational matter for the Crown Office and Procurator Fiscal Service and Police Scotland, because pre-conviction warrants should normally be obtained and executed only in the absence of an immediate alternative and because HM Inspectorate of Prosecution in Scotland and HM Inspectorate of Constabulary in Scotland are currently conducting a joint inspection of the citation process in Scotland with a view to recommending improvements.

In closing the petition, the committee highlights to the petitioner the option to submit a new petition during the next parliamentary session, should they consider that there has not been sufficient progress on the matter.

The Convener: Either the code of conduct will address the issue or it will not, and the petitioner could return the issue to us. Do colleagues agree with Mr Torrance's proposal?

Members *indicated agreement.*

The Convener: We thank the petitioner and hope that the development of the code of conduct will address the matter in hand.

Alkaline Hydrolysis (PE2084)

The Convener: The next continued petition is PE2084, which was lodged by Randall Graeme Kilgour Foggie. The petition calls on the Scottish Parliament to urge the Scottish Government to amend the Burial and Cremation (Scotland) Act 2016 to allow alkaline hydrolysis, accelerated composting and other more eco-friendly methods of disposal of human cadavers. We last considered the petition on 5 March 2025, at which

point we had all of that explained to us, and we agreed to write to the Scottish Government.

The Scottish Government's response states that an alkaline hydrolysis regulations working group has been established and that its first meeting took place on 3 March 2025. It is currently expected that draft regulations will be laid later in 2025, although the exact date is still to be decided. The eventual timeline will be informed by the considerations of the group and the development of the regulations.

Do members have any comments or suggestions for action?

Maurice Golden: I think that we should close the petition under rule 15.7 of standing orders on the basis that it is expected that draft regulations will be laid this year and that an alkaline hydrolysis regulations working group has been established and has begun exploring issues to inform the development of the draft regulations.

The Convener: Those seem to be the asks of the petitioner. Are colleagues content that we close the petition on that basis?

Members *indicated agreement.*

Scottish Rivers (Legal Right to Personhood) (PE2131)

The Convener: The final continued petition for consideration today is PE2131, which was lodged by Professor Louise Welsh and Jude Barber on behalf of the Empire Cafe. The petition calls on the Scottish Parliament to urge the Scottish Government to grant the River Clyde, and potentially other rivers in Scotland, the legal right to personhood by adopting the universal declaration on the rights of rivers, by appointing a nature director to act as a guardian of the River Clyde, with the responsibility for upholding its river rights, and by considering whether an alternative mechanism should be established to act for the rights of the river, its inhabitants—human and non-human—and society at large. When we last considered this petition on 5 March, we agreed to write to the Glasgow City Region.

The GCR is not able to provide a view on the action that is called for in the petition, as it falls outside the remit of the Glasgow and Clyde Valley cabinet. The cabinet is specifically responsible for decision making in relation to the city deal, strategic economic development priorities as well as any other activities agreed by the authorities.

We also requested more information from the GCR regarding the work to deliver the Clyde mission, as well as any action that could be undertaken to formalise and improve accountability in the management of the River Clyde. The response reminds us that, in August 2023, the Scottish Government transferred lead responsibility for the Clyde mission to the GCR and Argyll and Bute Council, as well as providing funding. Work on a strategic master plan was due to commence this summer, and the GCR indicates that a strategic outline business case was also going to be produced alongside that to strengthen decision making and underpin long-term investment.

The response states that, for the GCR, governance for the Clyde mission has been incorporated into existing regional structures; for Argyll and Bute, any reporting and approval is co-ordinated by council officers, with support from the GCR if necessary. The GCR highlights that a Clyde mission partnership board would in due course also be established and developed in parallel with the strategic master plan.

Do colleagues have any suggestions on how we might proceed?

David Torrance: In the light of the information that is before us, I ask the committee to close the petition under rule 15.7 of the standing orders, on the basis that the Scottish Government does not currently support the petition's proposals. Policy mechanisms are in place to balance the interests of nature, society and the economy, and work to progress the Clyde mission is on-going.

Fergus Ewing: I have no comment.

The Convener: Are we content to support Mr Torrance's proposal?

Members *indicated agreement.*

New Petitions

11:05

The Convener: Item 4 is the consideration of new petitions. As I always say before consideration of the first petition, the Parliament seeks the preliminary thoughts of SPICe, the independent research body in the Parliament, so that it can give us a proper briefing on the issues raised. We also get an initial response from the Scottish Government. As I have explained before, the reason why we do so is that, historically, those were the first two actions that we agreed to take, so it curtails the delay in our proper consideration of the issues at hand.

However, as I have also said and as we now have to say to petitioners, we are up against it and have just a handful of meetings of the committee left. Even with new petitions, we have to be pretty certain that we can do something meaningful in the time that is available to us.

Council Tax (Banding Alterations) (PE2172)

The Convener: The first new petition for consideration is PE2172, which has been lodged by Sarah McFadzean. A representative is in the gallery on her behalf this morning. The petition calls on the Scottish Parliament to urge the Scottish Government to amend council tax regulations to allow late banding alteration proposals in exceptional personal or compassionate circumstances such as bereavement, illness, sudden house moves or lack of rights awareness, particularly among tenants.

The SPICe briefing for the petition explains that, when someone moves into a new home, they can apply to have their council tax band changed if they think that their property is in the wrong band. This application or "proposal" must be made to the local assessor within six months of the person becoming liable for council tax on that property, which I suspect every MSP is aware of because they will have received representations on the matter. If the proposal is received outwith the statutory time limits, the assessor must deem it invalid. People have six months to make such an application, which is not necessarily properly understood.

The Scottish Government response confirms that existing regulations do not grant discretion to extend the statutory period for proposals in exceptional circumstances for personal or compassionate reasons. The Government states that, because each assessor has an on-going duty to maintain an accurate council tax valuation list, anyone could request a review, and possibly a correction, of the list itself based on potential error and without a time limit restriction.

However, as shown in the SPICe briefing, the Scottish Assessors Association suggests that the band review process

"is not a legislative option in Scotland",

whereas the proposal process is set out in existing legislation. Additionally, evidence presented to the Local Government, Housing and Planning Committee earlier this year showed that assessors are already under pressure with existing workloads.

The Scottish Government is currently conducting wider work on council tax reform in collaboration with the Convention of Scottish Local Authorities and based on research that was commissioned by the Institute for Fiscal Studies. The Government intends for that comprehensive work to inform a debate in the Scottish Parliament, which will shape proposals for the next Parliament to consider, in early 2026. Members might, in fact, recall that we have recently closed a different petition on that exact basis, which is that the issue will be the subject of a statement, a debate and a paper ahead of dissolution, with recommendations to follow next year. Now that I have said it, I do not know whether the Government will do all those things, but a paper will certainly be published that sets out the options.

Do colleagues have any suggestions as to how we might proceed? It is a new petition, but we have to look at it in the light of our ability to proceed.

David Torrance: In the light of your comments, I suggest that we close the petition under rule 15.7 of standing orders, on the basis that the Scottish Government is currently undertaking work with COSLA and the Institute for Fiscal Studies that will inform potential council tax reform proposals in the next parliamentary session.

The Convener: It might be worth pointing out that the Scottish Government published "Consultation: The Future of Council Tax in Scotland" on Monday. The public consultation closes on 30 January 2026, so it would be sensible to suggest to the petitioner that she could contribute to it.

Fergus Ewing: I support Mr Torrance's recommendation for the reasons that he set out, but it might be useful to reflect on the fact that the purpose of the petition is to allow there to be some regard to exceptional circumstances—namely,

"personal or compassionate circumstances, including bereavement, illness, sudden house moves, or lack of awareness of rights".

It occurs to me that, if some allowance is to be made for those factors, particularly illness and

bereavement, perhaps the more appropriate way to give effect to that would be through the system of reliefs for council tax, rather than changing the bands. The bands relate to the category of value in which a property was deemed to have fallen at the relevant date, which was, I think, back around 1990, when council tax was introduced to replace the poll tax. It seems to me that such matters are more in the territory of reliefs than the alteration of bands. For example, there is already relief for council tax in toto for someone who is severely mentally impaired, and the process for obtaining that relief is not that complicated.

I just thought that I would give that reflection. If the petitioner were to come back with another petition in the next parliamentary session, she might wish to consider that alternative route to achieving the aim that is set out in the petition.

The Convener: That could be set out in the letter to the petitioner confirming that the petition has been closed, if the committee is minded to close it. Is the committee minded to do so?

Members *indicated agreement.*

The Convener: We thank the petitioner and hope that the consultation, which covers the routes through which council tax might be changed in the next session of Parliament, will be a mechanism to take forward the aims of the petition.

Disposable Barbecues (Ban) (PE2175)

The Convener: PE2175, which was lodged by Paul White, calls on the Scottish Parliament to urge the Scottish Government to introduce new legislation that would immediately ban the sale of disposable or instant barbecues by retailers and introduce on-the-spot fines for anyone using a disposable barbecue in Scotland.

We have been joined by our colleague Edward Mountain for our consideration of the petition. Good morning, Mr Mountain.

The petitioner believes that, in recent years, there has been a rise in irresponsible outdoor access, which, combined with climate change, has increased wildfire risk significantly. The Scottish Government's response states that the ask of the petition is "not achievable" in Scotland. The submission states:

"Product standards and safety, and the regulation of the supply of goods to consumers are reserved matters. The United Kingdom Internal Market Act 2020 generally prevents banning the sale of an item in one part of the UK which can be freely sold in the others."

However, the SPICe briefing notes:

"Scottish Ministers can introduce regulations under section 140 of the Environmental Protection Act 1990 to prohibit or restrict the importation, use, supply or storage of injurious substances or articles for conservation purposes."

The restrictions on single-use plastic and single-use vapes are examples of instances when the Scottish Government has sought to do that. The briefing explains that new product restrictions of that nature could require a UK-wide approach or an agreed exclusion from the 2020 act's principles. Local authorities have the power to introduce byelaws that put in place temporary bans on the use of barbecues, including disposable ones, in the whole of, or any part of, their area. The SPICe briefing notes:

"The Cairngorms National Park Authority has recently submitted a 'fire management byelaw' proposal to Scottish Ministers which, if approved, would ban the use of disposable and other (non-gas) barbecues in the Cairngorms National Park ... between 1 April and 30 September"

except in certain circumstances.

Before I ask my colleagues whether they have any suggestions on how we might proceed, I would be delighted to hear from Mr Mountain.

Edward Mountain (Highlands and Islands) (Con): Thank you, convener. I understand why Paul White has lodged the petition. It is a matter of frustration to him and to many constituents that wildfires continue to be a problem. The issue was probably highlighted more than it has been by anything else by the wildfire at Dava, which burned thousands of acres. However, the petition comes on the back of other fires, on the Isle of Arran and in Glen Finglas, where wildfires have happened because of the use of disposable barbecues. I accept the Scottish Government's comments about the 2020 act. I also accept SPICe's comments about the Environmental Protection Act 1990, which might provide some scope for a ban to happen That is not something that the petitioner would reasonably expect to be achieved in this session of the Parliament.

11:15

When you come to consider closing the petition, which I am sure that you will do, convener, and, probably rightly so, given the time that the committee has left in the parliamentary session, a way forward would be to seek clearer guidance from the Government on when disposable barbecues could be used. It should be automatic that people are told not to use disposable barbecues when the fire risk goes up from moderate to high. There could also be a way of the Scottish Government making announcements so that people are asked to abide by a voluntary ban.

As a result of its slow action in relation to the Cairngorms byelaw, the Scottish Government has

slightly provoked this petition. The Cairngorms national park submitted a byelaw for approval to the Government, and it has taken it a huge amount of time to consider it. Even as we speak, I am not sure that the byelaw has been passed by the Scottish Government. I tried to find out, but I have been unable to do so. Therefore, if I might be so bold, I suggest that it might be worth writing to the Scottish Government to say that the committee is closing the petition and that you hope that it would be more proactive in saying when disposable barbecues should not be used and that there would be a speedier response to requests from local authorities for byelaws to ban the use of disposable barbecues. I hope that that is helpful.

The Convener: Thank you, Mr Mountain. Do colleagues have any suggestions for how we might proceed?

Maurice Golden: I agree with the member's comments. We should close the petition under rule 15.7 of the standing orders on the basis that, given the time constraints and the likely requirement for an exemption under the UK 2020 act, the Scottish Government's track record with regard to exemptions under that act, and the lack of the delegation of powers and governance in relation to the application of that act in the UK, the timescales mean that the committee could not progress the petition before the end of the parliamentary session. However, in closing the petition, I agree that we should write to the Scottish Government regarding how, from a circular economy point of view, it might look to tackle the issue of disposable barbecues and to ask whether it has engaged, or plans to engage, on that specific issue with the UK Government, including on guidance, as the member highlighted.

The petitioner might want to consider whether it is worth while lodging a new petition in the next session, and, if so, to consider the fact that, were we to ban disposable barbecues, it would be relatively simple to redesign said barbecues to make them reusable. As the member will know, we already have examples, such as hexamine stoves. With regard to tackling wildfires, a ban on disposable barbecues would take us no further forward. There would still be a risk; it is just that the risk would be from a reusable, rather than a disposable, product.

Fergus Ewing: For the reasons that Mr Golden set out, we should close the petition. However, having heard what Mr Mountain said, I agree that, in closing the petition, it would be helpful to write to the Scottish Government, in the terms that he suggested. The fire in Dava decimated everything for an area of 44 square miles, which is one half of the area of the city of Edinburgh, and it is of huge concern that the next wildfire could be even worse. An international expert in wildfires said that Governments do not take this issue seriously until the first 100 people are dead. I do not say that to be dramatic, but gamekeepers in my area tell me that there is a risk of a serious fire, which could decimate vast areas, and they can tell me exactly where it would happen, how, in what wind conditions and at what time of year.

Although I know that Mr Fairlie is taking the issue seriously, the need for swift action is absolutely overwhelming. We should ask the Scottish Government whether it will work with local authorities to put a ban in place, especially in times of high risk, and especially during April and the months in which bracken, gorse and so on in moorland are more susceptible to fire than they are at other times of year, although I am no expert.

I just wanted to back up what Mr Mountain was saying and make sure that we show the petitioner that we are taking the petition very seriously indeed. Otherwise, it could drag on for another five years, while draft byelaws here and there in little bits of Scotland are considered instead of national action, which the Government should surely not allocate to others but should take responsibility for itself.

The Convener: We seem to have come to a hybrid position. We are closing the petition but sending the biggest letter of suggestion to the Scottish Government in so doing. We might normally have done that if we were keeping the petition open. Notwithstanding that, we do not expect that there is a lot that we can do in this session, but we want to highlight the issues to the Scottish Government.

I hope that the clerks have been able to discern from that a course of action with which we can proceed. Is that acceptable to members of the committee?

Members *indicated agreement.*

The Convener: I would only say to Mr Golden that he coined the phrase "circular economy" in the Parliament, and I hope that they are the last two words that he says before he departs the chamber in 2026.

I thank Mr Mountain.

Mental Welfare Commission (Duty of Candour) (PE2176)

11:21

The Convener: The next of our petitions is PE2176, lodged by Warren Mitchell, calling on the Scottish Parliament to urge the Scottish Government to introduce penalties for organisations that fail to comply with Mental Welfare Commission recommendations in relation to duty of candour.

The petitioner submitted the petition after the tragic loss of his wife. He believes that there were organisational failures surrounding the circumstances that should have been addressed. The petitioner believes that the Mental Welfare Commission lacks the necessary powers to take organisations to task when recommendations for improvement are not actioned.

The Scottish Government's response to the petition highlights that the Scottish mental health law review recommended strengthening the commission's powers. The suggestions included that the legislation should include a level of direct accountability to the Scottish Parliament. That would include the power to make a report to Parliament if there is a serious failure by a public body, including the Scottish Government, to follow a recommendation. The review also recommended that the MWC should have the power to initiate legal proceedings to protect the human rights of any person or group that is covered by mental health and capacity law.

The response notes that the Scottish Government previously considered whether the legislation should be amended to include sanctions or penalties against organisations that fail to comply with the law, but it concluded that legislation is already in place that would hold organisations to account, if it was deemed necessary. The Scottish Government is therefore not minded to amend the regulations or the overarching legislation to include sanctions or penalties. The submission also points out that health professionals are subject to professional standards relating to their own profession, and that they can be subjected to an investigation and disciplinary action from their own regulatory body should they be found to be in breach of their obligations.

The Scottish Government states that it will consider strengthening the powers and responsibilities of the Mental Welfare Commission within the context of a wider long-term reform to mental health law.

This is a petition that has been motivated by tragic personal circumstances, and where we can go is identified for us.

David Torrance: Would the committee consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government considered whether the legislation should be amended to include sanctions or penalties against organisations that fail to comply with the law and concluded that legislation is already in place to hold organisations to account, and that it will consider strengthening the powers and responsibilities of the Mental Welfare Commission within the context of a wider long-term reform to mental health law?

The Convener: There is a process under way, and it would be open to the petitioner to come back in the next parliamentary session, depending on progress in relation to aspects of the issue that have been raised. However, that is when these matters are most likely to be addressed. Are colleagues minded to support Mr Torrance's proposal?

Members *indicated agreement.*

The Convener: We will close the petition but, as I say, we will write and encourage the petitioner to bear in mind the responses that we have received.

Mobility Services (Funding) (PE2177)

11:25

The Convener: The final new petition today is PE2177, which was lodged by Jordon Anderson. We considered another petition of his earlier. The petition calls on the Scottish Parliament to urge the Scottish Government to provide sustainable funding to organisations that provide mobility equipment. The petitioner says that mobility services are vital for access to shops, services and community life. His view is that, without secure financial support, such services face closure, putting equality, mobility and inclusion at risk.

The SPICe briefing explains that the funding of ShopMobility schemes varies by location, with funding coming from local authorities, health boards, charitable donations and grants. The briefing notes that there have been reports in recent years about ShopMobility centres having their funding cut or reduced by local authorities or health boards.

The Scottish Government's response states that local authorities are independent corporate bodies with their own powers and responsibilities and they are entirely separate from the Scottish Government. It states that it is up to individual local authorities to manage their day-to-day decision making and allocate the total financial resources that are available to them based on local needs and priorities.

Do members have any comments or suggestions for action?

David Torrance: I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government has not indicated that it will provide specific funding for the provision of mobility equipment, that it is up to individual local authorities to allocate funding to address local needs and priorities, and that the committee

has limited time remaining this session to progress the issues raised in the petition.

The Convener: Are Mr Torrance's suggestions sensible? In this instance, when we write to advise the petitioner of the position, the obvious question that could be raised with the Scottish Government is how, in light of reduced access to mobility equipment because of inadequate funding, people who have mobility issues can fully participate in their lives and communities in Scotland. However, we could consider that in the next parliamentary session. Are we agreed?

Members *indicated agreement.*

The Convener: I do not want to disappoint Paul Sweeney if he has arrived to discuss the petition on the personhood of rivers but we have just come to the end of our proceedings, having already done so, I am sorry to say.

That brings us to the end of the public session.

11:27

Meeting continued in private until 11:30.

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