HEALTH AND SPORT COMMITTEE

Wednesday 30 January 2008

Session 3

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HEALTH AND SPORT COMMITTEE
4th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Robert Carlson (University of Edinburgh)
Michael Clancy (Law Society of Scotland)
Dr Martin Donaghy (Health Protection Scotland)
George Jamieson (Law Society of Scotland)
Ranald Macdonald (NHS Scotland Central Legal Office)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Emma Berry

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 30 January 2008

[THE CONVENER *opened the meeting at 10:02*]

Public Health etc (Scotland) Bill: Stage 1

The Convener (Christine Grahame): I welcome everyone to the fourth meeting in 2008 of the Health and Sport Committee. I remind all members to ensure that their mobile phones are switched off—I had better check whether I have switched mine off, because I do not think that I have. Apologies have been received from Rhoda Grant, who has suffered a family bereavement. I welcome to the meeting Dr John Curnow, who is our special adviser on the Public Health etc (Scotland) Bill.

Under agenda item 1, we will hear from three panels of witnesses, each of which will give evidence on a different aspect of the bill. I welcome the medical director of Health Protection Scotland, Dr Martin Donaghy, who attended our round-table evidence session a few weeks ago. I understand that, with Dr Donaghy, we will look specifically at part 2, "Notifiable diseases, notifiable organisms and health risk states". I refer members to the helpful submission that Dr Donaghy has provided us with, which expands on points that he made previously. Unless Dr Donaghy wishes to make some introductory remarks, we can move straight to questions.

Dr Martin Donaghy (Health Protection Scotland): I would just like to say that although Health Protection Scotland is part of the national health service, we also provide advice to the Scottish Government and have been involved in the preparation of the bill and the provision of advice on it.

The Convener: I invite questions from members.

Ross Finnie (West of Scotland) (LD): I do not know whether the notification periods for practitioners and for persons who operate in laboratories are reasonable. My two medical colleagues who are sitting—not immediately—to my right no doubt know about such matters. In your submission, you say that three days is an adequate period to facilitate the taking of effective action. You make no comment on the longer period for notification that the bill gives laboratory directors.

I accept that the bill contains a provision whereby if there is a belief that there is a need for more urgent notification of a case, such notification should be provided but, for the benefit of the committee, will you explain the basis on which, for notification, three days are afforded to medical practitioners and 10 days are afforded to directors of laboratories? Will you guide the committee on whether, in your professional experience, those periods are adequate, and why?

Dr Donaghy: The key parameter to determine is the risk to the public. The primary purpose of public health action is to prevent more people from being exposed to a hazard to which it is known a number of people have already been exposed. The first period relates to the requirement on a clinician to notify a public health agency of a risk of a notifiable disease. By the time someone who has an infection presents to a clinician, they will have been exposed to the germ, which will have entered their body, brewed up within it and started to cause damage to it. That illness will have led to the patient presenting to a doctor. There is a gap between someone being exposed to infection and their coming forward.

When it comes to reducing the risk to the public and preventing further cases, the more quickly we can act after the initial exposure, the more effective we will be in preventing further exposure. If someone with an infection presents to a doctor and we let notification of the case slip, we will be even further away from the initial exposure to the germ. For many notifiable diseases, we need to curtail the lag between a patient going to the doctor and the disease being notified to a public health agency. With most such diseases, we would like notification to take place within hours, and certainly within three days. If the lag period goes beyond three days, it is more difficult for us to understand the circumstances in which the person was exposed and to intervene to prevent further exposure. I do not know whether that clarifies matters.

Ross Finnie: I must press you a little. You have explained to me the need for a degree of urgency when medical practitioners notify a public health agency of a notifiable disease. I would also like you to address the longer period for notification that directors of laboratories will have under the bill. You have given me a clear explanation of the gap between a person being exposed to an infection and their developing some form of symptom and presenting themselves to a medical practitioner but, with respect, you have not explained why the standard that is set in section 13 is three days.

Although you say that the bill will place on a medical practitioner the responsibility to notify earlier in the process if they think that that is

necessary, the standard that is set in section 13 is three days. I agree that the decision is arbitrary, but it tends to be better if such decisions are taken by experts such as you rather than by politicians such as me. Given the urgency that you have said is necessary, I seek guidance on why three days is a reasonable period for section 13 to impose.

Dr Donaghy: I think that I have clarified the need for us to be able to take action as soon as possible after the initial exposure.

Ross Finnie: I do not dispute that.

Dr Donaghy: When you consider the three-day notification period after detection by a clinician, you must consider the fact that there has already been a lag, which, depending on the incubation period of the illness, can be up to five or 10 days. Depending on the illness, people can be infectious—particularly for person-to-person spread infection—during the incubation period and in the immediate period after they are symptomatic. If we wait longer than three days and the person is infectious, they are capable of spreading the illness to others and therefore of increasing the number of people who have been exposed.

Three days is enough time to detect the illness, investigate the circumstances in which we think the person has been exposed and decide on an adequate intervention to prevent exposure—advice to the patient, immunisation or antibiotics. If we wait longer than three days, our chances of making an effective intervention diminish. The three-day period is arbitrary, but if diseases are notified after more than three days we do not have sufficient time to investigate the case, work out how the person has been exposed and provide a public health intervention to prevent further spread. Three days is the period that we estimate we need—for most illnesses—to be fully effective in our investigation and intervention to prevent further spread.

The Convener: I was going to let Richard Simpson come in on the three-day issue, before Ross Finnie moves on to laboratories.

Ross Finnie: I want Dr Donaghy to talk about the 10-day period in laboratories, but I am happy for Richard Simpson to pursue the three-day issue.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): We are in a relatively new situation in relation to severe acute respiratory syndrome, the possibility of avian flu pandemics and cases such as the E coli outbreak, when immediate notification is required. It seems to me that section 13 does not differentiate between common diseases such as measles, mumps and rubella, for which the relevance of reporting is for future statistical information, and those for which the earliest possible notification is crucial.

At least part of the point that Ross Finnie is making is that the bill does not distinguish sufficiently between the two types of disease. He is not saying that three days is okay or not okay. Surely there should be a much stronger statement in the bill that if a medical practitioner has a case of potential avian flu caused by human-to-human transmission, they must inform immediately. Schedule 1 lists the common diseases—such as the three I mentioned—and much rarer conditions in relation to which the danger of transmission and the importance of notification are stronger. Is the bill written clearly enough to reflect the current situation?

Dr Donaghy: It is. Last year, there was an upturn in measles, which was probably related to the problems that we have had with MMR vaccination. I will give an example. A cluster of measles impacted on a nursery in west central Scotland. Once we knew about the case, we needed to work out where the child had been, who the other children in the nursery were and whether any of them was particularly vulnerable because they had special needs and so on. If we had not received that information until three days after the doctor had known about the case, our chances of investigating it, going to the nursery, working with the nursery management and working with the local general practitioners to deliver immunisation to the children in the nursery, would have been reduced and our response could have been relatively ineffective.

I do not adhere to the principle that you are outlining: that a three-day period is not sufficient, or that we can be more lax, as it were, when it comes to diseases such as measles. Measles can be a severe illness, particularly when it impacts on children with special needs. We would obviously like to know about avian flu as quickly as possible.

If, with regard to the three-day provision, you are proposing to distinguish in statute between certain diseases, my response is that I do not know whether we can differentiate in statute between conditions about which we need to know immediately and those about which we need to know within three days. I would prefer to have in section 13(2) wording such as “no longer than three days” and to work with the profession to try to get over the message that we need to know about certain conditions immediately. For example, we had a case over the weekend of suspected viral haemorrhagic fever in a chap who had been in Angola. We knew about the case within hours, which shows that the system is working.

For routine practice and for the sake of clinicians, we need to put wording such as “no more than three days” into section 13(2). Indicating in the bill that that time limit should be

reduced for certain cases would just add another level of complexity.

10:15

The Convener: I think that Dr Donaghy is indicating that, if possible, notification should be made earlier in certain cases. Would it be possible to include after "must" in section 13(2) that notification should be made as soon as practicable and at least before the expiry of three days? The words "as soon as practicable" could cover urgent cases. Would such an amendment of section 13(2) cover what you suggest?

Dr Donaghy: Yes, but I would not like to see two different lines on the time aspect in section 13(2).

The Convener: But the section should state that the notification period should be no longer than three days?

Dr Donaghy: Yes.

The Convener: Would that satisfy Ross Finnie?

Ross Finnie: I accept that section 13(3) states:

"Without prejudice to subsection (2)",

which implies that notification could be made sooner than three days, but section 13(2) sets the standard time at three days, so the interpretation of urgency would start at three days and then work back. Given all the other evidence that we have taken, and given today's techniques, we are trying to accelerate the process. I do not for a minute suggest that the limit should go beyond three days; I was inviting Dr Donaghy to justify the limit of three days and suggesting that, in the modern situation, it is a rather long period.

Dr Donaghy: I think that it can be, as my examples have illustrated. The convener's proposed wording could cover that and tighten up the provision.

The Convener: Given the wording in section 13(3), perhaps it would just be a matter of turning the wording round for section 13(2).

Dr Simpson: It might be better if section 13(2) said that notification should take place as quickly as possible—without a requirement to justify the urgency. It could say that written notification should be provided within three days because the urgent cases can be notified orally. That is the crucial point: a health board will want to hear orally about a serious case as soon as possible.

If I had a case of measles in a nursery but it was the only one in my practice, I would not regard it as urgent, but six GPs may have one case from that nursery. If I phoned or e-mailed the health board to notify it of my case of measles, that would allow the board to see the general situation more quickly.

Dr Donaghy: I agree with that, but I do not agree that having only one case of measles would not be a matter for us. Our threshold for action is probably slightly lower than that for a GP.

The Convener: We will move on. I think that we can raise the point under discussion with the minister. Ross Finnie has a point on the reference to "10 days" in section 16(2).

Ross Finnie: Section 16(2) has a provision that is equivalent to that in section 13(2), but it is for laboratories, and the test is set at 10 days. That means that section 16(2) runs into the same argument that I adduced earlier, which is that if the test is 10 days in someone's mind, their interpretation of what might be reasonably expected of them in a more urgent case would work back from the limit of 10 days.

You explained the reason for the three-day provision in section 13(2), Dr Donaghy. Why, according to section 16(2), should a laboratory that is aware of a case of disease that poses a potential risk to public health have a 10-day limit in which to notify that risk?

Dr Donaghy: For clarification, most NHS laboratories have a doctor or clinician and a clinical microbiologist working in them, so if there were an urgent case, such as a meningococcal infection—a severe form of meningitis—we would expect section 13(2) to apply to clinicians working in a laboratory.

The notifiable organisms provisions in section 16 mainly cover instances when we need to know about the presence of organisms associated with cases of infection for reasons of broader surveillance, looking at trends over time and looking at clusters—that is, the spatial distribution of cases in the country.

The two provisions overlap, but they are for slightly different purposes. When we are estimating trends and looking at spatial distribution, the urgency to act is of a lower grade than when we think there is an urgent risk to public health, which is covered by the provision on notifiable diseases. However, there is still some time pressure on us to estimate trends, report on them and get a broader picture of what is happening with a particular infection in the community.

The differential in the standard is meant to echo the different functions of the two provisions: one is about the need for clinical notification, to ensure that we take urgent action; the other, on notifiable organisms, is to ensure that our broader surveillance function is timeous and provides an overview of the trends and distribution of cases within communities and throughout the country as a whole.

Ross Finnie: I really do not understand this. The bill is designed to deal with potential public health issues; it is meant to cover not individual cases of disease but the threat to the wider population. This is not about best practice. No one on the committee is suggesting that people who work in laboratories or clinical situations are not capable of exercising judgment. We are dealing with a proposed law to set out, with clarity, the obligations on people to notify where they have notice of a disease and where a laboratory has identified a notifiable organism. If a notifiable organism is something that a wider range of public health people ought to be told about so that they can take a view as to whether to put in place preventive steps—or take the steps that might be necessary if that organism exhibits itself in the population—I am still at a loss to understand why the standard to be set for that period of notification is 10 days.

Dr Donaghy: The point that I am trying to get across is that the two provisions overlap—

Ross Finnie: I am sorry to interrupt. I am not questioning your professionalism. I understand from your answer that you see no distinction. My problem is that I am trying to examine two separate provisions in the bill.

Dr Donaghy: Okay. If there was a case of methicillin-resistant staphylococcus aureus blood poisoning in a hospital, that would be notified and action would be taken under the previous provision that we talked about; there would be clinical notification by clinicians in the hospital, who would investigate it and take immediate measures—that is covered by the three-day provision.

My organisation operates a surveillance scheme that uses as a tracer for the levels of infection in the hospital counts of MRSA bloodstream infections so that, on a broader scale—within the hospital or the health board or throughout the country—we can deliver policies and intervention and monitor the effectiveness of them in reducing the rate of infection.

The notifiable organisms provision is meant to cover the second, broader, aspect, whereby we need within 10 days to aggregate the information so that we can monitor, through a surveillance scheme, the impact of policies in reducing infection.

The first provision, which is in section 13, is to cover urgent risk to public health; the second, which is in section 16, is to facilitate on-going surveillance and monitoring of infections in the community so that we can take forward policies and interventions to reduce infections on a more global scale. The 10-day reporting standard is to ensure that, for that second purpose, we get the information as timeously as possible to inform our broader surveillance function, so that we can consider whether policies and practices on a global scale are reducing the level of the problem.

The Convener: We can get back to the minister about that.

Ross Finnie: I think that we will have to.

Mary Scanlon (Highlands and Islands) (Con): You say in your submission:

> "There is no guarantee that non-NHS laboratories will participate voluntarily in notifying the isolation of pathogens signifying a public health risk."

Why do you say that there is no guarantee, given that section 17 says that failure to notify is an offence? Why do you not have the confidence that is stated in the bill?

Dr Donaghy: I do have the confidence that is stated in the bill. My comments in the submission refer to the current voluntary system in the NHS, under which laboratories report to us to monitor broad trends of infection in the community. It is working well in Scotland, but some of my colleagues have questioned the need to move from a voluntary scheme to one that is underpinned by statute. One of the reasons we need to do that is, as we are seeing in England, that there is now a broader range of health-care provision, either paid for by the NHS or which people access through private means. That greater provision engages non-NHS diagnostic laboratories in the diagnostic process and in isolating organisms. Therefore, any voluntary scheme in the NHS might not cover the whole range of diagnostic testing, or the reporting of notifiable organisms, that is being done in the country. One of the arguments for a statutory arrangement is that, given that greater variety and provision of health care, it would be useful to underpin it with some sort of statute.

Mary Scanlon: I understand that, but you are saying that there is no guarantee that non-NHS laboratories will participate in notifying organisms.

Dr Donaghy: Yes.

Mary Scanlon: So you are saying that, even though it will be an offence not to notify notifiable diseases, you do not have confidence that the bill is strong enough to ensure that non-NHS laboratories will notify voluntarily?

Dr Donaghy: I am not saying that. As an example, we are in discussions with private sector providers of health care about providing information on MRSA. The current situation is that there is no guarantee that laboratories will participate, but the bill will give us that guarantee.

The Convener: There is no definition in the bill of diagnostic laboratories, so we are talking about

any diagnostic laboratories. I think that that is the point, Mary.

Mary Scanlon: The point is that I thought that Dr Donaghy's submission, from which I quoted, was based on the bill and not on what is happening currently.

The Convener: Dr Donaghy has made it plain that he refers to the historic situation.

Dr Donaghy: I apologise for any confusion.

The Convener: I was looking desperately in the bill for a definition of diagnostic laboratories, but there is none. Let us move on to Helen Eadie, to whom I apologise for the long wait.

Helen Eadie (Dunfermline East) (Lab): That is okay, convener. Mary Scanlon has stolen my questions so I have had to identify—

Mary Scanlon: I apologise.

Helen Eadie: There is no need; I have another question. I refer Dr Donaghy to what he said in his submission about section 14. You talk about the experience of bioterrorism and you quote the polonium-210 incident in London. You go on to say that the definitions in section 14(7)

"should cover the need to ensure rapid notification in such instances."

You then refer to section 14(6), where you say that

"information detailed in (6) is the minimum required to facilitate effective action by the NHS Board notified."

Did you mean to imply that that provision should be strengthened?

Dr Donaghy: I do not think that it should be strengthened. We are looking for a basic statutory minimum requirement, which is provided for in the bill. Over and above that and depending on the circumstances of any such event, we might wish to collect more information, but it is difficult to cover, in statute, every possibility. We are looking for a statutory provision to give us the basics on which we need to build, and section 14 does that.

The Convener: I must correct myself: my colleagues have pointed me to section 16(8), where diagnostic laboratories are defined. I was looking in the definitions section of the bill earlier and slipped up.

10:30

Ross Finnie: According to the recommendation in Dr Donaghy's submission, that should be redefined.

The Convener: We are going to deal with that.

Michael Matheson (Falkirk West) (SNP): Your submission suggests that the definition of diagnostic laboratory in section 16(8) should include

"laboratories carrying out tests on samples of food and/or water".

The definition in the bill seems fairly clear. However, should I understand from your suggestion that there are distinct types of laboratory—for example, those that will carry out tests on food and water but which might not necessarily perform diagnostic test functions for human infections?

Dr Donaghy: That is correct. The definition is clear, but my point is that it covers only tests on humans. For public health purposes, we often need to know about tests on other types of specimen, particularly food and water, so that we can take action.

For example, with regard to food, there was a recent episode involving chocolate in which we became aware of the risk to public health because of tests that identified salmonella in specimens of chocolate. If we had not known about that, we could not have intervened to prevent further cases of infection. I am aware that the testing of food and notification of results are covered by food safety legislation, but currently that legislation does not provide for notification for public health purposes.

I wanted to bring to the committee's attention the fact that the bill might provide opportunities for the definition to be extended to cover other types of laboratory and testing in which we need to know the results so that we can take action.

Michael Matheson: That is a helpful explanation.

Section 16(8)(a) and section 16(8)(b) appear to give a wide-ranging definition of the director of a diagnostic laboratory. However, you suggest that that definition should be amended to include scientists and senior managers. Are they not encapsulated in those two sections?

Dr Donaghy: In my view, there are certain laboratories whose operations would not be covered. For example, there are scientists who run laboratories and who have professional qualifications similar to those of a doctor, so it is possible for a laboratory to be run by scientists without any doctors being present. In that case, there is no one mentioned in section 16(8)(b) to whom a doctor could delegate that responsibility, because there is no doctor.

People in different positions in the NHS are increasingly being drawn from a wider range of professional disciplines, and it is entirely possible that, in 20 or 30 years' time, a great many laboratories inside and outwith the NHS might not have a doctor working in them. Section 16(8)(a) and section 16(8)(b) therefore do not encompass the range of current or future possible ways of operating a laboratory.

Michael Matheson: That is a helpful clarification. Thank you.

The Convener: I am reminded by our adviser that the British Medical Association made the same points. It is useful for ministers to read such evidence in the *Official Report*.

Dr Simpson: My question is about section 13(6), section 14(6) and section 15(3), all of which are about the information that is required to be notified. Is it necessary for the name, address and postcode of the patient to be provided to the health board in every case?

Section 13(6) and section 14(6) state that the patient's occupation must be notified to the health board only

"if the practitioner considers that it is relevant",

whereas section 15(3) does not include that phrase. There seems to be an omission there.

It seems to me that the person's place of work or school—you mentioned schools earlier—could be important in terms of notification. If we are talking about a nursery school, having that stated might allow you to combine the information. Nothing in the bill requires notification of place of work, or school or nursery school. Do you think that that is an omission?

Dr Donaghy: Your first point was about the patient's name, address and postcode. It would be very difficult to investigate, decide what to do and intervene without such information. If the condition is of sufficient seriousness to be notified, because of the risk to public health, those pieces of information are essential. I cannot envisage circumstances in which we could operate the scheme without such information.

Dr Simpson: One could say that such information does not need to be notified in the first instance, but that the general practitioner, who has the patient's name, address and postcode, could be required to provide it in the event of there being a public health concern.

I am just considering how to protect the patient's rights, such as their right to confidentiality, as against the public interest. It might not be necessary to have notification of the patient's name, address and postcode in absolutely every case. I give the example of rubella. I am not sure that I can think of circumstances in which notifying the name and address of someone with a rubella infection would be crucial. I wonder whether there is a more sophisticated system, which would still allow you to do your job—and allow the board to do its job—but not require notification of such patient information in every case. Would such a system simply be too complicated?

Dr Donaghy: There might be circumstances in which such information is crucial. However, it is very difficult to determine that without having the information—it is a bit of a false dichotomy. We need to know the information to estimate the risk to public health. Without having the information, it would be very difficult to estimate that risk.

Dr Simpson: My second point was that, as far as I can see, there is no requirement to provide notification of school or place of work, even where it could be relevant.

Dr Donaghy: I agree that that could be relevant. That is a fair point, which could be considered further.

The Convener: I note that the NHS identifier, which is referred to in section 13(8), covers various bits of information. Does the NHS identifier provide addresses or information about a patient's GP? What information does it provide about us? I remind Dr Simpson that he is not giving evidence, although he can clarify the matter if he wishes; otherwise, Dr Donaghy can answer.

Dr Donaghy: Do you want clarification on the NHS identifier?

The Convener: Yes. What would my NHS identifier tell you about me?

Dr Donaghy: The NHS identifier is what we now call the community health index number, which is a standard identifier for all patients in Scotland who use NHS services. It has been cleared by the Scottish Information Commissioner.

We find that people change their names and the way that people's names are recorded differs, so there is a need to underpin the identification of a case by having a standard identifier. In particular, it gives us the ability to link with the hospital services or with general practitioners to get additional information. There can be different versions of a surname or forename, spelling mistakes can be made and so on. The presence of the identifier facilitates the investigation.

The Convener: I understand. Is it a bit like someone's national insurance number?

Dr Simpson: It is different.

The Convener: Could you tell, from the CHI number, where someone lives?

Dr Donaghy: You could access their health record, which has an address on it. There is no guarantee that that is where the person lives now, but having the CHI number would make it possible to route an investigation towards that.

Dr Simpson: The NHS identification number is the old number that was used and given to everybody at birth, or after registration at birth. The CHI number is the one that everybody is endeavouring to introduce and use in every setting, including hospitals. For the time being, the

CHI number is supposed to be the prime number that is used. There is a flaw in stating that both the NHS identifier, which nobody uses now, and the CHI number should be used. The convener is right that there is a need for clarification. A general term is needed to describe the number that is in current use for identification within the NHS; at the moment that is the CHI number, but another indicator could be used from time to time. That would ensure that there was flexibility in the primary legislation, but would not commit practitioners to using two numbers, which would be a nonsense.

The Convener: I have corroboration from Dr Donaghy and Ian McKee is nodding, so I have corroboration from two doctors.

Ian McKee (Lothians) (SNP): Section 16 is on the duties on directors of diagnostic laboratories. I want to clarify a point that emerged from your response to Mary Scanlon's question. Your submission states that the proposed legislation will have "no additional impact" on NHS laboratories, but that

"The same cannot be said for private diagnostic laboratories in Scotland."

First, can you say categorically that private diagnostic laboratories in Scotland are not giving information about important organisms in the community? That must have quite an effect on epidemiological studies and so on. Is that the case? Secondly, the list of notifiable organisms that directors of diagnostic laboratories have to identify within 10 days includes organisms such as norovirus, whereas the current advice to people in the community is not even to go near their doctor if they have that condition. What earthly purpose does it serve for someone to have to go to the extent of notifying norovirus? Thirdly, last on the list of notifiable organisms is:

"Any other clinically significant pathogen found in blood".

Who defines a "clinically significant pathogen"? Would that be you, or the director of the laboratory?

Dr Donaghy: On your first point, most private laboratories that undertake human testing in Scotland are linked to the provision of private health care. As I explained in my previous answer, we do not get reports of health-care associated infection in the private sector from those laboratories. We are in discussions with them, which are going quite well. We are trying to draw up a protocol for reporting on the matter, because there is a risk to the public of health-care associated infection. That is the current situation. As I explained, we do not know what the array of provision will be in the future and therefore the current voluntary arrangements should be underpinned by statute.

10:45

Your second question was about norovirus. Norovirus is usually identified by testing a patient when there is a cluster of cases, either in a health care setting or, as is often the case, in a private nursing or residential home. It is important to identify norovirus in order to put in place measures to prevent the virus spreading in a particular setting, whether it is a hospital, nursing home or residential home. If we did not know what the virus was, we would still put measures in place, but the knowledge that it was norovirus would give us added value and allow us to apply those measures more rigorously.

Identifying norovirus in the patient who attends the general practitioner with viral gastroenteritis is not as important as knowing when the virus arises in a health care setting, whether that is in a hospital or private nursing home. It is quite rare for norovirus to be an isolated, sporadic case in the community. Most of the testing for the virus occurs when there is a cluster or outbreak situation in a hospital. We agree with your general point, but we need to capture norovirus in hospital outbreaks because it can lead to the closure of wards and services, and to waiting list cancellations, which means that it impacts on access to health care.

Ian McKee: I want to follow up on that point before you answer the third part of my question. In order to satisfy the public health requirement, is the situation that you describe not covered by the three-day notification period of an infectious disease whereby the practitioner who has the test results must notify? However, you said that the 10-day rule was to allow you to get epidemiological evidence that would not be gathered if the vast majority of cases were not notified. The warning notification would come from the practitioner.

Dr Donaghy: I agree with your point about norovirus. We need to consider norovirus in the context of your point about the 10-day period being for epidemiological monitoring and the three days for action.

With regard to blood infection, you asked who would make the decision to notify. The laboratory director or the lead of the laboratory would do that. From time to time, certain rare pathogens or even commonplace organisms get into blood when they should not be there. Sometimes they are associated with devices that get contaminated by common environmental pathogens; sometimes it is the appearance of a new strain of an organism or a new organism. As a safety net, when someone who runs a laboratory picks up such pathogens in a blood specimen, which is always sterile, they should always notify.

Ian McKee: I am concerned that the provision of information could be variable if individual directors make different judgments.

Dr Donaghy: I accept that variable interpretation by different practitioners in different settings is a risk. We are trying to pick up when something new appears—I have given examples—and that is when the lab should notify, just in case we are seeing a new phenomenon in monitored trends.

Ian McKee: Yet it will be an offence not to notify. How would you deal with that situation?

Dr Donaghy: I agree that that is a problem. The legal provision might have to be tested and considered further. The provision was included to give us a safety net in case something happened. It is not as watertight as the other defined areas. I know that concerns have been expressed. We have tried not to include sexually transmitted infections, because we do not wish to put people off coming forward for testing and treatment. However, it is possible to pick up syphilis or HIV through a blood specimen. That area might need to be reviewed further and tightened up, given the points that you raised.

The Convener: Forgive me if I have missed this in the bill, but is it possible for ministers to designate diseases? Professor Sheila McLean has pointed out that porcine endogenous retroviruses are not on the list and she wonders why.

Dr Donaghy: Technology and science advance. An area that is developing is transplantation, such as xenotransplantation, whereby organs, tissues or cells from animals are put into humans for diagnostic purposes. We also have the phenomenon of so-called health tourism, whereby people go outwith the country, often in desperate circumstances, to get life-saving treatment. The situation is monitored through a group called the national expert panel on new and emerging infections, which is a United Kingdom group that monitors potential new infectious agents coming into the UK population. The current situation is that the viruses that you mentioned are a potential risk, not an actual risk. If, through the risk assessment process headed by the expert panel, they are identified as a risk, we would quickly include them.

The Convener: I put that point to you because it was raised in the briefing from Dr McLean, who cannot be here today.

Dr Donaghy: The matter has been considered a couple of times by UK-wide panels. The viruses that you mention are still considered a potential risk. If the evidence was that they were becoming an actual risk, the provisions would enable us to act on that.

The Convener: I thank Dr Donaghy for his evidence, which was very interesting. The session went on for longer than anticipated, but that is a good thing, generally speaking.

I welcome Dr Robert Carlson, from the college of medicine and veterinary medicine at the University of Edinburgh. Professor Sheila McLean is unable to attend because of illness, so we hope that she gets better soon. I thank Dr Carlson for his submission, which is paper PHB16. Unless you want to speak briefly, we will go straight to questions.

Dr Robert Carlson (University of Edinburgh): The only thing I want to say is that on rereading our submission I was rather embarrassed to see that a few typos had escaped our editorial process. I apologise for those and will send corrections to the administrators.

The Convener: As an MSP who types many of her own letters, I can tell you that I recognise my own typos and sometimes just have to live with them—Tipp-Ex is a great thing. I invite questions from members.

Mary Scanlon: You raise a few points in your submission about the definition of "health risk state"—you seem to be a bit concerned about that phrase. What exactly are you looking for in that respect?

Dr Carlson: I read the bill with the awareness that public health legislation tends to have a long lifespan. The Public Health etc (Scotland) Bill is intended to replace a 110-year-old act. In other jurisdictions, too, public health legislation tends to last a long time.

As I read the bill, therefore, I was thinking of people well in the future who would not have been involved in drafting the bill, and wondering whether the bill's wording could then be used for something for which it was not intended: for example, the introduction of a system such as one that operates to an extent in the United States, which restricts access of unvaccinated children to the public school system. I could not find anything in the definition of "health risk state" that would exclude the legislation's being used for such a purpose.

I wonder, therefore, whether health risk state should be defined as something that must be unexpected, unforeseen or out of the ordinary. I am not a lawyer, so I do not know what the best wording would be. Does something need to be added to the bill that would prevent health risk state from being interpreted so broadly that it could, in the future, be applied to situations for which it was never intended?

Mary Scanlon: That is helpful. In your submission, you also raise a point about the phrase "competent person", as have quite a few people. Under the bill, all actions would depend on the competency of the competent person, so what are your concerns? Poor judgment by the competent person could lead to either under-reaction or over-reaction in a public health

situation. The issue has come up previously in evidence.

Dr Carlson: My concern is that there is no provision for any restriction on who could be defined as a competent person. At the very least, there should be a check and balance that would mean that for anyone exercising authority as a designated competent person—such authority could be wide ranging and interfere in people's lives, and could be damaging if used poorly or without excellent judgment—there should be at least two levels of accountability. The competent person should obviously be accountable under their employer's disciplinary proceedings, but they should also be accountable to a professional body. That situation already exists for doctors and nurses, who are accountable to the General Medical Council and to the Nursing and Midwifery Council, respectively. Such accountability is not specified in the bill for other designations of competent persons.

The existence of two levels of accountability for all competent persons would provide two safeguards; first, there would be a more widely agreed level of professional standards on which they would be accountable and, secondly, in what would I hope be the unlikely event of an employing body acting for its own expediency in asking a competent person to do something that did not match normal practice in their profession, there would be the safeguard of another authority to which they could appeal. They would be able to say that they could not do what was being asked of them as a doctor, environmental health officer or whatever, because to do so would be contrary to the requirements of their professional body.

Mary Scanlon: Given that medical practitioners have a professional body—the GMC—are your concerns about the competent person mainly related to the competent person in a local authority setting?

Dr Carlson: No. I am concerned that the bill says that Scottish ministers can designate, according to their judgment, who is a competent person.

The Convener: Are you referring to the provisions in section 3(4), as distinct from the provisions in section 5, which refer to local authorities? I just want to keep the sections separate.

Dr Carlson: No. My concern applies to section 3 and section 5 because neither specifies further restrictions on who can be designated as a competent person. My understanding of current practice is that a qualified doctor or nurse would exercise the powers of a competent person within health boards, and that the competent person within local authorities would mainly be an environmental health officer. However, as the bill stands, the competent person category could be widened in the future. In 30 or 40 years, other groups of people, whom we cannot foresee, could be designated as competent persons.

11:00

Mary Scanlon: Do you agree that all action that is taken, whether it is over-reaction or under-reaction, is based on the judgment of that one competent person? Do you agree that in scrutinising the bill, we need to focus much more on their accountability?

Dr Carlson: Yes, I agree. Judgment, by definition, cannot be subject to a set of rules and protocols, or we are talking not about judgment but about adherence to rules and protocols. Much will depend on the clinical and professional judgment of who the competent people are. I was not concerned that the bill should specify how to exercise that judgment, because that is inherent in the training and practice of the people concerned. The bill should not, however, give free rein as to who can be designated as competent. Perhaps there should be a minimum requirement that they also be a member of a professional body beyond the immediate employing authority. Whoever exercises judgment under the bill must be professionally accountable for that. They should not be able to delegate the power to someone else.

Mary Scanlon: So, it is really more about the accountability of the person, rather than the specification of who they are.

Dr Carlson: It is about both. It is about accountability and defining who may be designated as being competent. In an avian flu epidemic, for example, there might be a need rapidly to recruit more people into managing the public health response. There has to be some guidance as to who would be a suitable type of professional person to recruit into that process. That is my concern.

The Convener: I am trying to get my head round this. Are you saying that there must be a check and balance on the competent person by some disinterested party or organisation?

Dr Carlson: Absolutely.

The Convener: We do not know how to phrase that. No doubt, the ministerial team can think about it and come up with something if an amendment is required. Perhaps the Law Society of Scotland witnesses, from whom we will take evidence later, will help us out.

Dr Simpson: I have two questions. One is on part 4 of the bill. Section 31(5), which I asked previous witnesses about, states:

"The board need not comply with subsection (3) or (4) where it considers that the risk to public health is such that the relevant action must be taken as a matter of urgency."

That, in effect, means that the health board, or the individual acting on behalf of the health board, is not required to give the person an explanation. I suggested to previous witnesses that that might be going far too far and that, in every case, the individual was at the very least entitled to an explanation. They might have to comply urgently without various niceties being gone through, but removing the nicety of giving them an explanation as to why they are being detained seems to be a step too far.

Dr Carlson: I did not pick that up from my reading of the bill, but I definitely agree that not giving such explanations would be contrary to the openness that seems to pervade other aspects of the bill. I am just having trouble finding your reference in my papers.

Dr Simpson: I was quoting section 31(5), which is on page 20 of the bill. Sections 31(3) and 31(4) set out clearly how people should be treated.

Dr Carlson: The tension that is inherent in a bill such as this is between its not being so prescriptive that we are restricted and cannot respond to unforeseen emergencies, and its protecting all the rights that we are concerned to protect. Would the provision apply to an event such as radioactive contamination, when the urgent need would be to move people out of an area immediately, restrict their movements and provide an explanation afterwards? If that is the kind of situation for which the provision in section 31(5) is intended, could the wording be made more appropriate? For example, it could say, "An explanation must be provided at the earliest practicable opportunity."

Dr Simpson: That wording would be helpful and suitable—it satisfies me.

The Convener: Yes. It sticks out like a sore thumb—unless I have missed something, which is highly likely—that nothing in section 31(5) says that the board must, as soon as it is practicable to do so, comply with the requirements of sections 31(3) and 31(4).

Dr Simpson: My next question is more general. When I was an MSP in the first session of the Parliament, we were beginning the practice of writing on the face of bills their underlying principles. The bill's preamble indicates what powers the Scottish ministers will have and the responsibilities that health boards and local authorities will have, but there is nothing about the responsibilities of the citizen. In your helpful and detailed written submission, you drew attention to the bill's provisions on quarantine; you said that quarantine must be regarded not as a punishment but as a public interest measure. Would it be worth while exploring whether the bill should include a section on the rights and responsibilities of the citizen? Should that be briefly laid out in the principles in the preamble?

Dr Carlson: That question brings into clear focus something that we constantly try to explain to medical students in their training, which is the difference between the ethical ideals to which we aspire, which can be written into a bill's preamble, and the need for the law to prescribe minimum standards below which we must not fall, or sanctions will ensue.

Those who examine the bill from an ethical point of view would welcome anything that spelled out what the ideal response of the conscientious citizen should be in the face of a public health threat. I am not sure, however, because I am not a lawyer, how that would relate to the need to have a set of sanctions available, as the bill has in respect of a person's absconding from quarantine thereby putting others at risk, for example. Those two aspects go hand in hand in a bill such as this. Unless a section on the citizen's rights and responsibilities would complicate the parts that set out the sanctions for falling below the minimum standards, its inclusion would certainly help future generations understand the original intent, if the eventual act lasts as long as the Public Health (Scotland) Act 1897.

Dr Simpson: I was out of Parliament for four years and watched with interest what happened with what we in the first parliamentary session thought were good bills. Some acts went through a court process because we had not made our intentions clear enough in certain sections, which led to difficulties in, for example, free personal care under the Community Care and Health (Scotland) Act 2002.

I do not know whether it would be helpful, for judges who are faced with consideration of legal requirements, to include in the Public Health etc (Scotland) Bill Parliament's intentions on citizens' rights and responsibilities, I do not know, because I am not a lawyer.

The Convener: Before Ross Finnie comes in, I point out to Dr Simpson that, as far as I know, a bill's preamble cannot be amended. I think you suggested that it could include a reference to the duty of the citizen, but we would need to find out from ministers whether that would be competent. In addition, ministers will not have consulted on what would be a substantial alteration to the duties in the bill—the citizen's duties might be implied and so would not need to be written in. We will have to explore that issue.

Ross Finnie: I have a supplementary question on that. It seems to me that there is a distinction to

be drawn between placing a statutory obligation on the citizen, in the general sense—that appears to be the line that we are following—and placing a statutory obligation on health boards or local authorities, which clearly have statutory obligations under the bill. It is right and proper to expect them to discharge such obligations and to demand that they do so.

In the absence of statutory obligations on the citizen, there is, as Dr Carlson rightly said, an ethical question. The aim is not to say that a person has a statutory obligation to render themselves up to the state if they believe that they ought to be quarantined—it is the other way round. We are talking about provision within the law whereby there is an expectation that certain persons will be quarantined because of circumstances, and that if they fail to respond a penalty will be imposed. That is a different matter, because the circumstances have been specified. A general principle is not set out whereby the citizen will be expected to render himself or herself up to the state. It seems to me that two very different concepts in legal provision are involved. With respect to Richard Simpson, I do not share the view that we should statutorily specify such obligations for the citizen. An ethical issue is involved—I understand that—but he is talking about a very different system of law.

Dr Carlson: The argument is complex. If I understand Ross Finnie correctly, he is saying that the bill should primarily be seen as applying to health authorities and local authorities and that it should set out their responsibilities, including responsibilities for providing appropriate quarantine facilities if need be. You seem to be saying that it should only secondarily provide a legal instrument that would apply to the citizen, and that it should apply only to citizens who, for whatever reason, had decided to resist measures that were recommended to them in the interests of public health. Is that what you are saying?

Ross Finnie: Yes, broadly speaking. I am saying that to impose a general obligation is to create a very different form of obligation on the citizen, whose rights and liberties would be severely impinged on by doing so.

Dr Carlson: Most people would agree that, as an ethical principle, citizens have responsibilities alongside their various rights, but I would have to defer to the legal experts on whether there would be a problem if a statement on the citizen's role and responsibilities were included in the bill. From an ethical point of view, it is unquestionable that there will be responsibilities for citizens, but I am afraid that considering where those fit within a legal instrument goes beyond my expertise. I have no disagreement with the general tenor of what Ross Finnie said.

Helen Eadie: You say in your written submission that "the wording is unclear" in section 62, "Absconding from quarantine". You quote section 62(5):

> "the period beginning when the quarantined person absconded and ending when that person is detained in accordance with subsection (1) is to be left out of account."

You are concerned about that subsection, and you make an interesting and important point. You ask whether, if a person absconds during the quarantine period, the period of absconding would be disregarded or whether the quarantine period would be extended when the person returned from absconding. The submission then deals with the punishment of that individual, and illustrates why we should, ethically, keep the two situations separate. What should we do to strengthen that distinction in the bill?

Dr Carlson: I could not understand section 62 when I read it. I will give an example. Say someone who is quarantined for 14 days absconds after five days and then returns to quarantine five days after that. The question whether they have been apprehended or have voluntarily returned is not material. I do not understand whether those five days of absence would not count as quarantine, so the person would have to go through another nine days of quarantine, or whether being absent for those five days would not count against them, so they would have only another four days of quarantine.

11:15

That stimulated me to ask about the purpose of the quarantine. Surely there is a public health purpose to the quarantine and the act of absconding and returning should prompt a review of that purpose by the person who imposed the quarantine. What period of further quarantine would be required to achieve that purpose? The quarantine was not imposed as a sentence; it was imposed to achieve a public health purpose.

Section 62 should have a subsection that initiates a review of the quarantine period by the competent individual who imposed it in the first place. Whether the quarantined person has endangered others and therefore carried out criminal acts is a separate issue, but absconding from and returning to quarantine should prompt a review of the quarantine period so that its initial purpose can be achieved.

Helen Eadie: That is helpful.

Ian McKee: Dr Carlson, I was interested in your statement that we should consider the bill in view of how it could be interpreted later on, perhaps in a way that we might not expect. I will tease that out with the example of organisms that need to be notified by the directors of diagnostic laboratories.

Sexually transmitted diseases have been left off the list—I gather that that is because the Government does not want to inhibit people coming forward for treatment—but it includes

"Any other clinically significant pathogen found in blood".

In view of the fact that that is at the end of the list, would it be possible for a Government, without making any other subordinate legislation or going through any parliamentary procedure, to notify laboratories that it regarded HIV or syphilis as clinically significant pathogens and expected them to be notified to the health board and the common services agency with a name and address? Once the bill has become law, could that paragraph provide an ethical justification for a director of a diagnostic laboratory to notify HIV, syphilis and other sexually transmitted diseases and, therefore, create the fear among people who come forward for treatment that their personal details could be notified to the health board even though they were assured that they would not be?

Dr Carlson: In answer to your first question, it is concerning that there is such a sweeping provision in the bill. I think that I raised concerns about that in our submission. My understanding is that the power for the Scottish ministers to review the list has no timeframe. If a new organism emerged that needed a rapid response, something could be added to the list by an emergency provision—virtually overnight if need be.

Having that catch-all risks reintroducing to the list of notifiable organisms pathogens that it has been decided should be excluded by virtue of the fact that they may stigmatise people or that notification may put them off coming for treatment. There is no clear-cut ethical answer to that problem; some jurisdictions have notification of sexually transmitted infections. The question is more whether the bill could be used in a way in which it was never intended to be used. You have illustrated that point with a pertinent example, according to my understanding of the wording

"Any other clinically significant pathogen found in blood".

That gives too much latitude. As long as there is provision for rapid amendment of the list in the face of a newly emergent, unexpected organism, the protection of public health should be covered. The protection of human rights and confidentiality is perhaps endangered by having the catch-all provision on the list and leaving it subject to the judgment of individual laboratory directors or politicians many years down the line who want to use the bill to monitor HIV more closely, for example.

Does that answer both your questions? I am not sure whether I caught the second one.

Ian McKee: I think that you have answered my questions. As you said, it seems that conditions could be added to the list speedily and openly, so why should we include a catch-all provision? If the bill is passed without the list being amended—by Government or anyone else—might a laboratory director think that it would be a criminal offence not to report everything that could be considered clinically significant, including sexually transmitted diseases, even though the Government's intention was not to include STDs?

Dr Carlson: I agree that that could happen. The bill places what seems to be an undue burden of interpretation on laboratory directors.

The Convener: In your submission, you say:

"The terms 'significant risk' and 'health risk state' seem insufficiently defined".

I do not think that anyone has picked up on that.

Mary Scanlon: My first question was about health risk states—

The Convener: Did we deal with the term "significant risk", as it is used in section 20? [*Interruption.*] I think that I am being criticised from the sidelines; Mr McKee might not get to ask supplementary questions.

Dr Carlson: Are you looking at section 20, "Public health incidents"?

The Convener: Yes. Did you deal with the issue? I might have been distracted.

Dr Carlson: In retrospect, I think that that section is less of a concern, because it allows for the exercise of judgment with respect to proportionality of the risk.

The Convener: You responded to Mary Scanlon's question about health risk states, but did you deal with the term "significant risk", which raises different issues?

Dr Carlson: In response to questions or in the paper?

The Convener: In response to questions. In your paper, you said that the term is "insufficiently defined". Under section 20(1)

"A public health incident exists if—

(a) a circumstance mentioned in subsection (2), (3), (4), (5) or (6) occurs; and

(b) there are reasonable grounds to suspect that the circumstance is likely to give rise to a significant risk to public health."

Under subsection (2)

"The first circumstance is that—

(a) a person has an infectious disease".

Would measles be a significant risk to public health? The issue was raised by medical colleagues.

Dr Carlson: Measles can pose significant risk to an individual and if there were an epidemic there would be significant risk to public health.

When I wrote about the definition's insufficiency, I was wondering whether something could be added to the bill that would give flesh to the concept of proportionality. For example, an additional definition could make it clear that "significant risk" meant that the risk of not undertaking public health action outweighed the harm inherent in, for example, restricting people's movements. I am not sure how such a provision would be worded, but it could be made more explicit that issues of proportionality must have been weighed up with respect to the condition about which action was proposed.

If measles was moving through a school and there were many cases among children who were particularly vulnerable to the disease's effects, the person who would be called to account for their professional judgment would be able to say, "I weighed those things up in deciding what to do." The question is whether "significant" alone would provide adequate guidance in such a situation or whether there should be an additional provision that, in deciding whether something is significant, the proportionate risks of not taking action or taking action must be weighed up by the relevant competent persons. I am not a legal expert, so I cannot recommend the exact wording.

The Convener: Thank you. I wanted to flesh that out on the record, given that you mentioned it in your submission.

Helen Eadie: In relation to section 33, do you suggest an omission from the bill? Your submission talks about the issues when someone is deemed to need disinfection or disinfestation that might be against that person's will. You say that the ethical question arises of whether distributive justice or retributive justice should apply and you appear to say that we should apply distributive justice, so the bill should make the provision that it does not make for giving greater weight to the public health benefit than to the individual's position. Is that what you are saying in relation to section 33?

Dr Carlson: That is not so much my concern there. A general ethical principle in consent is that any competent person can refuse any treatment, even if that is to their detriment or if their doctor thinks that they are exercising bad judgment. In other situations, people experience some compulsion about treatment, as with providing a specimen if they are accused of driving under the influence. People can refuse to do that, but refusal counts as a marker of guilt. Compulsion also applies under mental health legislation, but its application requires the person not to be in a competent state at the time.

My concern relates to the dilemma that a health professional would be in if a fully competent person refused to co-operate with the examination or the procedures that are necessary for disinfestation or disinfection. What ethical situation would such a health professional be in? What would happen should that person complain to the General Medical Council or the Nursing and Midwifery Council that they were in effect assaulted by a person who undertook an examination against their will is also unclear.

One hopes that that situation would be very rare and that most people would be only too pleased to be examined and helped. However, the issue illustrates that the bill's purpose is to protect public health, not to be an instrument to make people have treatment or examinations for their own good—that is a separate issue and the bill should not be used in that way. I do not know whether amendment of the bill to make the position crystal clear is important, but clarification at least is needed of the professional situation for a practitioner who faces a competent patient who says, "I want none of this." Perhaps the General Medical Council would need to be approached for a view on that.

For public health protection, it might be necessary to consider such a patient to have the health risk that is being looked for until such time as they are happy to have it confirmed that they are not in that health-risk state. That would need to be considered if the bill were to be amended.

Helen Eadie: That was helpful.

The Convener: That concludes evidence from Dr Carlson, whom I thank. Ethics and human rights are another interesting aspect of the bill.

I suspend the meeting for a five-minute break, after which we will discuss legal issues.

11:28

Meeting suspended.

11:40

On resuming—

The Convener: We resume our evidence session, and I welcome the final panel: George Jamieson and Michael Clancy are from the Law Society of Scotland, and Ranald Macdonald is a legal adviser at NHS Central Legal Office. I thank you for your submissions. As our five-minute break was rather extensive, we will move straight to questions.

Michael Matheson: I want to pick up on the evidence that was submitted by the Law Society of Scotland on section 27, "Public health investigation warrants". You raise some serious

concerns, particularly on the process of summary application for a warrant by the investigator. You say that the bill provides for a summary application to a justice of the peace, but that there is currently no procedure in the Scottish justice system to do that. Will you explain your concerns and why the summary application provision should be deleted?

George Jamieson (Law Society of Scotland): It can be very easy to misunderstand what a summary application is. It is often thought that it is a simple and speedy process to the sheriff, but that is not the case. It is a formal court action that takes out much of the procedure but leaves in the requirements to have a court writ, to serve the action on a defender and to have a hearing. It is entirely inappropriate to have a summary application as the procedure for a warrant to enter premises in conditions that will normally be urgent. The normal formula in legislation is simply to empower either the sheriff or a justice of the peace to grant a warrant. That means that there is no need to serve, or to consider serving, a court action on the person who will be affected by the warrant.

The situation is similar to that of a search or arrest warrant in criminal proceedings—we do not give people notice that we are going to arrest them or search their premises. In public law, when there has been such a request, it is normally inappropriate to have a summary application. If a warrant is granted and there is a question of compensation, that is another issue.

There is simply no need for a summary application because a warrant could be issued by the sheriff. The person who sought it would go before the sheriff in chambers to explain why it was required, and to take an oath if that was required. The sheriff can then grant the warrant immediately, which cuts out any formal need for a summary application. Justices of the peace are used to granting such warrants in certain statutory contexts but not under summary application, which is a technical term that applies only to the sheriff court. There can be no summary application in the justice of the peace court or before a justice of the peace acting outwith the court—at home, for example.

If an emergency arises and it is necessary for the competent person to enter premises the next day, there cannot be a formal court action. The competent person could go to the justice of the peace or sheriff at home and get the warrant granted there. There is no need for the court action, and there are other legal measures to challenge warrants.

I hope that this explanation makes plain our view that such an investigatory warrant is just a warrant, not a summary application.

Michael Matheson: That is helpful. It would also help to know whether there is an existing procedure in Scots law that could be easily transferred to the bill. You mentioned the process that you think could be used.

11:45

George Jamieson: I think that we could just delete the reference to "summary application" so that the subsection would read:

"The sheriff or justice of the peace may, on application of the investigator, by warrant authorise the investigator to enter the premises".

That would be standard wording. Sheriff Stoddart's book on warrant procedure suggests that any reference to "by warrant" will be understood to mean that a warrant could be granted.

Michael Matheson: The reference to "summary application" seems to be quite a fundamental legal error in the drafting of the bill. What might the draftsman have been trying to do in including the reference to summary application?

George Jamieson: I think there has been a misunderstanding of what a summary application is. The explanatory notes make it clear that the intention is to find a speedy procedure, the need for which I can understand in the context of a bill on public health. However, "summary application" is something of a misnomer, as such an application is not necessarily a speedy procedure. A summary application starts with a formal court writ being presented to the sheriff clerk. The writ is presented to the sheriff, who normally grants a warrant to serve the summary application on the defender. The defender then has 21 days in which to lodge a response. The matter comes back to the sheriff for a hearing, usually around six weeks after the presenting of the summary application to the sheriff court.

The only reason why such applications are described as "summary" is that, after their first hearing, the sheriff can dispense with many of the formal procedures that apply to other actions. For example, the options hearing that occurs with most ordinary actions is dispensed with in a summary application. In effect, many of the formal procedures that take place between serving the action and resolving it by way of proof are eliminated, but the matter is still a formal court action because it must be initiated formally and be resolved by formal proof if there is no agreement. Evidence must be presented and recorded and the sheriff must issue a written judgment. The only reason why a summary application is summary is that the middle part of normal procedure is taken out in order to truncate the procedure. It remains a formal court procedure. Summary applications are used in public law because they have an element

of flexibility. A summary application will generally be used for statutory applications to the sheriff.

Does that make the situation plain?

Michael Matheson: That is helpful. Using such a procedure for requesting a warrant for an investigator to enter a premises does not strike me as being the appropriate procedure, given that explanation.

The Convener: It is helpful to have heard that distinction. The warrant to investigate is to be granted by a JP or sheriff. In what circumstances would a summary application—the procedure for which has been helpfully explained—be used?

George Jamieson: It could be used in a huge number of circumstances—

The Convener: Could we have a few examples for the record to make the distinction clear?

George Jamieson: I will try to give an example in the context of the bill. The provisions on quarantine and detention are useful examples. For quarantine or detention, a first instance application will need to be made to the sheriff.

The Convener: What I am driving at is the 21-day induciae. My understanding is that the person making the application could, if necessary, ask for that to be really truncated.

George Jamieson: In the context of detention or quarantine, the first problem for the sheriff would be to ask, "What do I do in relation to this? Do I order service on the defender or not?" The tension in the bill is—we think: we are not very clear—that the drafter is trying to get at a power of interim detention or interim quarantine. That would mean that, if there were an urgent public health need to have someone detained or quarantined, and no period of service could be allowed because of the public health risk, the sheriff would have a power to order that person to be taken into detention or quarantine immediately without notice being given to the person. There has to be an effective legal measure for such a person to challenge their continued detention or continued quarantine. If there is no such measure, the bill will run contrary to article 5 of the European convention on human rights. It is not at all clear from the bill whether there is any such interim power.

The thinking seems to be—from my understanding of how the bill is drafted—that the summary application was intended to allow the sheriff to order a person's detention or quarantine without a hearing. That was in the drafter's mind because of the provisions for appeal to the sheriff principal. Under the proposed scheme, the sheriff is being asked to grant an order for someone's quarantine or detention without that person's being given prior notice. The only redress that the person has against that is to go to the sheriff principal. Our view is that that is inappropriate and does not fit in with normal procedures. The sheriff should be able to grant power for interim detention or interim quarantine. He could do that when the application came before him in chambers. He could then order the writ to be served on the defender. There would be a further hearing, say, seven days later, and the sheriff would then be able to hear from the defender or his or her solicitor as to continued detention or quarantine.

The Convener: I understand. That is a clear explanation. What I am getting at is the current lack of procedure to allow a sheriff to do that. Is that what you are talking about? Could an existing procedure be adopted for that purpose? Do we need something in the bill?

George Jamieson: Something is needed in the bill because the matter is so fundamental to human liberty. If such a case were to come before a sheriff, the procedure would not be clear: it must be made clear, otherwise it will be left to implication. We might therefore end up with all sorts of appeals to the sheriff principal and the Court of Session to sort matters out.

Ross Finnie: I want to carry that thought forward. Part 4 of the bill is where we start finding references to applications to the sheriff. I am choosing my words carefully and not specifying how or where, but it looks like there is quite a bit of redrafting to be done. There are specific references to appeals in section 58, which makes it clear that rights of appeal start to apply to sections 37 onwards.

As Michael Matheson and the convener have pointed out, you believe that there has been an error in drafting the provisions. I want to ask about something you have not commented on—the applications that are required in sections 33, on medical examination, and in section 34, "Order for medical examination". In effect, the provisions of section 35 come under section 34. Then, we go on to section 36. In each of those sections, an appeal procedure does not appear to be explicitly provided for. As a matter of law, are you satisfied that that is safe in each of those sections?

George Jamieson: Summary applications are a bit of a hotch-potch, generally. We may find that, within one statute, an application will go to the sheriff and there is a right of appeal to the sheriff principal. In another context, there might not be such an appeal right, such as in the Antisocial Behaviour etc (Scotland) Act 2004. We just have to live with that.

Under section 33, the health board may apply to the sheriff for a medical examination order. Under the normal law relating to summary applications, an appeal to the sheriff principal does not need to

be provided for. Normally, there will be a right of appeal anyway. It is a court process—there can be a right of appeal to the sheriff principal.

In some legislation, the appeal procedure to the sheriff principal is regulated by the relevant act. Normally, that is done to lay down the basis on which an appeal can be made—for example, to restrict the appeal to questions of law and not to questions of fact and law, as would be the case if the matter was left to implication. I did not comment on that because the matter is covered by normal procedures. My view is that there is not necessarily a defect in that regard.

Ross Finnie: I will press you on that, if I may. I wholly accept that implicit in any reference to an application to a sheriff is a right of appeal. As you helpfully outlined, that is normally the case. In the bill, there is an appeals procedure under part 4, and a separate appeals procedure under part 5 for appeals against notices under that part. In part 4, an entire section—section 58—is devoted to appeals. By specifying in section 58 the sections to which the appeals procedure applies, I am concerned that we may run into difficulties in interpretation. I have no difficulty in understanding your position—you set it out clearly—which is that the right of appeal is implicit in an application to a sheriff, as long as the application is worded properly. However, I remain concerned that section 58 makes express provision only for certain sections of the bill.

Michael Clancy (Law Society of Scotland): The answer is that the provisions in section 58 relate to exclusion orders and restriction orders and to detention and quarantine orders, which relate to personal liberty. Serious ECHR issues are raised when personal liberty is restrained, restricted or removed. ECHR law requires appropriate judicial oversight, which substantiates our theory that, in the mind's eye of the drafter, there was an anticipation of a quick ex parte procedure under which the sheriff could grant an order and a person could be detained. In order to make the provision ECHR compliant, the bill had to provide for judicial oversight; hence the appeal provision. That is where all this comes from. If there is time before the end of the meeting, we could elaborate on issues of ECHR jurisprudence that we have found in relation to the detention and quarantine provisions.

George Jamieson: I agree fully with that. I also take Mr Finnie's point that if, in a later section, express provision is made for appeal, the implication arises that there is no right of appeal in respect of an earlier section. That is a risk. If the committee wants to make it clear that there is a right of appeal to the sheriff principal, that will have to be included. Appeal is excluded only by necessary implication. Whether that is the case would have to be the subject of an appeal to the sheriff principal—

Ross Finnie: That is what I am trying to avoid. I am uncomfortable about the situation. Michael Clancy explained the ECHR provision, which I would have addressed in any event. I am concerned about a construct that allows the argument to be advanced that the bill makes explicit provision for the right of appeal only in certain sections. Surely that is not a particularly clever construct to have in the body of an act.

The Convener: Let us unravel the position that you advocated, which was that use of the phrase "summary application" is a fundamental error. In terms of the appeal procedure against an exclusion or restriction order—or all the other things—a note of appeal would have to be lodged to the sheriff principal against a decision of the sheriff. Surely, if we unravel it that way, section 58 becomes superfluous. We would have a clear line of hearing: summary application; decision taken; note of appeal and so on. Am I correct that duplication of provisions is confusing?

12:00

George Jamieson: That is confusing—the best policy is always clarity. As Mr Finnie said, if there is any doubt, and the committee is concerned about that doubt, it should be made clear under what sections there is to be a right of appeal to the sheriff principal. That is really a matter of policy, because there is the rule about appeal being excluded but only by necessary implication. You may not want to have a situation in which you are asking whether an appeal is excluded by necessary implication. That could certainly be a concern.

The Convener: I am trying to get back to procedures. You have clarified for the committee that a warrant can go to a justice of the peace—to use colloquial terms, it is an on-the-spot type thing. All other procedures should go by way of summary application, as you have described. There is a possibility of writing in to the bill interim orders for detention and so on, which would then be subject to the full hearing. A party who had an interest in the matter—who might not have been a party to the proceedings to start with—could then come in and appeal by way of note to the sheriff principal on the decision of the sheriff.

George Jamieson: Yes—anyone who is eventually a party to that action can appeal to the sheriff principal by note of appeal.

The Convener: That would deal with section 58, for example.

George Jamieson: Yes.

Michael Matheson: I just want to be clear. Section 66 mentions "appeal by summary application", which from your earlier explanation is another distinct legal process. Are you suggesting that if we had a process of interim orders, rather than having to start another summary process, the appeal would happen, as the convener has expressed, by note of appeal and consideration by the sheriff principal?

George Jamieson: That is right. What we want to avoid is a situation in which, by means of a summary application, the sheriff makes a detention or a quarantine order. Such an order having been made, if someone wishes to challenge it, a separate court action is then initiated against the sheriff's decision to the sheriff principal. That does not happen in practice—there is no need to raise a separate court action before the sheriff principal to challenge the sheriff's decision. If one wishes to appeal, one puts in a note of appeal. There is one court process rather than successive court processes. It is nonsense to have more than one action on a case. There should be one court action and, if there is an appeal, the appeal should be by way of note of appeal to the sheriff principal in that existing court action.

Michael Matheson: Are there any other areas of public law in which there is a process such as the one that is proposed in the bill, in which there is one summary application and a further summary application?

George Jamieson: No. I have a book here about summary applications. There are thousands—or hundreds; it is hard to quantify them—of summary applications. I have never come across the idea that a sheriff's decision would be challenged by a separate summary application to the sheriff principal.

Michael Clancy: George is being too modest—he wrote that book.

Ross Finnie: So he does know.

Michael Clancy: The book is "Summary Applications and Suspensions", and it is published by W. Green.

The matter flows through all the provisions about detention, and variation and extension of detention. In each instance, a person has to apply to the sheriff. In terms of section 66, that means a summary application.

George Jamieson: Can I develop that point? In relation to detention which lasts for three weeks, there is, under the bill, to be a summary application. If it is sought to extend that detention for up to a year, there has to be a second summary application. If the competent person wanted only six months extension, then wanted a second six months to take it to the 12 months, there would be three separate court actions, which would be crazy.

What normally happens is that there is an initial summary application and the Court of Session then lays down rules of procedure that any subsequent application for a continuation can be by means of what is called a minute or motion—an informal procedure within the existing process.

The Convener: I must say that the draftsmen's ears must be burning.

Ross Finnie: Or they will be rushing off to buy a book.

The Convener: Mr Macdonald makes a point about jurisdiction in relation to section 33(2), which states:

> "The board may apply to the sheriff for the area within which the board has its principal office for an order under section 34(1) in relation to the person."

Mr Macdonald, your point was that, in a scattered area such as that covered by the Highland NHS Board, it would be more appropriate to have the procedure in the local sheriff court. Does the provision preclude that? It says only that the board "may" apply to the sheriff for the area; it does not say "shall".

Ranald Macdonald (NHS Scotland Central Legal Office): It would be difficult for health boards to go against the provision as it is drafted, but it would certainly be better to reflect the current rules that an action against someone is raised in the sheriffdom in which they are domiciled. Highland NHS Board is unusual in that it arose from the break-up of Argyll and Clyde NHS Board and has a huge area to cover. If someone was living in Campbeltown, they might have to deal with the Inverness sheriff court, which is 200 miles away—that is heavy going. It would be more hassle for the health board in Inverness to deal with the Campbeltown sheriff court, but it seems only fair that the person who is directly affected by the process should be allowed the opportunity to go to the local sheriff court, instruct local lawyers and so on.

The Convener: And have local knowledge. Thank you—I just wanted to get that on the record.

My other point, which Rhoda Grant would have made had she been here, is on access to justice. There are some draconian measures in the bill. If, for instance, a summary application was made against someone and they wanted to enter an appearance to resist at a hearing, would they have access to legal aid?

George Jamieson: That is one advantage of the summary application procedure. Any formal court action in the sheriff court, such as a

summary application, will allow someone who qualifies on financial grounds to apply for legal aid. As such, there is no need for a special legal aid provision.

The Convener: My attention has been drawn to an issue that members will have seen mentioned in an e-mail from the clerk. Mary, do you want to raise it in particular, or will I ask about it?

Mary Scanlon: I am not sure that it is the same issue—I wanted to ask about legal aid.

The Convener: It is not the same issue, but you can ask your question now.

Mary Scanlon: The Law Society of Scotland submission says that ministers should be given power to allow legal aid in proceedings at the Lands Tribunal for Scotland. You say also that there is no need for an arbiter on compensation, as the president of the Lands Tribunal should be the final arbiter. Will you elaborate on those two points?

George Jamieson: Access to justice was in our minds.

Mary Scanlon: Can you confirm whether legal aid is available for the Lands Tribunal?

George Jamieson: There is legal aid for the Lands Tribunal, but not for arbitration; that is the important point to grasp.

What we are talking about is distinct from summary applications about detaining and quarantining people. It deals with what happens once the investigatory powers have been exercised and loss has arisen—that is financial loss relating to the premises rather than liberty of the person. The bill gives a sheriff or justice of the peace the authority to empower someone, by way of warrant and no hearing, to enter premises. It is important as a counterweight to that to provide adequate measures of compensation if there is loss.

To refer to arbitration under legislation is an old-fashioned formula—there is no legal aid for arbitration. The Legal Aid (Scotland) Act 1986 provides that legal aid is available for proceedings before the Lands Tribunal. Schedule 2 of that act can be amended by statutory instrument. The presumption is that all compensatory proceedings that went to the Lands Tribunal would attract the right to apply for legal aid. However, the Scottish ministers could amend schedule 2 to take that provision out or to allow legal aid only in certain circumstances.

Mary Scanlon: Alternatively, we could follow your suggestion that the Lands Tribunal be given the power to act as arbiter. If the decisions were made by the Lands Tribunal rather than by an arbiter, people would have access to legal aid for the whole process. Is that right?

George Jamieson: Yes. We are suggesting that there be an option. Someone who had been affected might want privacy. Arbitration gives privacy, and it also offers finality. There would be no appeal to the Court of Session. That might be an attractive course for some people. We are advocating that there should be arbitration, but at the option of the person who claims financial loss, who could refer the matter to the Lands Tribunal. We think that that would be the best way to secure access to justice. People would then be free to arbitrate.

We are making the somewhat technical point that people should be able to select the Lands Tribunal as an arbiter, or the president should be able to appoint another person to be the arbiter. The main point concerning access to justice is that there is no legal aid for arbitration but, if someone is given the option to go to the Lands Tribunal, they may have the right to legal aid.

Mary Scanlon: So if the Lands Tribunal deals with everything, rather than an arbiter being brought in, the person does not need to worry about getting legal aid for the arbitration.

George Jamieson: That is correct. It should be borne in mind that arbitration can be a very expensive process for someone who does not have much money. It might be better for that person if they had access to the Lands Tribunal.

Helen Eadie: I was looking at the provisions for the recovery of expenses under section 44. You suggest that there should be a right of appeal to the sheriff against a notice served by the local authority under those provisions. I have no quarrel with that; I think that it is absolutely the right thing to do. That applies in the context of small domestic premises or other small premises.

However, we might also imagine a situation involving bioterrorism at a massive airport, for example. The cost of a clean-up there would amount to hundreds of thousands of pounds. In such cases, the local authority might have the right to impose a condition on the owner—BAA, for instance. There might also be a requirement for the state to get involved in the clean-up operation. It would be essential for the airport to be cleaned up. What are the thoughts of the Law Society on that point?

George Jamieson: It is a question of who will pay for the administrative actions that are taken by health boards or local authorities. It is a matter of policy. If it is felt that the state should be paying in certain circumstances, I am not sure that we can form a view on that.

Michael Clancy: That is not something that we would essay on.

Helen Eadie: But you agree that there is a policy matter around that.

Michael Clancy: Yes.

George Jamieson: Yes. What we can say is that there is a gap in the bill as drafted. There is no provision for the person who has a house that has been disinfected and cleaned. If the local authority says that it cost it £20,000 to clean up that person's house and serves a statutory notice, there is no provision in the bill as it is framed for that person to challenge the notice by way of summary application. That happens in other contexts, however, such as under the Antisocial Behaviour etc (Scotland) Act 2004.

Helen Eadie: There was something in the media recently about people having thousands of pounds of clean-up costs imposed on them following a murder.

George Jamieson: Again, the human rights issue is that such a decision could be made without being subject to challenge. The only way in which that decision could be challenged would be by judicial review in the Court of Session. That is not necessarily an appropriate remedy for a householder, for example. We make the point—as a justice point, really—that someone who is served with a notice claiming money should have the right to challenge it before the sheriff.

The Convener: That is a fair point.

12:15

Ross Finnie: Mr Macdonald's submission points out that section 39, "Application to have person quarantined", provides that quarantine orders require the approval of a sheriff, whereas the matters under sections 37 and 38 may be dealt with by the competent person in the health board. Mr Macdonald's submission raises an issue about whether that is fair and equitable.

While I have the eye of the convener, I want to ask Michael Clancy whether, in his response to that question, he could also take the opportunity to elaborate slightly on what he said previously. He indicated that he had one or two reservations about the consistent application of the ECHR throughout the bill. I think that the committee would welcome further comment on that—

The Convener: Heaven forfend that I stop you in full flow, Mr Finnie, but are you referring to the e-mail that we received about the ECHR implications of the Enhorn v Sweden case?

Ross Finnie: I am, in general terms. Michael Clancy was good enough not to interrupt the flow of the earlier discussion when he indicated that there were ECHR issues. Further comment on that would be welcome.

However, I first ask Mr Macdonald and the other members of the panel to respond on whether it is appropriate that the bill draws a distinction between the provisions in section 39, which require shrieval powers, and those in sections 37 and 38, in which health boards are considered to be sound enough in themselves.

The Convener: Thereafter, perhaps Michael Clancy can deal with ECHR issues generally and also comment on the Enhorn v Sweden case, which I think Professor McLean would have put before us had she been able to attend today. Perhaps Michael Clancy can wrap that issue into his response.

Ranald Macdonald: Let me deal first with exclusion orders and restriction orders. From my reading of the bill, it seems a little strange that a distinction is made between those orders—for which the health board acts as judge and jury in the process vis-à-vis the interests of the individual—and quarantine orders. Application for a quarantine order must be made to a sheriff, who is a separate and disinterested party.

The drafting of the bill perhaps reflects the current procedure whereby local authorities may make such orders at their own hand. However, in drafting a new bill, it seems better to have a consistent format for dealing with the rights and liabilities of individuals. This might not be an issue in dealing with schoolchildren, but I question whether it is right that, in restricting the activities of an adult or a vulnerable adult, the competent officer of the health board should be able to say, "You may not go to your place of work for the next 14 days." The person will have the right of appeal during that period, but that seems a fairly strong process for an individual in a health board to undertake at their own hand. The health board's lawyers will be available to advise the competent officer, but the bill makes no provision for a third party, such as a sheriff, to revisit the process and double-check that the rights of the individual against whom the order is made are properly protected.

The procedure as drafted may be all right for dealing with competent adults, but the people with whom we tend to have to deal in these scenarios are vulnerable adults, such as people living rough, who do not have a complete understanding of the law and of their rights and obligations. It seems a little bit strange that the bill draws the distinction that it does.

George Jamieson: This goes back to the issue of summary applications. Sometimes, the bill requires that an application is made to the sheriff straight away; at other times, the bill allows a public authority to do something off its own bat but provides a right of appeal to the sheriff. From my reading of the bill, an appeal can be made to the

sheriff against decisions initiated by a competent officer. Restriction and exclusion orders may be initiated by the public authority but there will be a right of appeal to the sheriff.

The bill certainly draws a distinction between, on the one hand, exclusion and restriction orders—which are decided on by the public authority in the first instance—and, on the other, quarantine and restriction of liberty orders. We can only guess why that was done. The drafter probably felt that, where personal liberty was involved, taking someone into detention was a more serious step that required to be dealt with by a sheriff in the first instance, otherwise it would not be compliant with article 5 of the ECHR. We are only guessing, but we can see a logical reason for the distinction that was made. However, it is a matter of policy whether the committee thinks that it is more appropriate for all those orders to go first of all before a sheriff for approval, or whether a competent person should have the first decision on the exclusion and restriction orders, subject to an appeal to a sheriff.

The Convener: Keeping off policy, would the procedure be clearer if exclusion orders and restriction orders were also dealt with by summary application, with the ability to have an interim order, as you described?

George Jamieson: It is not that there should be a procedural simplification. Our main concern is that it is clear how something can be challenged.

The Convener: I was trying to get you to answer in a non-policy way and give you a gateway just to say yes to my suggestion.

George Jamieson: Yes. If you want to make it simple, do what you suggested.

Ranald Macdonald: From the point of view of the lawyers who will deal with this, it would be simpler and more practical to have the same process across the board; anything else creates unnecessary difficulties.

The Convener: I was trying to be subtle, but I failed.

Michael Clancy: It is an issue not just for lawyers, but for anyone looking at the statute, whether they are administrators, members of the public or MSPs. We all need clear, simple law and the more of that we get, the better for everyone.

The Convener: Mr Clancy, can you deal with the ECHR implications?

Michael Clancy: I looked at European Court of Human Rights jurisprudence in this area. There are not many cases involving the detention of persons suspected of having been exposed to the kinds of conditions referred to in the bill, with one exception. The case of Enhorn v Sweden, to which the convener referred, sets the standard that the European Court of Human Rights expects of parties to the convention and the way in which legislation works.

I do not know the extent of the e-mail that the committee received from Sheila McLean, but the case of Enhorn v Sweden is relatively recent. It concerned a Swedish national who was infected with the HIV virus and who infected another person with whom he had sexual contact in 1990. In 1995, a county medical officer in Sweden applied to the county court—the Landsraad—for an order for the detention of Mr Enhorn under the Swedish Infectious Diseases Act 1988.

The court made the order requiring the detention of Mr Enhorn. He did not like that and escaped on a number of occasions, so orders to prolong the deprivation of liberty were issued continuously for six-month periods from 1995 until December 2001. In all, he spent about a year and a half in detention. He thought that that was contrary to article 5(1) of the ECHR, so an appropriate action was raised in the European Court of Human Rights, which found in his favour.

The European court was satisfied that there was a basis for detention under Swedish law. However, because there was a limited amount of directly relevant case law, the court said that it was necessary to establish whether the criteria that had been applied in this case were such that the detention complied with the principle of proportionality and was not arbitrary. The court found that the essential criteria for assessing the lawfulness of detention were whether it would prevent the spread of an infectious disease; whether the disease was dangerous for public health and safety; whether the detention was a remedy of last resort; and whether less severe measures had been considered. Those are the kinds of conditions that the European Court of Human Rights thinks ought to be applied in such cases.

The provisions of section 41 of the Public Health etc (Scotland) Bill are about applying to have a person detained in a hospital. Section 41(1) states that the section applies where

"(a) a health board knows that a person …

(i) has an infectious disease; or

(ii) is contaminated; and

(b) it appears … that …

(i) there is a significant risk to public health; and

(ii) it is necessary, to avoid or minimise that risk, for the person to be detained in hospital."

The question is whether that formula meets the criteria of the European Court of Human Rights.

One would want health boards to grapple with certain questions before they used the detention provision. For example, they could consider whether the detention was a remedy of last resort, or whether someone with an infectious disease was a risk to public safety. One would hope that health boards would consider such matters before using the section 41 provisions, but there is no bar that a health board must get over. There is no statutory provision that links the provisions to the thought process that must happen prior to their use, in order that their use complies with the ECHR.

Ian McKee: I have a supplementary question. Section 41(1)(b) states:

"it appears to the board that as a result—

(i) there is a significant risk to public health".

I am a layman with regard to the law. However, is there not a legal difference between saying that something "appears" to be a risk and saying that it is a risk? Would it be a justification for a board to say that something appeared to be a risk? From a layman's point of view, the term "appears" seems fairly weak. Should not a board just have to say that there is a significant risk to public health and then have to prove that?

Michael Clancy: I would prefer it to be clearly expressed that there is a risk.

The Convener: Thank you for putting that on the record. We are nearing the end of taking evidence on the bill and we have lots of things to get our teeth into. It will be an interesting stage 1 report for ministers and others to read. I thank all the witnesses for their evidence.

That concludes the public part of the meeting. We will now move into private session, so members should not leave their seats.

12:27

Meeting continued in private until 12:45.

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