HEALTH AND SPORT COMMITTEE

Wednesday 20 February 2008

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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HEALTH AND SPORT COMMITTEE
5th 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 Sara Davies (Scottish Government Healthcare Policy and Strategy Directorate)
Duncan McNab (Scottish Government Environmental Quality Directorate)
Molly Robertson (Scottish Government Public Health and Wellbeing Directorate)
Shona Robison (Minister for Public Health)
Stella Smith (Scottish Government Legal Directorate)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Emma Berry

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 20 February 2008

[THE CONVENER *opened the meeting at 10:01*]

Subordinate Legislation

Condensed Milk and Dried Milk (Scotland) Amendment Regulations 2008 (SSI 2008/12)

The Convener (Christine Grahame): Good morning. I welcome to the fifth meeting of the Health and Sport Committee in 2008 members of the committee and the Minister for Public Health, Shona Robison, who is accompanied by Scottish Government officials. Neil Rennick is head of the older people's unit and Shaun Eales is a policy adviser.

Agenda item 1 is consideration of a Scottish statutory instrument. SSI 2008/12 is a negative instrument that implements directive 2007/61/EC by amending the Condensed Milk and Dried Milk (Scotland) Regulations 2003. The regulations will amend the definitions of partly dehydrated milk and totally dehydrated milk in the principal regulations.

No comments on the regulations have been received from members and no motion to annul has been lodged. The Subordinate Legislation Committee made no comments on the instrument. Do members agree that the committee does not wish to make any recommendation in relation to the regulations?

Members *indicated agreement*.

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2008 (Draft)

The Convener: Agenda item 2 is consideration of motion S3M-1235 in respect of an affirmative instrument. No comments on the instrument have been received from members of the committee and the Subordinate Legislation Committee made no comments on it. Does any member wish to debate the motion?

Members: No.

Motion moved,

That the Health and Sport Committee recommends that the draft Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2008 be approved.—[*Shona Robison*.]

Motion agreed to.

The Convener: There will be a brief pause while the officials change over. That was an easy beginning to the morning for those gentlemen. I hope that their day continues in the same way.

Public Health etc (Scotland) Bill: Stage 1

10:05

The Convener: The changeover of witnesses was impressive. The clerk's training is paying off.

The Minister for Public Health remains with us for item 3. She is joined by Scottish Government officials: Dr Sara Davies is the medical adviser; Molly Robertson is the bill team leader; Stella Smith is from the legal directorate; and Duncan McNab is from the air, noise and nuisance team. I also welcome Dr John Curnow, the committee's adviser.

I invite the minister to make opening remarks before we ask questions. I intend to take each part of the bill in turn.

The Minister for Public Health (Shona Robison): Thank you. I welcome the opportunity to discuss with the committee the provisions of the Public Health etc (Scotland) Bill and I am pleased that the Scottish Government has taken an early opportunity to prioritise an important piece of legislation that is vital for the future health protection of the people of Scotland. I acknowledge that the previous Administration did much work to develop and consult on the proposals that underpin the bill—I put that on the record.

I thank the committee for the thoroughness with which it has approached a complex topic. You have had a number of informative evidence sessions. The ability to involve stakeholders in the scrutiny of bills is a strength of our parliamentary system and helps to ensure that we pass legislation that is practicable and relevant to the people who must implement and use it. I am glad that all stakeholders voiced their support for the principles behind the bill and for the clarity with which it sets out roles and responsibilities.

I reiterate a couple of important points, to put the bill's provisions in context. Infections cause more than a fifth of deaths and a quarter of illnesses in the world and still account for more than 10 per cent of deaths in the United Kingdom. In 2007, the World Health Organisation said that new infections and

"diseases are emerging at an historically unprecedented rate."

In addition, the world faces greater than ever risks of chemical, biological or radiological contamination, whether by accident or malign act. Scotland is not immune from such incidents, and globalisation of travel and trade means that diseases that were formerly restricted to far-flung corners of the world can reach us in a matter of hours. Only last month there were outbreaks of viral haemorrhagic fever and other serious communicable diseases in sub-Saharan Africa and elsewhere, in countries where many Scots holiday and work. A person can be in such an area one day and back in Scotland the next.

Civil contingency legislation is in place and could be used in some public health situations, but emergency powers are wide ranging and powerful and are designed for use only in extreme circumstances. The bill will allow us to bridge the gap between voluntary compliance with public health measures and the use of more extreme civil contingency powers. It will also ensure that Scotland complies with the most recent international health regulations. The UK Government and the National Assembly for Wales are updating their public legislation along similar lines. Such legislation is also common to a number of European and other countries. It was only due to assertive action in Hong Kong and Toronto, including the use of quarantine, that the severe acute respiratory syndrome outbreak in 2003 did not become a worldwide epidemic.

Legislation must be proportionate to the risks that are posed. People who are infected or contaminated or who are responsible for premises that are at risk usually take voluntary measures to reduce the risk to individuals. However, it has long been recognised that legislation is necessary to address situations in which people do not take voluntary measures or in which public authorities need to step in to apply measures to protect the community at large. The few who do not accept advice or do not comply with restraints have the potential to undermine measures to limit the spread of a serious and potentially catastrophic epidemic.

A balance needs to be struck between our duty to protect the public and the rights of individuals. The bill achieves such a balance. European convention on human rights issues were fully considered in relation to the powers in the bill and we are satisfied that all powers are ECHR compliant. Those powers can be used only in strictly defined circumstances and when the person concerned poses a significant risk to public health.

I am aware that some have asked why "significant risk" is not defined in more detail in the bill. I think that attempting to pre-empt future scenarios, many of which are unknown, would be impossible. We do not want to tie unnecessarily the hands of health professionals, who are trained to risk assess situations and to exercise professional judgment that is based on the circumstances of each case, often as part of multidisciplinary teams. We do not want the bill to jeopardise that flexible approach. I also point out

that, as far as I am aware, existing legislation that restricts individual liberty in some situations has never been abused.

It is extremely important to do nothing in the bill that would unnecessarily or inadvertently undermine the health protection workforce. Committee members have been informed of the proposed content of regulations on the qualifications and experience of people who are expected to undertake the health protection functions that are outlined in the bill for local authorities and health boards. Professional groups have not reached unanimous agreement on professional competence issues, but I am satisfied that we have reached a reasonable balance and developed effective proposals. The draft regulations will of course be subject to consultation and I will consider carefully all the responses before reaching a final decision.

Our decision to work with Ken Macintosh to include provisions to regulate sunbed use has created interest. I am pleased that we can work with members on a cross-party basis to benefit the people of Scotland and I am proud that Scotland is the first country in the UK to propose legislation on the subject. I am now in a position to outline the Scottish Government's proposals so, with the convener's leave, I will say a few words about that when we discuss part 8.

On the workability of the provisions, the Law Society of Scotland has helpfully suggested several changes to the legal processes that are in the bill. I reassure the committee that those issues, which are largely technical, are being addressed.

I am happy to answer any questions. If members require further information after the meeting, I will be happy to provide it.

The Convener: Thank you. The committee would prefer sunbeds to be addressed more substantially when we reach part 8.

We will start with questions on part 1.

Mary Scanlon (Highlands and Islands) (Con): Are we going through the bill section by section?

The Convener: We are proceeding part by part, so we are starting with part 1, which is on public health responsibilities.

Mary Scanlon: My question is about section 3 in part 1. The minister mentioned professional competence issues, which I presume relate to the designation of competent persons by health boards, on which we have heard quite a bit of evidence. The British Medical Association has said that only a person with clinical experience should be a competent person. Other witnesses, such as the General Medical Council, have talked about the need for professional accountability. I listened carefully to what the minister said and I got the idea that the matter is still being discussed and will be dealt with in regulations. Will the minister update us on the designation of competent persons?

Shona Robison: On what the BMA said about qualifications, it might help to make it clear that the Faculty of Public Health of the Royal Colleges of Physicians, which is the professional body that is responsible for setting standards in the public health profession, has recognised that public health specialists need not be doctors if they can show a similar level of knowledge and competency and can meet accreditation requirements that are equivalent to those that the GMC sets for doctors as specialists.

In my introduction, I touched on the working group, which has unanimously agreed on the qualifications and experience for local authority competent persons and for health board competent persons who have a clinical background. Discussion and disagreement have taken place on the training route and the portfolio route. The group's majority view is that individuals who are on the public health register through the training route should be treated the same as doctors and that individuals who are on the public health register through the portfolio route should be able to demonstrate two years' work experience in health protection. The important point is that such people will have to demonstrate their competence through experience.

Following consideration of the outcome of the working group, I have decided to consult on the draft qualifications and experience that are set out in the bill team's letter to the committee dated 6 February. I certainly hold to the established principle that there are people who have the qualifications and competence who are not necessarily doctors, but we will hear back from a number of stakeholders on the detail of the draft qualifications and experience.

10:15

Mary Scanlon: You mentioned local authorities. Would the competent person in a local authority be a trained environmental health officer?

Shona Robison: Yes—with two years' experience.

The Convener: We move to questions on part 2, on notifiable diseases and organisms, and health risk states.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have some general concerns about the recording of sensitive information. Clearly, it is necessary to pass information to the appropriate authority for action to be taken in relation to an

individual. I refer to section 13(6) and section 14(6) in part 2, on page 8 of the bill, where there is a list of various bits of information that are to be collected.

I will comment on two things with regard to that list. As has been suggested to the committee in evidence, it might be appropriate to have the place of work or school actually listed, because if there is an outbreak in a school of a condition that requires action it would be helpful if the notification came from a number of different general practitioners who have patients registered at that school. The board might not be collectively aware that an outbreak is beginning.

The other more general issue is the anonymisation of that information as it is passed up to different levels. A lot of personal information would be passed up to the health board level—I understand that that is necessary, because the board might be required to take action. However, the information is then mostly passed to the Common Services Agency and my concern is that that is not appropriate. I do not want to go on at great length, but we need to consider the anonymisation of data before stage 2 and I refer the minister to the Information Commissioner's Office's supplementary information to the committee, which discusses the interaction between the Data Protection Act 1998 and the information that will be required under the bill. Those two things together need to be examined very carefully to ensure the protection of data. We are well aware that, through no real fault of ministers, data can go missing.

The Convener: I wonder where you got that idea from. Minister, do you want to respond to that?

Shona Robison: That is a very topical point. First of all, I reassure members that the patient's name would not be passed on. The information that would be passed on would be the patient's postcode, occupation, sex and date of birth. I will reflect further on the issue that Dr Simpson has raised about the place of work or school, but the fact that the data are anonymised is important. I am happy to examine his concerns about the CSA. I want to examine the Information Commissioner's Office's supplementary evidence concerning the privacy impact assessment, because that evidence has come in at a fairly late stage and I want to reflect on what it means, what we want to look at and how we take that forward. I am certainly happy to do that before stage 2.

Dr Simpson: The comments about the interaction with the Data Protection Act 1998 should also be taken on board.

I have a second question.

The Convener: Is it on the same issue?

Dr Simpson: It is on very much the same issue; it is on the "NHS identifier" that is mentioned in section 13(8). At the moment, three options are given in paragraphs (a), (b) and (c). The patient's national health service identification number seems to be the primary number, but I am slightly surprised at the ordering. I had thought that the community health index number was now the primary number to be used by all health services, so I thought that it would the one in paragraph (a), with the second and third numbers given as alternatives preceded by the word "or". That would give a focus.

In primary legislation, a more general wording may be required, because from time to time we have changed the index number that is used to identify patients. That might be covered by the phrase "any other number"—

The Convener: Yes, paragraph (c) seems to cover that, but I will allow the minister to respond.

Shona Robison: Section 13(8)(c) refers to

"any other number or other indicator which from time to time may be used to identify a patient individually."

That is to future-proof the identifier, because obviously things may change.

Dr Simpson: Yes, but the primary number is the one given in paragraph (a), which is the national health service identification number. Why is that number given first? If somebody reads subsection (8) and sees that the number can be the one in paragraph (a) or (b) or (c), they—

Shona Robison: It can be any of the numbers. I do not think that the numbers have been ranked; it is just the way that they are listed in the subsection. It can be any number, depending on what is available.

Dr Simpson: I ask the minister and her team to reflect on which number should be the primary number. Any practitioner who reads the list will choose the first number if they can; they will not bother going to the second number unless they have to. The first number given should be the number that the health service and others are primarily using at this point in time.

Shona Robison: Okay, we will take that point on board.

Mary Scanlon: I want to ask about some small points that were raised with us in evidence. For example, the norovirus is a notifiable disease, but over the winter we heard doctors on television telling us to stay at home and not go to our doctor, so that we did not spread the disease. If people with the norovirus are told to stay at home, how can it be an offence for a doctor not to notify?

In a recent document, I noticed that there had been quite a rise in cases of certain sexually

transmitted diseases. How did you come to the conclusion that those diseases should not be notifiable? It would be helpful to have your answer on record.

I also noticed in the financial memorandum the withdrawal of the fee to general practitioners for notifying. I appreciate that it is only £3.50 but if you want co-operation, it would seem reasonable to continue with that.

When giving evidence, others have asked whether there should be a penalty and whether it should be placed on individuals or on laboratories. Should there be a sanction or penalty on people who refuse to comply with the legislation?

Shona Robison: Right. Okay.

The Convener: I should have warned you that Mary Scanlon asks multiple questions.

Mary Scanlon: There were only four this time.

The Convener: She operates on the principle of asking all her questions at once just in case she does not get back in later.

Mary Scanlon: I did not suggest that that might happen.

Shona Robison: Sexually transmitted infections are obviously notifiable through other means such as genito-urinary medicine clinics. When considering whether it was appropriate to include infections in the legislation, we had to consider how they are transmitted. We did not think that it was appropriate to include STIs. That is not to say that we do not take very seriously the rise in sexually transmitted infections, but we are dealing with the issue in another way.

You asked a number of other questions.

Mary Scanlon: I asked about the norovirus.

Shona Robison: I ask Dr Davies to answer that point.

Dr Sara Davies (Scottish Government Healthcare Policy and Strategy Directorate): As Mary Scanlon says, the issue of norovirus has been raised before. Norovirus is the organism; we are asking for not the disease but the organism to be notified. As Dr Donaghy of Health Protection Scotland has said, we are interested in surveillance so that we can capture instances.

Again as Mary Scanlon says, people with norovirus are advised to stay at home. However, when outbreaks occur in hospitals or in home-care settings such as residential homes, people are at home already. They get sick and specimens are taken because we need to know what is going on. That is why it is the organism and not the disease itself that is mentioned.

Mary Scanlon: So if, for example, a general practitioner was aware of an individual who had the norovirus and was told to stay at home, that GP would not have a responsibility to notify the health board.

Dr Davies: No, because the responsibility would be on the laboratory to report the organism to us, not on the GP to report the disease.

Shona Robison: On fees, the majority of current payments relate to the notification of chicken pox and food poisoning, which will no longer be notifiable under the bill. Any current problems with levels of notification are more to do with the number of unnecessary diseases on the list and a lack of awareness about the system, which is outdated. Notification should be undertaken as part of the general duty of care on GPs or medical practitioners. They do not always claim fees at the moment anyway so, although the BMA raised the matter, generally speaking it has been a small issue, and we do not believe that the withdrawal of fees will have any impact on the bill's workability.

The Convener: What was your last point, Mary?

Mary Scanlon: Should there be a penalty on a laboratory or a GP for not reporting a notifiable disease or organism?

Shona Robison: There is a penalty.

Dr Davies: We have left the imposition of penalties for a general practitioner's failure to notify to professional regulation. The General Medical Council requires all doctors to exercise professional accountability. Therefore, if a doctor does not report a notifiable disease, the health board will probably come to know about it and it will be a professional accountability issue. It will stay in that setting.

For laboratories, there is a penalty because organisms can be reported and we have said that it will be an offence if laboratories do not report.

Michael Matheson (Falkirk West) (SNP): I will make three points on section 16, which is to do with notifiable organisms. The section places the responsibility for reporting a notifiable organism on the director of a laboratory. Health Protection Scotland raised some concerns about that in its evidence to the committee. The bill defines the director of a laboratory as a

"clinical microbiologist, consultant pathologist or other registered medical practitioner".

However, Health Protection Scotland highlighted the fact that some private laboratories are led not by individuals within those professional groupings but by other scientists. It is also likely that, in future, we may find that other clinicians who do not fall within that definition are directors of

laboratories. Therefore, it is suggested that we revisit the definition to ensure that we include the scientists and senior managers of such laboratories so that, in future, we do not find ourselves limited to the definition as it stands.

Shona Robison: We will reconsider the definition for stage 2 because we have taken on board some of the points that you made. I hope that you will be satisfied when we come back to the issue at stage 2.

Michael Matheson: That is fine.

My second point relates to the 10-day period in which notification must take place. Concern has been raised about when exactly the clock for that starts ticking. It has been highlighted to the committee that, often, when a sample is analysed, a presumptive result and then a confirmed result are obtained. The time between those two results might be fairly limited, but it has been suggested that the clock should start ticking at the first one so that early action can be taken. Should that aspect of the bill be amended to clarify when the clock starts ticking for the 10-day rule?

The Convener: Which section is that, Michael?

Michael Matheson: It is section 16(2).

Shona Robison: At the moment, laboratories report organisms on a weekly basis and the period of 10 days is allowed in order to cover weekends. Again, that is in line with the duty on registered medical practitioners and lab staff to notify the relevant health board by telephone as soon as practicable, if there is an urgent need to do so. It is possible that the point at which the clock starts ticking might need to be tightened up. Dr Davies might have something to say on the matter.

10:30

Dr Davies: You are right to say that there is a difference between an organism being identified and that identification being confirmed. We want to ensure that we strike a balance. The expert working group on laboratory directives said that 10 days was a workable period. For example, in the case of meningitis, one would see an organism under a microscope but one would need a further few days finally to confirm which organism it was. The time between when the organism is defined and when it is reported needs to be practicable.

Michael Matheson: Section 16(8) deals with laboratories that perform diagnostic tests for human infection. Health Protection Scotland has suggested that other types of laboratories that conduct certain types of tests, such as tests relating to food and water, should be included in that provision. Would you consider extending the definition in section 16(8)?

Shona Robison: We are consulting the Food Standards Agency on those issues and we will give the matter further consideration.

Ian McKee (Lothians) (SNP): You will be pleased to hear that I have only one question.

Included at the end of the long list of notifiable organisms on pages 68, 69 and 70 of the bill are the words:

"Any other clinically significant pathogen found in blood".

It is quite clear to a director of a laboratory that if he or she finds yersinia pestis, notification must be made, but the words "clinically significant pathogen" suggest a degree of clinical decision making by the director or someone else. The concern has been raised in evidence, and by the Subordinate Legislation Committee, that if those words remain problems could arise if, for instance, a conference of directors of laboratories decided that chlamydia or HIV should be reported in future. If reassurance is being given to people with certain sexually transmitted diseases that confidentiality will be maintained but the director of the laboratory feels that he or she has an obligation to report certain organisms when they are found, that understanding will be broken.

Another problem relates to the fact that a director of a laboratory who is aware that there is a risk of a criminal offence if an organism is not reported might err on the safe side by reporting every organism that could be considered to be clinically significant.

As you can add organisms to the list at fairly short notice, will you consider taking out that last line?

Shona Robison: Ian McKee has identified an important issue.

The expert working group that developed the list considered that it would be wise to include the words so that public health professionals could be alerted to any new risk. That was the thinking behind it, but we acknowledge that the description is wide and could include organisms that might not be worth reporting and, indeed, the sexually transmitted infections that Ian McKee referred to.

Despite the best efforts of the bill team, it has proven difficult to devise an alternative description, particularly one that is legally sound—the fact that there is a criminal sanction for non-reporting means that we have to get this right. It would not have been appropriate to use guidance to interpret legislation on such a matter. In the light of that, and following the reservations that have been expressed, we have agreed to remove, at stage 2, the final statement.

I would like to reiterate a point that Ian McKee made: the regulation-making power in section

12(3) would allow additional organisms that met the criteria for notification to be added to the list relatively quickly, so there is a safeguard. I hope that that response reassures Ian McKee.

Ian McKee: Thank you.

The Convener: I will let Richard Simpson in, as his question is on the same issue.

Dr Simpson: You have limited the provision to blood. Should it not include any other sterile solution, such as cerebrospinal fluid? That is unlikely to be involved, but it might just happen—and we want to cover the bases.

Shona Robison: I ask Dr Davies to answer that.

Dr Davies: The intention behind the provision was to limit it to sterile areas. We considered that it was just blood that we needed to look at initially because of the blood-brain barrier. We found it impossible to devise a legally sound alternative definition that was not too wide, so we have not at this time.

Dr Simpson: We will perhaps come back to that.

The Convener: I do not know whether I understood that answer. We will come back to that.

Ross Finnie (West of Scotland) (LD): I return to section 16—not the detail, but the point that I explored when the bill team gave evidence. I am grateful to the bill team leader, Molly Robertson, for her letter to the committee and, in particular, for the helpful summary of biosecurity arrangements for laboratories that she provided in annex B.

Perhaps because I did not ask my question terribly cleverly, the letter does not tell us whether the Government is satisfied with the arrangements. My question, which I perhaps did not express clearly, arose out of the breach of biosecurity that occurred last summer at the Pirbright laboratory. I want to stress that I was not suggesting in my question that there is a read across from an animal disease to public health; I am more concerned that there was a demonstrable breach of biosecurity at a UK Government laboratory that was subject to most of the regulations that are explained in annex B.

My question was whether the Scottish Government is reflecting on the breaches of biosecurity. Given that the bill is intended to update the arrangements for public health, are you satisfied that the regulations outlined in paragraphs 1 to 5 of annex B address that question, or are you reserving your position on the serious matters that arose at Pirbright?

Shona Robison: The most relevant part of annex B is paragraph 6, which says:

"Members may also wish to be aware that Westminster's Innovation, Universities and Skills Committee launched a UK wide inquiry into biosecurity at the end of last year".

That inquiry will highlight any additional requirements that are needed, and we will consider its report with great interest. That paragraph shows that work to consider what lessons need to be learned from the incident and, more generally, what more can be done to ensure that security is as good as possible is on-going.

Ross Finnie: Do you have a sense of the timing for that inquiry?

Shona Robison: We do not know, but we can get you information about the timing and when the report is due.

Ross Finnie: That will be a third report. There have already been two reports into the incident, which simply confirmed that there had been a breach of biosecurity—not perhaps the most profound conclusion. I take your point, minister—I am not disagreeing with you—but it seems to be quite an important matter in relation to laboratories.

Shona Robison: Absolutely. We will let the committee know when that report is due.

The Convener: As I recall, in the anthrax case, the tests were done outside Scotland. Sometimes, tests are done in the United States. What happens when the laboratory is not within Scottish jurisdiction?

Stella Smith (Scottish Government Legal Directorate): That point has not come up until now—perhaps we could look into it and come back to the committee in writing.

The Convener: I recall that there was nowhere in Scotland to test anthrax. It went down to England and then it went to the United States.

Dr Simpson: There was a problem at the time. I was deputy justice minister. We were getting a lot of packages that needed to be tested. The testing facility in England was overwhelmed by them. It was at the time of the anthrax scare in the United States, which was not just a scare but a reality. I had discussions with civil servants in the Justice Department about whether they should consider having a testing facility in Scotland because of the pressure that was on the United Kingdom laboratory. I do not know the outcome of those discussions.

The Convener: I shall leave that there just now.

Shona Robison: We will get you an answer to that.

Helen Eadie (Dunfermline East) (Lab): I refer to section 16(8)(a) and (b). In its submission to the committee, the BMA expresses particular concern

about managerial control within an establishment. We have touched on that this morning.

The BMA's specific concern is about an individual in a laboratory, such as a microbiologist or a virologist, not having managerial control. It says:

"Some of our members have reported working within organisational and resourcing constraints which can impede turnaround time and create backlogs."

It believes—I accept this point—that

"it would be entirely reasonable to penalise an individual staff member who failed to meet such a target due to incompetence",

but that

"it would be unjustifiable to hold an individual member of staff to account for any delay which occurred as a result of organisational issues outwith their control."

It believes that that

"should be reflected in the legislation."

I agree. As it says,

"It would be more relevant to place this duty on the owner or manager of the diagnostic laboratory."

Will you comment on that?

Shona Robison: Section 16(8)(a) defines a director. The duty falls only on the director or any other person to whom the task of notification has been specifically delegated. It does not apply to any member of the lab staff. An individual would be prosecuted only if he or she failed, without reasonable excuse, to comply with the statutory notification arrangements. If the fault was the organisation's lack of processes and procedures to effect notification, the body corporate could be held responsible for the offence. That partly answers your question. Equally, in that situation, the individual director may be able to establish the reasonable excuse defence. There is enough there to cover all the circumstances. The bill clearly says that the duty applies only to the director or to any other person to whom the task of notification has been specifically delegated, and not to any member of staff. That is important.

Helen Eadie: I am sure that the BMA will be listening and that if it has any remaining concerns it will be back in touch.

I have one further question, which is in connection with a submission that results from the consultation. There are concerns about the proposal that, as part of the bill, the AIDS (Control) Act 1987 should be repealed in Scotland. According to the submission, that act serves two important roles that are not currently met by other means. One relates to accountability: the act enables health boards' work on HIV/AIDS to be scrutinised to establish whether locally and nationally determined priorities are being addressed.

Secondly, HIV Scotland conducted studies on behalf of the Scottish Government's health directorate into the work that is being done in Scotland for gay men and people with African background. The AIDS (Control) Act 1987 reports were the primary sources of information for those studies. The point is that each health board must produce an annual report of its work on HIV/AIDS, especially given that the incidence of infection in Scotland is at an all-time high, which makes the prevention and testing effort more important than ever. Is there a way round those concerns?

10:45

Shona Robison: Convener, may I have a couple of minutes to respond to that? This is a very important area and I want to give some reassurance.

The Convener: Absolutely.

Shona Robison: Committee members might be aware that the AIDS (Control) Act 1987 was introduced during a time when knowledge of HIV and AIDS was much more limited than it is today, and survival rates were very low. We no longer need the returns to manage the disease's spread or to ensure the best treatment for patients throughout Scotland.

The 1987 act required health boards to provide very detailed statistics and information about those who were diagnosed with HIV or AIDS, and about the provision of local facilities, services and funding. That information is no longer used locally or nationally because more relevant information is now available from other sources, including, of course, Health Protection Scotland.

In addition, the Scottish public health network is carrying out an HIV care needs assessment, for which we have provided funding. It is due to report this year. It will identify gaps in data collection and consider the appropriateness of the data that have already been collected. Although HIV Scotland's initial response to the bill consultation outlined its preference for retaining the 1987 act, as the member said, it also acknowledged that it might be possible to transfer provisions of the 1987 act to other reporting procedures. There is now a much better understanding of the disease, and several measures are in place to help to reduce the rate of infection, including the offer of HIV testing in all GUM clinics. Beyond HIV Scotland, the bill consultation responses almost unanimously supported repeal of the 1987 act.

HIV Scotland raised a point about funding, on which I also want to give reassurance. The level of blood-borne virus prevention funding that is provided is not directly related to the returns that are required under the AIDS (Control) Act 1987. The decision to ring fence that funding was a

policy decision, and it will remain so regardless of whether the 1987 act is repealed. Through performance management, we will ensure that NHS boards report on how they spend the money that is allocated to them. That structure will remain in place.

I hope that I have reassured the member and the rest of the committee that the repeal of the 1987 act will have no impact on the operation of services.

Helen Eadie: Thank you.

The Convener: Yes. That was a very interesting question. Ian McKee, is your question short? I want to move on.

Ian McKee: Yes. My question is probably more for the minister's team.

An organism is often identified by an antibody reaction that shows that the organism is present. Are you happy that that is covered by the proposals?

On occasion, it is possible to identify whether the organism is important only by a rise in titre of antibodies over two tests, so does notification have to be given when the first test identifies the organism, or only when the second test shows a rise in titre, which shows that the organism is present and active at that time rather than at some time in the past?

Shona Robison: I will ask Dr Davies to answer that.

The Convener: I love having Ian McKee and Richard Simpson asking such questions. The rest of us just sit here amazed.

Dr Davies: It is a very good question and it is why notification 10 days after identification was used as a compromise. In the example that Ian McKee has given, a level of clinical judgment should be allowed. If the first antibody titre that is identified is of a very serious condition, we would expect that to be notified within the first 10 days. If the condition is not so serious from a clinical perspective, we would expect it to be notified after the second rise in titre, because that is when it is identified.

Rhoda Grant (Highlands and Islands) (Lab): I have a tiny supplementary question. We have talked about ensuring that duties are clearly identified. As there could be legal charges if a negligence case is pursued, what defence would someone have in that circumstance?

Dr Davies: My understanding is that, in those circumstances, there has not been a breach of the legal process, because the identification is in two stages—the identification of the first titre and the identification of the second titre.

Rhoda Grant: But you are saying that it is down to clinical judgment whether the notification takes place at the first or the second stage.

Dr Davies: Yes—the stage at which the person would let the health board and others know is down to clinical judgment.

Molly Robertson (Scottish Government Public Health and Wellbeing Directorate): The notification is required when the organism is confirmed, which I presume would not be until the second stage.

Dr Davies: That depends on the identification.

The Convener: I want to make progress so that we can have a short break at 11 o'clock. We will move on to part 3.

Ross Finnie: Section 21, on "Public health investigations", deals with the appointment of persons to carry out an investigation. I seek clarification on the construct of the bill. Part 1 properly and helpfully gives duties to health boards and local government officers and requires the appointment of competent persons. The inference can be drawn that the co-ordination is in the first instance in the hands of health boards and local authorities and that the competent persons will drive the process. However, when we get to part 3, health boards can appoint different people. There appears to be no connection between that and the clear purpose that is set out in part 1—of having competent persons who on the face of it will drive the process. Why do we have investigators and other persons who do not appear to be quite so connected? It seems to create potential for diffusion of the clarity that is introduced in part 1.

Shona Robison: National guidance on managing incidents that present actual or potential risk to public health will be produced. The guidance will ensure that clarity exists on who should take the lead in such investigations. I hope that that will bring greater clarity to the situation that Mr Finnie outlines. Molly Robertson may want to add something.

Molly Robertson: The aim in section 21 is to ensure local flexibility in relation to who appoints investigators. Normally, if an incident control team is set up to investigate a particular public health threat, the health board will take control of the incident and appoint an investigator, who may well be a local authority environmental health officer. Competent persons will be required to certify that certain action is required. So with orders that are made under part 4, the competent person will have to certify that the criteria have been met either to apply an exclusion or restriction order or to go to the sheriff for the more serious orders. Under part 5, a competent person will have to certify that the criteria for a place to be disinfected

or decontaminated have been met. Thereafter, other people can do the work.

As I said, section 21 aims to provide flexibility in appointing investigators. The matter will be clarified in guidance. In our letter of 6 February to the committee, we provided a link to the current guidance on managing incidents, which goes into detail on local working arrangements and who should do what. The guidance is being updated and will be updated further once the bill has gone through Parliament.

Ross Finnie: Obviously, maximum flexibility is needed in any incident, but it seems odd that, having given great clarity in part 1 on how a major public health incident will be handled—who in a local authority or public health body will do what—later in the bill, you allow for the same boards and bodies to appoint other persons without any reference to the clear provisions in part 1.

I do not seek to circumscribe the flexibility in the bill, but I am somewhat puzzled about its construct. The bill team leader has just told the committee that additional guidance will have to be produced to give clarity. Part 1 is pretty clear. Why muddy the waters? Unfortunately, that is what has happened in the drafting of section 21.

Shona Robison: There is guidance on managing incidents, but we are saying that we will add to it so that it reflects not only existing provisions but the provisions in the bill. Is the point of confusion the idea of appointing other people to undertake investigations?

Ross Finnie: The inference to be drawn at the outset is that the person who will do the investigation is the competent person. Part 1 is clear about the two bodies involved and the competent person. If anyone wants to know who is in charge, they will find out. All of a sudden, in part 3, instead of the competent person deciding whether an investigation is needed, we are told that we have to go all the way back to

"the Scottish Ministers … a health board … the common services agency … a local authority".

Surely, under part 1, people have been appointed to take charge of the matter.

Shona Robison: We will reflect on that. The point of the provision is that other people may be required to be involved. The competent person will remain the competent person, but they may require to call on other people to carry out—

Ross Finnie: With respect, minister, that is not what the bill says. Section 21 does not provide for the competent person to be in charge of whether to carry out an investigation. We go all the way back to the umbrella organisations.

Molly Robertson: There are times when public health investigations are not contained within one health board area. Sometimes the outbreak covers a number of health board areas. In the case of a large incident of that nature, Health Protection Scotland, which comes under the legal entity of the Common Services Agency, would take charge.

Ross Finnie: But part 1 requires bodies "to co-operate". The bill sets that out with great clarity. It is clear that you want to get rid of all the mumbo-jumbo of the present legislation, but you have introduced a degree of obfuscation in section 21.

Shona Robison: We will reflect on the point. I see exactly where Ross Finnie is coming from, but the provision is in the bill to achieve flexibility. We will consider whether the revised guidance will be adequate to make it clear to everyone so that there is no confusion or whether a drafting change is required.

The Convener: I will summarise for the sake of clarity. Ross Finnie sees a conflict between section 3, which provides for the competent person—the person at the top of the tree, so to speak—and section 21, which provides for others to investigate. We could call them quasi-competent person—

Mary Scanlon: We are talking about sections 3 and 5 in part 1.

The Convener: Yes, sections 3 and 5. Ross Finnie is right. A real issue is involved.

Ross Finnie: I am grateful to the minister for saying that she will reflect on the matter.

Shona Robison: We will certainly have a look at it.

11:00

Michael Matheson: I turn to section 27, which is on public health investigation warrants. The officials have doubtless had time to reflect on the evidence from the Law Society of Scotland, which was not entirely generous in its comments on section 27. Its evidence raises a number of issues, including the proposed summary application procedure, which will apply when an investigator wants to gain entry to a premises.

The Law Society's evidence on the matter was clear: it said that the proposed summary application was completely inappropriate. If I recall correctly, it stated that making a summary application to a justice of the peace is not the normal process in Scotland in the first place. That raises serious questions about the bill containing what appears to be a fairly alien process in Scots law, on the seeking of a warrant to enter premises.

Given the concerns that the Law Society has expressed about the idea of summary application,

which is a detailed process involving writs being served and a hearing being held, will you consider looking into the matter and drawing the provisions into line with other legislation in Scotland, which is very much about having a hearing following an application to a justice of the peace or a sheriff, and a warrant being granted? That would be a much cleaner and quicker process for dealing with such instances, which could involve an urgent application to gain access to premises.

Shona Robison: As I indicated earlier, we have taken on board the requirement to amend the bill to ensure that the court procedures are suitable in relation to fulfilling the bill's policy intentions. A modified summary application procedure is required, rather than the full summary application procedure, with the detail to be set out in court rules, as is normal practice. That will ensure that the warrants and orders that are applied for under parts 3, 4 and 5 may be granted as a matter of urgency, if necessary, and that the applications and orders are user friendly, which is always a good thing.

I am very grateful to the committee and to the Law Society of Scotland for their constructive advice, as I have already said. I reassure the committee that we will be lodging suitable stage 2 amendments, which will ensure that the necessary procedures can be put in place. I invite Stella Smith to say more about the amendments that are being worked on.

Stella Smith: In relation to section 27(2), we fully accept that summary application does not apply in the district court or to justices of the peace. We will be removing that reference. As the minister said, we will provide for a modified form of summary procedure.

Michael Matheson: Could you give me more of an idea of what that modified procedure will be? Will an application be made to a justice of the peace or to a sheriff for a warrant?

Stella Smith: We intend to lodge amendments at stage 2 to provide that forms of application for warrants may be prescribed by the Scottish ministers. That could be used to ease the process. We will provide that orders and warrants may come into force immediately, and we will include an express provision in the bill that will refer to the Court of Session's power to make court rules, so that we can supplement the provisions in the bill with court rules.

Michael Matheson: To be honest, that does not seem to be as simplified as the Law Society felt that it should be. How can a bill come before the committee that proposes a legal procedure that does not exist in Scots law, namely the making of a summary application to a justice of the peace?

Stella Smith: We accept that that will need to be changed, and we intend to lodge amendments at stage 2 to change it. I cannot really say any more about that.

Shona Robison: It is unfortunate that that happened. I hope that lessons are learned, and that such matters are looked at in more detail in relation to such a basic point. That is my view of the matter. We are working closely with the Law Society on the detail that will need to be provided at stage 2, which I hope will be in accordance with what the Law Society recommends. I hope that that provides reassurance to members.

The Convener: I will say this with my former lawyer's hat on—this is where I can enjoy myself a bit. You are talking about a change in sheriff court rules.

Stella Smith: Our initial intention in the bill was always to follow normal practice, with summary procedure being used and the detail left to court rules. We do not put all the detail—

The Convener: So, to implement this legislation, you are seeking a change in Court of Session and sheriff court rules.

Stella Smith: Only in sheriff court rules. We will lodge a suitable amendment to ensure that the bill refers to the Court of Session's power to make rules for the sheriff court.

The Convener: And you need a change in sheriff court rules before the provision can be implemented.

Stella Smith: Yes. The idea is to consult the Sheriff Court Rules Council and give it a say on rules that might be put in place. I should say that that is quite standard procedure—it has certainly happened with other bills.

The Convener: With respect, we will leave the matter there. The committee might well take more evidence at stage 2, if it thinks that that is required.

Ross Finnie: Can I get some clarity on the issue?

The Convener: We are certainly not getting any at the moment.

Ross Finnie: In response to Michael Matheson's first question, the minister suggested that, notwithstanding the error that might have been made, she intended to adopt the procedure that has been recommended to us by the Law Society of Scotland. With all due respect to the lawyer who is present, she has suggested a different procedure and a change in the rules.

Minister, we are not trying to catch you out. We are simply trying to be helpful. The Law Society's suggestion seemed to us to be eminently helpful

and sensible, and your comment appeared to concur with our view. However, I regret to say that your official from the legal directorate is suggesting a different procedure. That is not helpful.

Shona Robison: As far as I am concerned, our proposal is in accordance with the Law Society of Scotland's suggestion. Indeed, the Law Society is content with it.

The Convener: We will have to come back to the issue.

Dr Simpson: Instead of waiting to see the stage 2 amendments, we could ask the minister and the bill team to write to us with clarification. That would allow us to take another look at the matter.

Shona Robison: I am happy to do that.

The Convener: I remind the committee that, although it is not normal practice, we can take evidence from witnesses at stage 2 if we are not content with substantive amendments that have been lodged.

I call Helen Eadie. I suggest that we take a break after she asks her questions—not that that means anything, of course.

Helen Eadie: You will have had enough of me by that time.

Ross Finnie: We do not want to influence you in any way, Helen, but you stand between us and a break.

Helen Eadie: Such a burden, to stand between a man and his food.

My first question, which returns to a theme that was highlighted by Ross Finnie, relates to the City of Edinburgh Council's submission. With regard to the provisions on public health investigations that are set out in section 21(1) and (2), the council expressed concern that in investigations involving two or more investigators there is "no clear primacy role" for the joint investigator, and made it clear that that is

"seen as an essential element if arrangements are to progress effectively."

That point is important. After all, as we all know, if everyone thinks that everyone else is doing something, no one actually progresses anything.

Shona Robison: You are wondering who will take the lead in a joint investigation.

Helen Eadie: Yes.

Dr Davies: As we have said, we will update guidance on incident management control. Section 21 relates to cases in which investigations must be carried out as a result of the various circumstances—for example, infection and contamination—that are set out in section 20. At the time of an outbreak, an incident control team, which would be staffed by the competent officers from health boards and local authorities, would jointly agree whether an investigation was needed. That is what the provisions refer to. The incident control team would need to appoint a lead investigator.

As the minister said, if the incident was at a national level, the lead investigator would be appointed by Scottish ministers through Health Protection Scotland or another part of the Common Services Agency. If the incident related to a local area, the local health board or local authority could appoint a competent officer as investigator. That is what the provisions are about. The bill does not aim to ensure that every investigation of every incident goes through a legal process. For instance, dealing with an outbreak of E coli in a nursery would not require that legal process; things would go on as normal.

Shona Robison: Essentially, things will go on as they do at the moment.

Helen Eadie: I think that the issue that the City of Edinburgh Council raised has been taken on board. I think that the council just wanted clarity on which body would have primacy in appointing a lead investigator.

My second question is on a point that was made by the Law Society of Scotland, which raised an issue about section 30, which is on public health investigations: compensation. The Law Society expressed concerns about section 30(4), which provides that any dispute

"is to be determined by a single arbiter appointed by agreement between the person who appointed the investigator and the person claiming loss or damage, or, if agreement cannot be reached, by the President of the Lands Tribunal for Scotland."

The Law Society's submission suggests that

"the Lands Tribunal for Scotland be given jurisdiction to determine disputed questions of compensation."

Will the minister comment on that?

Shona Robison: We are giving consideration to that arbitration role. We will come back to the committee on that at stage 2.

The Convener: Before the minister leaves her seat, and before we close down our consideration of part 3, I have a brief question on money. A local authority raised an issue about the potentially significant costs of analysing samples and taking remedial action. Will those costs be borne by the local authority, the health board or the individual who caused the incident? Who will bear those costs?

Molly Robertson: As happens at the moment, the costs would be borne by whoever took the samples.

Dr Davies: The bill allows for the current process to continue with legal backing. We do not assume that there will be more investigations than currently take place or that there will be different types of investigations. Costs will be borne as under the current system. The bill provides the legal method for what is currently done.

The Convener: In the anthrax incident, significant costs were involved because the samples had to be sent to the States. I think that the health board bore those costs. Will health boards continue to bear such costs, as happened in the anthrax incident?

Shona Robison: The costs will be borne in the same way as happens at the moment. The bill simply provides a legislative underpinning to existing processes, and we do not envisage any increase in the number of incidents.

Clearly, if health boards or local authorities had a particular problem because they had to bear a sizeable cost for something that was outwith the normal course of events, we would discuss that with them. We have the power to direct allocation of resources in situations in which it would be unreasonable for one board or authority to bear the costs in the normal course of fulfilling its duties.

The Convener: Where is that power of direction?

Shona Robison: Section 11 provides that, if required, such assistance can be given.

The Convener: I will allow Rhoda Grant a supplementary question before we break.

Rhoda Grant: Will the individual who caused the incident bear any of the costs? The bill provides that people whose property has been damaged can claim compensation if they were not the cause of the incident. Does that also mean that the person who caused the incident would be liable for the costs?

Dr Davies: As I understand the position, if an individual's actions were the cause of the incident, their loss could not be compensated for at that point. However, perhaps you were asking a different question.

The Convener: I think that the question is about who would bear the costs of the investigation if the incident was caused maliciously.

11:15

Shona Robison: I think that the question is whether, if someone was responsible for causing something, the costs could be recovered from the individual concerned. The answer is yes, under the powers in part 5 of the bill.

Molly Robertson: If a local authority had to disinfect or decontaminate premises and the incident was the fault of the person who either owned or occupied the premises, the local authority would be able to recover the costs—

The Convener: Which section is that in?

Molly Robertson: That power is in part 5. However, it does not allow the recovery of the costs of taking samples and so on during a public health investigation, which would be borne by the investigating authority.

Shona Robison: Section 76(1) states:

"A local authority may recover any reasonable expenses it incurs in doing anything it is entitled to do under"—

Molly Robertson: That covers disinfection and decontamination.

Shona Robison: So, there is provision—

The Convener: There is provision for recovery.

Shona Robison: Yes.

Helen Eadie: There is also the issue of a person who might want to appeal against the recovery of expenses. The costs to any organisation or individual could be significant, so, in my opinion and that of the Law Society, there should be—

The Convener: Can you direct me to the section that you are talking about?

Helen Eadie: Sorry—it is section 76.

The Convener: We will come to that later—that is in another part of the bill. I do not want the discussion to stray.

I think that we are getting a little frayed at the edges—I am—so I will suspend the meeting for exactly five minutes. We have a lot to get through.

11:16

Meeting suspended.

11:26

On resuming—

The Convener: We will now consider part 4, which is on the public health functions of health boards.

Ross Finnie: Minister, I think that you will be aware that we have taken evidence that questions the consistency of approach in part 4. Sections 33 to 36 do not include any provision for appeals. Under sections 37 to 39, the health board or other body will be applied to for orders, whereas later sections refer to applications to sheriffs. In taking evidence, we found that there was unease about the lack of equity in view of the absence of an appeal and concern about the fact that boards will

get fairly serious powers, although applications to sheriffs are required later in the bill. Have you had time to reflect on the evidence that we have taken and the inconsistent approach that is shown in the bill?

Shona Robison: I think that the point that you are making relates to whether a sheriff's approval is required for exclusion orders and restriction orders, for example, and to such approval being required for quarantine and detention orders and medical examinations.

Ross Finnie: That is part of my question. However, there is also the fact that the right of appeal does not arise until section 37. Section 33 does not provide such a right. Those concerns were raised in evidence to the committee.

Shona Robison: I will deal with medical examinations first. There will be no right of appeal, but a sheriff's approval must, of course, be given before a medical examination can take place without a person's consent. In determining what action is required, a health board will always have to adopt the least restrictive action to protect the health of the population. A decision to carry out a medical examination without consent would be taken only when it was crucial to obtain evidence on whether an individual, or group of individuals, had an infectious disease that would have an impact on public health, and such a decision would be taken only as a last resort after engagement with the individual or individuals to try to persuade them of the necessity of such an examination. As I have already said, a sheriff would have to be convinced that a significant risk to public health existed.

Orders that restrict liberty—whether they are exclusion, restriction, quarantine or detention orders—will remain in force while any appeal is being considered. However, that would not be possible when a medical examination was required, because an appeal mechanism would delay that examination, which could have an impact on the potential spread of a disease. That relates to what I said initially: we have to strike a balance between the rights of the individual and the requirement to protect public health.

11:30

We have to bear it in mind that health boards are required to undertake the least intrusive or invasive procedures necessary to achieve the purpose for which the examination is being carried out. In the majority of scenarios, the procedure would be the taking of saliva samples. We have to consider the context in which the power would be used. It would be used only in very unusual circumstances in which someone was not complying voluntarily and there was a significant public health risk, of which a sheriff would have to be convinced.

With quarantine and detention orders, there can be no appeal before the order is granted, but, of course, there can be an appeal once the order is granted. In such fast-moving situations, taking any other approach could put public health at risk.

With exclusion and restriction orders, there is no need for a sheriff's approval, but the person affected can go to the sheriff to appeal an order that has been put in place.

I believe that what we are proposing strikes the balance between the rights of individuals in all cases and the need to respond to fast-moving and difficult situations in which we must ensure that health professionals on the ground can act quickly and with maximum flexibility.

The Convener: I seek clarification. In relation to exclusion orders, you said that an appeal would not prevent an order from being made, but there would be a right of appeal afterwards. Why does that not apply to the medical examination? We all know that, with the best will in the world, sheriffs do not always make the same decisions. Appeals can be useful if they set bars and standards across sheriffdoms. I am a wee bit surprised, because I do not know whether what you have outlined is ECHR compliant. The person having the enforced medical examination does not necessarily have the right to be heard, but article 6 of the ECHR is on the right to a fair hearing. Providing an appeal procedure would be a belt-and-braces approach. Where the sheriff indicated that there had to be a medical examination, the individual could then appeal that decision. Even if such an appeal was unsuccessful, the individual would have had a hearing on the issue, which they would not have had otherwise.

Shona Robison: We are talking about situations in which someone could have a fatal, contagious disease, meaning that an urgent medical examination was required, but refuses to comply voluntarily. Of course there will be on-going dialogue with the person to try to persuade them to comply voluntarily, but we are talking about unusual situations in which the person refuses to comply for whatever reason, although they may be harbouring a serious contagious disease. In such situations, if there was an appeal against the decision to carry out a medical examination, but we needed to identify the condition—

The Convener: I accept that. It might be that, in extremis, the medical examination had to proceed prior to any appeal. However, what I do not understand is why, even after the examination, the individual would have no right to appeal the decision. We are talking about grey areas of the law.

Shona Robison: You are referring to situations in which, even though the medical examination had happened, there could be an appeal against the decision to allow the examination to go ahead.

The Convener: Yes. An appeal could consider whether, on the facts and circumstances of the case, the sheriff came to the correct conclusion. In that way, a national standard or test would begin to be set. I cannot see how that would imperil public health. It would comply with the right to a fair hearing under the ECHR. I just wonder why you provide the right of appeal in one circumstance but not in another.

Shona Robison: All the provisions are ECHR compliant, but I take on board your point that, after the medical examination had been done, someone who might feel aggrieved—they might feel that the examination was not required or was not done in the right way—would have no recourse. I want to reflect on that.

Stella Smith: An appeal right normally applies before a medical examination has taken place. If the examination had been done, the appeal right would not be substantive, because the person would already have been medically examined.

The Convener: You ask what the point would be.

Stella Smith: Well—

The Convener: There is a point: to establish whether the sheriff's decision was appropriate given the facts and circumstances. An appeal procedure and decision would set a test for other sheriffs.

Shona Robison: The test would be whether the law had been applied appropriately.

The Convener: Absolutely.

Shona Robison: We will reflect further on that, because I see the point that you make.

Ross Finnie: I return to my original question.

Shona Robison: Sorry.

Ross Finnie: No—I did not want to interrupt.

I understand all that you said, but I am not entirely clear on what is different about sections 37 and 38, under which a health board can make the decision. I understand the emergency nature and urgency of such situations, but it is difficult to see the difference between a quarantine order and an exclusion or restriction order and to understand why a board would decide on an exclusion or restriction order rather than there having to be an application to a sheriff.

Shona Robison: The process for exclusion and restriction orders is followed at the moment, and we want to put in place the legal underpinning for it. If an outbreak of E coli occurred at a nursery, the health board would use restriction or exclusion orders to prevent children from entering the nursery. However, there are questions about whether legislation underpins such action, which is why we want the bill to cover that—we have perhaps been fortunate that everyone has voluntarily complied with a restriction or exclusion requirement. We want the bill to put such orders on a firm footing.

Quarantine and detention orders are different. If a person does not comply voluntarily—that is the key issue—a sheriff's approval must be obtained to detain and quarantine them against their will, because their liberty would be affected.

The orders are distinct. The exclusion and restriction order process happens in practice to prevent the spread of infection after an outbreak of E coli in a nursery, for example, as I explained. Quarantine and detention orders will be required when a person needs to be removed from a situation because they have a serious and potentially contagious disease and they will not comply voluntarily. Such orders will remove someone's liberty, so a sheriff's approval will be required. The difference in those circumstances is in the extent of the public health threat.

Ross Finnie: I will not labour the issue and I will not go into the public health aspect, but I have great difficulty in understanding the different effect on a person's liberty. Section 37(2)(a) will prohibit a

"person from entering or remaining in any place",

which is not far removed from being quarantined. I accept wholly that the circumstances and the immediacy of situations might be slightly different, but an exclusion order would nevertheless interfere with a person's right of passage, so I have difficulty in seeing the distinction that makes it competent for a health board to decide on that in one case while a sheriff is required to decide in another.

Shona Robison: The restriction on liberty is different in the two cases. In one, someone would be excluded from their workplace or from whatever place was deemed necessary. With quarantine and detention, their liberty to go anywhere would be restricted. Those are different restrictions, which is why there are different requirements for approval from a sheriff.

Dr Davies: I confirm what the minister says. The current practice is for health boards to use exclusion orders not quite routinely but relatively regularly. They have never been abused; people are not excluded from a degree of involvement in normal society. There would not be anything like the liberty restriction that quarantine would involve, so there has been no example of exclusion being

used to the degree that would warrant a sheriff's oversight.

The Convener: We will have to return to the procedural issues and consistency. We are concerned about health boards having some powers and sheriffs having others, as well as there being a right of appeal in some circumstances but not in others. Will the bill team consider that? We could dig at it the whole time. Our concerns about the processes have been well aired previously.

Dr Simpson: I return to section 31, and subsections (3) and (5). Subsection (5), which is written from the point of view of the health board needing to act very quickly, suggests that a board does not need to explain its actions or to provide information to the individual concerned. That is a step too far, particularly as the situation is already covered by the phrase

"in so far as it is reasonably practicable to do so"

in subsection (3). As the minister is probably aware from examining the evidence that the committee has taken, it is unacceptable to me to add an explicit catch-all provision to the effect that there is, in certain circumstances, no need to explain what is going on. I will certainly seek to delete subsection (5) if it is not amended. Will you comment on giving information to the individual concerned before restriction or exclusion is imposed?

Shona Robison: It is hard to envisage a situation in which that information would not be given. However, I can think of one or two. For example, in a fast-moving and difficult situation in which the person's language was not English, the time that might be taken to get a translator to explain what was going on might not comply with the timescale for getting an order. In such circumstances, to restrict the health board such that it had to arrange translation and impart the information before an order could be granted might not give the flexibility that we need.

Dr Simpson: I accept that, but such a situation would be covered by

"in so far as it is reasonably practicable to do so".

You do not need a catch-all provision that entitles people to opt out of subsection (3) on the ground of urgency.

The Convener: Would it cure the problem if section 31(5) read "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, but must comply thereafter as soon as is practicable"?

Dr Simpson: That is certainly an alternative way of addressing the same problem.

The Convener: We appreciate that there might be circumstances in which language or learning difficulties could be a barrier but, once the deed is done—

Shona Robison: We will consider that.

Mary Scanlon: Under section 33(1), the health board may apply to have a person medically examined if it "knows or suspects" that the person

"(i) has an infectious disease;

(ii) has been exposed to an organism which causes such a disease;

(iii) is contaminated; or

(iv) has been exposed to a contaminant".

Section 33(2) says:

"The board may apply to the sheriff for the area within which the board has its principal office".

Why is it important that it be that area? In evidence, the example was given of a resident of Campbeltown, which is a good four-hour journey to Inverness. The same question would arise if the person was in one of the islands or north-west Sutherland. Would not an application to a local sheriff be more appropriate?

11:45

Shona Robison: I understand that the provision will be amended.

Stella Smith: We intend to lodge an amendment that will provide that a health board can address the problem by applying to any sheriff court in the board's area.

Mary Scanlon: That is fine.

Rhoda Grant: There are similar provisions throughout the bill. Will they also be amended?

Shona Robison: Yes.

Rhoda Grant: On the appeals process, given the potential for contamination if a person is quarantined, how will you ensure that people have proper access to justice, in accordance with their human rights, but are not able to cause a public health problem?

Shona Robison: Access to a solicitor for someone who has an infectious disease or who might be contaminated could be facilitated by practical measures such as electronic or telephone communication. The Law Society of Scotland has confirmed that.

Rhoda Grant: I think that such means of communication are allowed for vulnerable witnesses in court cases. Could such opportunities be extended to people who appeal against an order made under the bill, so that they can appear in court by videolink, for example?

Shona Robison: I am sure that we can consider such issues.

Molly Robertson: Such practical matters are not for the bill.

Shona Robison: They are implementation issues, although it is important to flag them up so that we can consider them in the context of guidance.

The Convener: A sheriff can determine such matters.

Stella Smith: I mentioned court rules. We hope that there will be flexibility, for example about where an appeal hearing might take place. In the exceptional circumstance of a person's being unable to leave quarantine and wanting to appeal, it might be possible for the sheriff to go to the person while wearing appropriate protective clothing, for example.

The Convener: I think that a sheriff can currently go out to a bedridden witness, for example.

Stella Smith: We intend that there will be such options.

Helen Eadie: The Information Commissioner's Office, in its submission to the committee's consultation on the bill, said that in relation to applications to the court

"for the various orders introduced in the Bill or any appeal to the court against said orders, the ICO believes that the application should be made privately unless there is an overwhelming public interest to do otherwise."

The ICO went on to

"reiterate the recommendation that clear and extensive guidance regarding the type of personal information that is to be disclosed and the use to which it will be put, is given to those who are required to disclose."

How do you respond to those two points?

Stella Smith: Under section 66—which we are considering, as I said—an application can be heard by the sheriff in chambers. That is not the same as excluding the public, but it is an option.

I am sorry, what was the second point?

Helen Eadie: The ICO was concerned that there should, in order to protect an individual's privacy, be "clear and extensive guidance" about the type of personal information that could be disclosed and the use to which it could be put,.

Shona Robison: That will be covered in guidance.

Helen Eadie: Will you revisit the ICO's point about the need for more clarity on privacy in relation to court hearings in chambers, for example?

Stella Smith: Yes. Perhaps it would also be helpful to add that a provision such as the information sharing provision is subject to the Data Protection Act 1998.

Helen Eadie: Do you think that the point that the commissioner is making in his submission is that he wants reassurance? We do, as committee members.

Shona Robison: We will certainly provide that.

The Convener: Just as a matter of interest with regard to protecting the identity of an individual, when an application is made, will it appear on the court rolls? They are public, so people could see who was up on application.

Shona Robison: That is an interesting question.

The Convener: I am sorry—I am full of them at the moment.

Shona Robison: Can we come back to you about that? That issue had not been considered.

The Convener: Okay. We will now move on to part 5, on public health functions of local authorities.

Rhoda Grant: I would like clarification regarding small local authority areas. I am assuming that the bill does not expect such authorities to hold equipment and expertise for disinfection and decontamination, and that it will allow them to take on contractors to fulfil that role as long as they can preside over it.

Shona Robison: Section 67 is about ensuring the provision of facilities. It will, in the main, be the responsibility of local authorities, but they need not have facilities available all the time or provide the facilities themselves—they need to ensure access to facilities when they are required.

Rhoda Grant: So authorities could buy that in—for instance, on a small island an outside contractor could bring in such facilities, rather than there being a need to have them available at all times?

Shona Robison: Exactly.

Helen Eadie: Professor Tony Wells of Tayside NHS Board makes an important point related to that in his response, regarding the issue of resourcing. Among many other related points, he says that training and identification of competent persons will require significant new resources. Are you thinking about the resource implications in the context of that element of the bill?

Shona Robison: We do not believe that there are significant resource implications—the bill gives legislative underpinning to what is happening at the moment, but provides more clarity concerning roles and responsibilities. Given that that is

essentially the nature of the bill, there should not be any additional significant cost to health boards or local authorities. Training, for example, has to happen anyway, in relation to the requirements for preparation concerning public health matters and competent persons. I do not see why it would entail any additional costs.

Helen Eadie: I think that Tony Wells is really thinking about the need to have another look at the existing legal framework and existing practices. He is saying that there are very new public health challenges, particularly to do with microbiological and chemical techniques and treatment options, and that a range of training will be required in such areas, which no one can predict. We all see people having to plan and prepare for unexpected and unpredicted incidents in all kinds of emergency situations across Scotland. That can involve really quite serious issues, and the whole finance dimension needs to be taken on board. I ask you to take seriously the points that he has made in his submission.

Shona Robison: Of course we do, but there are a couple of things to say about that. One is that public health professionals will always be expected to keep up to speed and continue training to a level that takes into account new and emerging issues, advances in technology and so on. We expect them to do that, as other professionals do.

We have other procedures and processes in place for responding to major incidents. Of course, resourcing of that would be a separate matter. It is quite a different issue from the provisions in the bill, which are not about major catastrophic incidents.

The Convener: We will move on to part 6, which deals with mortuaries.

Helen Eadie: One of the submissions—I think it is from Dundee City Council—expressed concern about the requirement to build new mortuaries and asked for assurance that there will be a commitment from the Scottish Government to provide funding for the required new mortuaries. Can that assurance be given or will local authorities have to find that money in their existing budgets?

Shona Robison: There is no requirement for new mortuaries in the bill and we do not anticipate any change to the current financial arrangements. In effect, the bill underpins what currently happens; it simply clarifies who does what and when, in relation to mortuaries. Those fears are without foundation.

The Convener: It was, indeed, the submission from Dundee City Council, so you will have to stand by those words, minister.

As there are no questions on part 7, which deals with international health regulations, we will move on to part 8, which deals with sunbeds.

Shona Robison: The Scottish Government is concerned about the rise in skin cancer in Scotland. Over the 20 years between 1994 and 2004, the reported incidence of non-melanoma skin cancers has trebled and the incidence of melanoma skin cancers has more than doubled. Just one session a month on a sunbed will double the average individual's annual dose of ultraviolet radiation. Medical evidence on the use of sunbeds is increasing, with links to premature skin cancer, premature ageing, eye damage, photodermatosis and photosensitivity. We are therefore keen to work with Ken Macintosh, who lodged a member's bill on the subject last year, to develop suitable proposals to highlight to the public the dangers of sunbed use. As the committee is aware, a marker provision was placed in the bill for operators of sunbed premises to provide information to users on the effects on health of sunbed use.

I am happy to outline now the proposed provisions that ministers have agreed to support as amendments at stage 2 of the bill. They have been agreed with Ken Macintosh, and should enable him to withdraw his member's bill on sunbed licensing.

The first provision will ban operators from allowing use of sunbeds by under-18s in commercial premises. International evidence suggests that there is a risk of melanoma in people who first use sunbeds in their teens and early 20s and the World Health Organization recommends that people under the age of 18 do not use sunbeds. Introducing a ban on sunbed use for under-18s would be in line with WHO recommendations and with the advice that was produced in 2006 by the European Commission's Scientific Committee on Consumer Products.

The second provision bans operators from allowing unsupervised use of sunbeds. Again, the WHO has recommended that unsupervised use of sunbeds should be banned. Introduction of such a ban will increase the level of health protection by reducing the incidence of inappropriate use of sunbeds. It will also help to ensure that people under the age of 18 do not use unsupervised sunbeds as a way of circumventing the new legislation as it relates to them.

The third provision requires sunbed operators to provide sunbed users with a package of information on the dangers of sunbed use. That is in line with the current marker provision in the bill. Provision of information on the health risks of sunbeds will help to ensure that adults can make informed decisions on whether to use them. We propose that the package of information that sunbed operators will be required to issue to users

will be included in regulations and will be based on World Health Organization advice. Failure to comply with the provisions will be a criminal offence and will be subject to a fixed penalty notice or a fine on summary conviction. The legislation will be supported by a communication campaign to highlight the dangers of sunbed use.

12:00

Local authority environmental health officers will be empowered to enter premises to monitor the adherence of sunbed operators to the legislative provisions. However, we do not intend to introduce a requirement for a compulsory inspection regime in local authorities. We envisage that EHOs could visit premises while conducting other visits in the vicinity. Many EHOs will already be visiting local operators.

I am unconvinced of the need for a national licensing regime. Although licensing would control access to commercial sunbed premises, it would not prevent individuals from hiring or buying a sunbed, nor would it prevent exposure to the sun. In addition, it is not clear that introducing a requirement to record and monitor customers' sunbed use would be effective. It would therefore be unlikely to prevent abuse. In my view, licensing moves the balance too far away from the need to allow individuals to make their own informed choices.

The proposed provisions are proportionate. They will set the correct balance between regulation by Government and an individual's personal responsibility to make choices that minimise the risk to their health. With the provisions, Scotland is taking a leading role in the introduction of health protection measures against inappropriate use of sunbeds. We are implementing the WHO's recommendations.

Ian McKee: I believe that one trade organisation has a code of practice for its operators, but that organisation covers only about 20 per cent of sunbed operators. Would you consider a statutory code that covered all sorts of factors, such as the type of equipment and maintenance of equipment? The code could cover all sunbed operators rather than just 20 per cent of them.

Molly Robertson: To legislate on regulation of equipment that is used in sunbed salons is outwith the competence of the Parliament. The issue is covered by health and safety at work legislation, as well as by consumer protection legislation.

The other issues that Ian McKee raises would, more or less, be part of a licensing scheme. As the minister said, we have not seen evidence to suggest that a licensing scheme would be any more effective than the provisions that we propose.

Ian McKee: We have heard evidence of wide variations in safety and use of equipment. Would the minister consider making representations to the United Kingdom Government? It may be a reserved matter, but we are talking about people in Scotland who are suffering and the health risk has been made clear to us in evidence. Even if the issue is reserved, we should make every effort to do something about it because of the health risk.

Shona Robison: As Molly Robertson said, safety is broadly a reserved matter. However, local authorities have a duty to ensure compliance with health and safety and product safety legislation; they are funded to carry out that duty under their general settlement.

Ian McKee suggests that I raise the issues with the UK Government—I am quite happy to ask whether the UK Government believes that more could be done on the health and safety aspects.

The Convener: I think that the committee would support that.

Ross Finnie: I read diligently the letters that we receive from the bill team leader. Among our papers today is one letter in which she has helpfully set out in annex C the various regulations that relate to this issue. There is a glaring problem. Although the measures that you have introduced are interesting, if the equipment gives out uncontrolled UV rays, even for a limited time, the whole thing falls apart. The issue centres on what the sunbed actually produces.

A range of issues are raised in annex C, not the least of which is that the European harmonised standard is currently being revised. That could be very important. However, as I read annex C, the situation has got worse: paragraph 11 points out that, even if the standard radically improves the situation, it has been the UK Government's habit to issue regulations, in relation to the 1999 regulations, that have no legal force. That seems rather remiss and puts us into difficulty, not least because health and safety legislation is a reserved matter. My question is this: if you persuaded the UK Government to tidy up the situation, would it be possible for enforcement to fall within the responsibilities of Scottish authorities? If so, that makes persuading the UK Government all the more important.

Shona Robison: I suppose that the issue would involve environmental health officers.

Stella Smith: As I understand it, environmental health officers—wearing a reserved-issues hat—are currently responsible under health and safety regulations for enforcement in relation to products and in various other reserved matters.

Shona Robison: I think that, in some cases, they inspect as part of their work.

Stella Smith: Yes—but the matter is all reserved.

Ross Finnie: I am sorry—my point is not about what is reserved. If EHOs have statutory powers, that is fine. However, the point in paragraph 11 is worrying: the UK Government has chosen to issue regulations—the current one is INDG209, entitled "Controlling health risks from the use of UV tanning equipment"—but they are not legally binding, which completely diminishes their effect. Even if we have the ability to suggest to EHOs that they implement reserved regulations, it is unhelpful if the reserved regulations do not have the force of law.

Shona Robison: That is an important point. The thrust of the bill is to persuade people not to use sunbeds, to ensure that they are fully informed about the risks if they do, and to restrict their use by certain groups of people. Product safety is an important aspect of that. I am more than happy to raise the committee's concerns and perhaps even to use the exchange that we have had today as a way into the discussion. It may be that the UK Government needs to consider the status of the approved code of practice and whether to tighten it up.

Stella Smith: The letter to the committee outlines the regulations that are in place under the Health and Safety at Work etc Act 1974 and which are legally binding. They require employers to carry out health and safety risk assessments, which are policed by the Health and Safety Executive through its various enforcement agencies, such as local authorities.

The Health and Safety Executive has also issued guidance—the INDG209—but that is in addition to the regulations.

Ross Finnie: With all due respect, the employee or employer is not the issue. We are concerned about the person who uses the equipment. That is the committee's exclusive concern, apart from the new European framework and harmonised standard. The only regulation that matters in respect of the import of what the minister is trying to do is the regulation that covers use of UV tanning equipment. That is the one that does not have the force of law.

Shona Robison: I am certainly happy to relay the committee's concerns to the UK Government. We will inform you of the response that we receive.

The Convener: Let us move on from that point.

Helen Eadie: I very much support the points that Ross Finnie made in describing his concerns. My concern is that there will effectively be postcode-based controls rather than universal controls. At the moment, although there is

> "licensing and inspection in some parts of Scotland, this has not been implemented in all regions. In two published studies conducted jointly with Environmental Health it was shown that four out of five sun beds emitted UV levels that exceed the maximum permitted in the British Standard."

I appeal to you to revisit the issue of licensing. If some local authorities can do it successfully, I fail to understand why we cannot revisit the matter and have universal licensing in Scotland.

Shona Robison: It goes back to product safety issues, which lie outwith the scope of the bill. As I have said, I will raise the issues in discussions with UK ministers. The bill gives a permissive power to EHOs to enter and monitor premises to ensure that operators are complying with the legislation. I hope and expect that, in practice, the EHOs in each local authority area will know the premises that they need to visit and keep an eye on. EHOs know their patches—they know what is happening on the ground. I am confident that operators that require it will be monitored by EHOs. We will seek to ensure that the postcode lottery that you describe does not come about. I know that EHOs are keen to carry out their work, and I am sure that they will do so in a targeted way, which is exactly what we want—we want officers to focus on those cases that need to be given attention. The permissive power will allow them to do that.

Helen Eadie: Do not get me wrong, minister; I warmly welcome the fact that you have taken on board the work that Ken Macintosh has done. However, as Ross Finnie rightly said, the issue is not the equipment but vulnerable people. As we know, there is an epidemic of skin cancer in Scotland. I am still not satisfied on the matter. Let us examine the local authorities where licensing is successfully under way, see how they manage it and then ask what the barriers are to following their best practice.

The Convener: I take that point. I also take it that licensing was not included in the bill with the agreement of Ken Macintosh.

Shona Robison *indicated agreement*.

The Convener: I wanted to get that on the record.

Mary Scanlon: Before getting further clarification on what Ross Finnie and Helen Eadie have been discussing, I refer to your earlier statement that the incidence of melanoma in Scotland trebled between 1984 and 2004. How can you attribute that to sunbed use, minister, when more and more people are going on sunny holidays?

Shona Robison: The evidence comes mainly from epidemiological studies in various countries where there has been an increasing trend in the use of artificial tanning devices by people with pale

skin. That has been the consistent factor in the countries concerned. For example, a study on the use of sunbeds and sunlamps and the incidence of malignant melanoma in southern Sweden found a generally increased risk of malignant melanoma for people who had used sunbeds. Compared with matched controls, melanoma patients under 30 were seven times more likely to have used a sunbed more than 10 times a year. I have a list of numerous other international studies that all back up that evidence.

Mary Scanlon: So research has been done, and those who are affected by melanoma have been regular users of sunbeds.

Shona Robison: Yes. That link has been established.

Mary Scanlon: I return to a point that Helen Eadie made. We received some supplementary information from the Convention of Scottish Local Authorities, which still seems to be in favour of a licensing scheme. However, I would not wish to enforce that—we are not looking for more licensing schemes.

The Convener: I wonder why you are glancing in my direction when you say that. I am working on you, Mary.

Mary Scanlon: My party always prefers a lighter approach to be taken.

As Helen Eadie said, eight local authorities have licensing schemes. Are those schemes different to what the Government proposes? Will you expect local authorities to continue ad hoc with their licensing schemes under the Civic Government (Scotland) Act 1982 or will they have to adhere to the proposal in the bill?

12:15

Shona Robison: If the local authorities want to continue their schemes, nothing in the bill will stop them doing so. They are all doing different things, but the thrust is around data collection. Certainly, the systems are more formal than those under the permissive power in the bill, which will allow EHOs to target premises that are perceived to be a problem. In effect, the licensing schemes will enable EHOs to monitor all premises where sunbeds are used in their area.

COSLA's concern is the bureaucracy and costs of a mandatory licensing scheme, which are not insignificant. Again, we are talking about a balance between Government legislation and individual responsibility. Clearly, we will have to keep the situation under review, but I am confident that EHOs will use the permissive power in the bill to address operators who require to be monitored in terms of their compliance with the legislation. That said, there is nothing in the bill to stop local authorities going further, if they want to do so. The decision to establish more formal licensing systems is entirely a matter for authorities.

Mary Scanlon: Does current data collection include information on issues that the committee has raised today, including whether UV rays are dangerous to people? Earlier, you talked about knowing when there is a problem, but how will EHOs know that there is one? Who will report problems? We discussed that when we took evidence from Kenneth Macintosh. Also, you spoke about EHOs being able to pop into salons when they are in the area. What will they look at when they do that? Will visits be announced or unannounced? I seek clarification on those points.

Shona Robison: Those are matters for the professional judgment of individual EHOs. If they have concerns about premises, I assume that they will make unannounced visits. As is often the case in such circumstances, we will rely on the public. People monitor what is going on—

Mary Scanlon: I am sorry to interrupt, minister, but how will members of the public get to know about problems? If a 12-year-old or a 14-year-old—someone who looks very young—is involved, the public will get to know, but how will people know to say, "You let in someone with blue eyes and blonde hair, but that is against the law"?

Shona Robison: But the provisions are not about that; clearly, they are about under-18s, coin-operated, self-operated machines and information provision. Operators will have to comply with the provisions, and if they do not they will commit a criminal offence. There will be serious consequences for operators who beach the legislation. We will rely on the professionalism of EHOs in picking up concerns that they hear about. Indeed, EHOs do that all the time. They also rely on members of the public to alert them to concerns.

Mary Scanlon: They probably rely more on members of the public.

In making pop-in visits, what will EHOs be looking for?

Shona Robison: Under the bill, EHOs will seek evidence of anyone who is underage using sunbeds; they will check whether salons are using unsupervised, coin-operated machines; and they will find out whether salons are giving out information packs containing advice about the use of sunbeds and outlining the concerns about them.

The Convener: We will have the opportunity to explore that further when the amendments are lodged. I want to move on. These issues can all be raised—

Shona Robison: Can I make one final point?

The Convener: I was thinking of you in trying to move the discussion along.

Shona Robison: EHOs could also have their reserved-issues hat on, in terms of product safety, when they carry out their inspections. It would make sense for them to do that.

The Convener: Right. So we will have two-hatted EHOs. As you can see, none of us who are sitting, weary and pale faced, round the table use sunbeds.

We move to part 9, on statutory nuisances. This is Duncan McNab's moment. He has been waiting for hours. Can somebody please ask a question of Mr McNab? Everyone has fallen silent, but they are rallying. Fear not, Mr McNab—a question is coming.

Mary Scanlon: I do not want him to feel that we do not value his presence.

The Society of Chief Officers of Environmental Health in Scotland has suggested that the imposition of a fixed-penalty notice, under section 95, could be problematic. The proposed notice will be different from fixed-penalty notices that are served for littering or speeding—whereby the initial instance leads to the serving of a notice—and the society thinks that it might not be appropriate. You may wish to clarify why you feel that a fixed-penalty notice is necessary.

Shona Robison: I am bound to hand over to Duncan McNab.

The Convener: I am so glad. He is on the starting block—we are the sport committee as well. You may spring into action, Mr McNab.

Duncan McNab (Scottish Government Environmental Quality Directorate): The fixed-penalty notice regime is a voluntary alternative to prosecution—we are looking to be flexible—and deals with non-compliance with an abatement notice, which gives a warning to an offender and offers him an opportunity. If he breaches the abatement notice and does not abate the nuisance, he will be given a fixed-penalty notice. Detailed guidance will accompany the regime, including information on how fixed-penalty notices can be issued.

Mary Scanlon: Sorry, but I have not read all the information on the provision. How many fixed-penalty notices will someone get before further action is taken? Will issuing a fixed-penalty notice be a way of telling someone that their card is marked—like penalty points for speeding, et cetera? Is it the same system?

Shona Robison: Further notices could be issued and the offence could, ultimately, lead to prosecution.

Duncan McNab: We are looking to tighten up the provisions on the basis of the responses and written evidence that we have received from quite a few parties. We will produce an amendment at stage 2 to do that. There are various options at the moment. If a person does not abate the nuisance, the local authority can abate the nuisance under current legislation and charge the offender accordingly.

Ian McKee: For the sake of clarification, can you confirm that the issuing of a fixed-penalty notice will not close off other legal avenues and cause the episode to be concluded legally? Could it be reopened?

Duncan McNab: Certainly.

The Convener: If it continued, but if somebody paid up and did not offend again, that would be it.

Duncan McNab: That would be it.

Ross Finnie: Minister, can you clarify that, under section 96, the phrase "sewerage nuisance", which is to be substituted for "nuisance" in the Water Services etc (Scotland) Act 2005, covers odour from sewage?

Shona Robison: Good question.

Ross Finnie: That is why I am here.

Shona Robison: Would you like to handle that one as well, Mr McNab?

Duncan McNab: Certainly. Yes, the intention is to include odour nuisance. The provision is a technical amendment and is being introduced to address an anomaly in the 2005 act, which it was felt disapplied certain provisions in the Environmental Protection Act 1990.

The Convener: You say that that is the intention. Will it succeed?

Duncan McNab: We think so.

Ross Finnie: So the sewage code includes the issue of odour.

Duncan McNab: Yes. The current statutory code includes odour.

Ross Finnie: That is good. Thank you.

The Convener: We have got rid of bad smells now.

Rhoda Grant: I want to go back to the fixed-penalty issue. Under section 95(2), proposed new section 80(4A) of the Environmental Protection Act 1990 will refer to

"offering the person the opportunity of discharging any liability to conviction for that offence by payment of a fixed penalty."

When would such an offence be deemed to begin and end? For example, if the person responsible

for a light nuisance paid a fixed penalty for it, their liability to conviction would be discharged and they could leave the light on.

Duncan McNab: That would be dealt with on the basis that an abatement notice can refer to a nuisance that occurs or recurs. If someone discharged their liability by abating the nuisance, but it recurred, a further fixed-penalty notice could be issued.

Rhoda Grant: However, what if that someone is given a fixed penalty that must be paid in 14 days and they say that they will pay it and get the problem sorted, but that it will be three weeks before someone can sort it, and then they do not get somebody to sort it out. Could the matter be taken further?

Duncan McNab: Certainly. They would be in breach of the abatement notice, so they could be referred for prosecution, if that were deemed necessary. Furthermore, we will allow flexibility, whereby a local authority will be able to amend the period of the abatement notice. That is normally the circumstance now, whereby local authority EHOs negotiate with offenders how long it will take to abate a nuisance.

The Convener: Yes, I was going say that we are back with the situation of the sewage odours. It might be quite difficult to—

Rhoda Grant: Perhaps the wording of section 95(2) needs to be re-examined, because it reads as if paying the fixed penalty will discharge a person of all future liability.

Shona Robison: We will look at that.

The Convener: I want to move on to part 10, on which we have two questions.

Dr Simpson: I have two quick questions. First, section 98(5) states that information can be disclosed

"only if the individual consents."

Might not there be circumstances in which the individual does not consent but you wish one body to refer to another body? I am not sure that that point is covered by section 98(5), but I may not be reading it properly.

Shona Robison: My officials tell me that our intention is to amend section 98(5) to take account of the point that you have made.

Dr Simpson: Thank you. My other point is a general one that arises from section 102, on regulations and orders. The bill indicates in a number of places—I can list them later, convener, rather than go through them now—occasions on which the minister will have powers to amend or create regulations, which is appropriate. However, the word "consult" is singularly lacking in the bill—it hardly appears. Sections 19(1), 56(6), 89(1), 95(11) and 98(8) are examples of where I think there needs to be something about consulting appropriate stakeholders before regulations are drawn up. It might be better to cover that with a general requirement under section 102 for the minister to consult, if that can be constructed.

The Convener: Is that usually included in primary legislation?

Shona Robison: Not that I am aware of. In practice, there would be consultation with appropriate stakeholders, but I am not aware of that practice being provided for in bills.

Dr Simpson: It is. It was in some health bills that we introduced, for example the mental health bills and the Adults with Incapacity (Scotland) Bill.

Shona Robison: My officials tell me that the provision is in some bills but not in others. We will give that point further consideration.

The Convener: You have now raised it, Dr Simpson.

Helen Eadie: My point is on section 97, on equal opportunities. The submission from the Scottish Council of Jewish Communities refers to Jewish law—halachah—which regards the human body as sacrosanct. The submission states:

"According to Halachah, there should be as little interference with a dead body as possible, it should not be left unattended, and burial should take place as early as possible, preferably before sunset on the day that death occurred."

The submission calls for sections 82 and 83 to include reference to more than mortuary provision, and states that

"in addition to providing 'premises and facilities'"

there should be facilities for

"relatives who wish to stay with the body until after the burial. Ideally there should be more than one area, so that, for example, families of different religions, or of none, would be able to occupy separate spaces, so as not to disturb each other's ritual and the start of the grieving process."

The submission also refers to burial and cremation. The Scottish Council of Jewish Communities is adamant about cremation, and states:

"any disposal other than burial would be strongly resisted, as Jewish law does not permit cremation."

12:30

The Convener: I will summarise: how does the bill take into account religious and cultural requirements?

Shona Robison: The presumption is that there will be as little interference with bodies as possible. The mortuary issue is about standards of

provision. We can examine existing guidance on that, but we would always expect the concerns that Helen Eadie expressed to be dealt with under standards of provision.

Cremation has come up in discussions with various faith groups. Of course we want to respect the wishes of faith groups as far as possible, but overriding public health concerns may sometimes require cremation to be considered as the only option. That is unfortunate, but it is the reality when dealing with potentially contagious diseases. Clearly, however, that option will be a last resort.

The Convener: I think that members' earlier questions dealt with schedule 1. As we have dealt with all parts of the bill—I am not going back over them—do committee members have any further, quick questions?

Helen Eadie: Just on the finance issue.

The Convener: We touched on that earlier when we raised with the minister concerns about costs, expenses and so on. Perhaps we can deal with that again at stage 2.

Thank you, minister, for the time that you have spent before the committee.

12:33

Meeting continued in private until 12:35.

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Friday 29 February 2008

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