HEALTH COMMITTEE

Tuesday 12 September 2006

Session 2

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HEALTH COMMITTEE
19th Meeting 2006, Session 2

CONVENER
*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER
*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES
Mr Kenneth Macintosh (Eastwood) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Margaret Smith (Edinburgh West) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:
Lesley Boal (Lothian and Borders Police)
Glenda Cook (NHS Greater Glasgow and Clyde)
Harry Garland (Orkney Islands Council)
Andy Leigh (Lothian and Borders Police)
Dr Donny Lyons (Mental Welfare Commission for Scotland)
Dr Sheena MacDonald (NHS Borders)
Sandra McDonald (Public Guardian)
Eibhlin McHugh (Scottish Borders Council)
Eileen Moir (NHS Borders)
Liz Norton (Scottish Commission for the Regulation of Care)
Louis Skehal (North Ayrshire Council)
Val de Souza (Convention of Scottish Local Authorities)

CLERK TO THE COMMITTEE
Simon Watkins

SENIOR ASSISTANT CLERK
Graeme Elliott

ASSISTANT CLERK
David Simpson

LOCATION
Committee Room 6

Scottish Parliament

Health Committee

Tuesday 12 September 2006

[THE CONVENER *opened the meeting at 14:00*]

Mainstreaming Equalities

The Convener (Roseanna Cunningham): Good afternoon. I welcome the witnesses who are at the committee for the first evidence session this afternoon on the Adult Support and Protection (Scotland) Bill. If they will bear with us, we have an item to deal with before we come to them.

Item 1 is on mainstreaming equalities. Members will be aware that the Equal Opportunities Committee has endorsed a policy for the consideration of equal opportunities issues by subject committees. The paper outlines a possible approach to those issues in the context of the two bills that we will consider in the coming weeks. It identifies a number of areas for possible action. I invite members to comment on the recommendations. When we have had a brief discussion we will deal with the recommendations. Does anyone have any comments?

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I do not see any difficulty in choosing recommendations a, b and c, although that may be pre-empting the discussion. It is a particularly important subject in relation to the Adult Support and Protection (Scotland) Bill.

The Convener: I am sorry, but can you clarify to what you are referring?

Dr Turner: The recommendations at the bottom of the final page of the paper are to

"a. write to the sponsors of each Bill seeking a written response to the specific issues outlined above.

b. bear these issues in mind when questioning the Bill sponsors"—

The Convener: Are you supporting the recommendations?

Dr Turner: Yes. They are all important.

The Convener: Okay. I wanted to ensure that everyone had the opportunity to comment on the paper before we decided whether to support the recommendations.

Mrs Nanette Milne (North East Scotland) (Con): We are not being asked to choose between the recommendations.

The Convener: That is right.

Mrs Milne: That is fine.

The Convener: If no one else has any comments, can I take it that the committee agrees to the recommendations in the paper?

Members *indicated agreement*.

The Convener: I should say that much of what is outlined is what we have already been doing, but this clarifies our approach and puts it on the record.

Adult Support and Protection (Scotland) Bill: Stage 1

14:02

The Convener: Item 2 is the continuation of our evidence taking at stage 1 of the Adult Support and Protection (Scotland) Bill.

There are two sets of witnesses today; the first panel is already in place. I welcome the witnesses from the Borders, who have been working on specific projects that are of relevance to the bill. Eibhlin McHugh is from Scottish Borders Council; Eileen Moir and Dr Sheena MacDonald are from NHS Borders; and Detective Sergeant Andy Leigh and Detective Chief Inspector Lesley Boal are from Lothian and Borders police.

I will ask for opening statements from the panel. Three groups are represented on the panel, so I will confine the statements to three individuals rather than all five. We will start with Eibhlin McHugh and in the meantime the other witnesses can decide who will make the brief opening statement.

Eibhlin McHugh (Scottish Borders Council): On behalf of the Scottish Borders vulnerable adult protection committee, I am pleased to share with the Health Committee our experiences in this area of work. Adult support and protection have been and remain a major priority for us. Our work has been about ensuring that staff have the right skills and that the right systems and processes are in place to ensure that the needs of the individual are at the heart of everything that we do.

Overall, we welcome the principles and provisions of the bill and recognise the opportunities that it provides to enable us to fulfil our responsibilities. We have considered some cases where the bill will provide opportunities that are not currently available to us and would be happy to share those with the committee.

Eileen Moir (NHS Borders): NHS Borders welcomes the bill and supports its general principles. The bill provides an opportunity to contribute to the future protection of vulnerable adults and we are keen to support it.

Andy Leigh (Lothian and Borders Police): I speak on behalf of Lothian and Borders police, primarily from the Borders aspect. We and the Association of Chief Police Officers in Scotland support the principles of the bill.

As detective sergeant in the Borders region, I have responsibility for the family protection unit, which deals with child protection, vulnerable adults and sexual offences. Since 2004, we have worked diligently in response to concerns about vulnerable adults. I act as the single point of contact in the police for social work and health staff and I collate all concerns and risk assessments with regard to vulnerable adults. We are also involved in training; we collate and disseminate information within the division; and we take part in case conferences and strategy meetings.

Kate Maclean (Dundee West) (Lab): I have a question that any of you can answer. I would be interested to hear what the various organisations think. Nobody would argue against anything that can be done to protect vulnerable adults. We have all read about cases in recent years in which vulnerable adults have been abused and I am sure that some of us have dealt with casework in which certain situations have caused concern. What provisions in the bill will allow you to do things that you cannot do at present? From the written evidence that we received and the evidence that we have heard so far, it seems that the bill might allow you to do things more quickly but that there is nothing in the bill that is not picked up in other legislation. Will you highlight some of the powers that the bill will give you that you do not have at present?

Lesley Boal (Lothian and Borders Police): The bill will, in principle, allow the agencies to work together. From a personal point of view, and from the police perspective, one of the omissions from the bill is that the police are not specifically included in the duty to co-operate. The bill contains a list of persons and agencies that have that duty, such as the Mental Welfare Commission for Scotland, but the police are not included in the list, although we could fall under section 5(1)(e), which refers to

"any other public body or office-holder as the Scottish Ministers may by order specify."

The police in Scotland—I speak specifically for the police in Lothian and Borders—are a vital and integral part of the protection of adults. The police have to be included in that list because the duty to co-operate is essential. Provisions on information-sharing facilities could be added to the bill as well, because there is no clear onus on public bodies to share information with one another for the protection of vulnerable adults.

Eibhlin McHugh: The bill will allow us to intervene in ways that we do not have powers to do at the moment, particularly—

The Convener: Will you outline those ways?

Eibhlin McHugh: Yes. They relate particularly to investigation. In reviewing the work that we have done, we identified a small minority of cases—I reiterate that it is a small minority—in which we were unable to access the individual about whom there were concerns in order to carry out a full investigation. In such cases, for example,

the individual or the carer might be unwilling to co-operate with us. At the moment, if we know that a person might be vulnerable and there are concerns about them but we cannot intervene under the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003, we do not have the powers to investigate.

The other power that the bill gives us relates to the removal of an individual for the purposes of assessment. The bill will allow us to make safe the individual's living arrangements during an investigation and immediately thereafter. Those emergency powers are important because they will enable us to ensure that individuals are safe from harm.

We have worked in a number of situations in which we believed that the individual was under undue pressure. In such cases, we need to separate the vulnerable individual from their carer so that we can make a full assessment of the degree of pressure. However, our intervention is not just about the assessment. It is also important to be able to access the individual so that we can give them information and make them aware of the alternatives that are available to them. Some folk might choose to live in a particular situation because they do not have information about the support and alternative options that are available to them. The bill will allow us to carry out an assessment and ensure that individuals have that information.

Kate Maclean: I am still not clear. I would have thought that you would be able to do those things in any situation that might arise currently. Often it will be a criminal act that has taken place and reporting it to the police would allow an investigation to take place. Anyone is entitled to give anyone information; no one can stop any agency from giving someone information. In fact, I can go to someone's door and give them information if I want to even if I am not part of any agency.

It is not clear to me where the bill works. If you could give an example of a situation rather than just a generalisation, it might make it clearer. Depending on how we define risk and abuse, I am concerned that the bill might make it more difficult to deal with the situations of vulnerable adults. Could you give us a specific—hypothetical, obviously—example of where the bill would allow you to assist someone in a way that you cannot currently do, even if you had to act more slowly or get through more red tape?

Eibhlin McHugh: I can give you an example of a woman who was living with a carer who was not her relative. Several agencies, such as housing and voluntary organisations, expressed concern about the well-being of that individual. They were concerned that she might be being subjected to emotional and financial abuse. However, no substantial evidence accompanied those concerns. In our initial discussions with the police, we became aware that her carer was known to the police for a number of alcohol-related offences. We were also made aware that colleagues of her children and family had concerns about the carer and, in particular, about his relationships with vulnerable women.

The carer was unwilling to give us access to the individual and was particularly antagonistic towards the social work department and the police. He was unwilling to allow them to have any form of contact with the individual about whom the concerns had been expressed. The only point of contact that that individual had was with the local general practitioner. I must highlight here the importance of the relationship with the general practitioner. In such situations, the GP is often the only person who might be allowed access to or have on-going contact with the individual.

For more than a year, we were unable to investigate the concerns because we had no access. We were particularly fortunate in that a friend who was living abroad contacted us and shared similar concerns. That friend facilitated an assessment by bringing the individual to the local GP practice where she met a social worker and someone from mental health services. We were able to make an assessment in that situation. However, if that friend had not appeared, there is no way that we could have checked out the concerns and provided that individual with the information.

Kate Maclean: Obviously, in that case, it was suspected that criminal acts were taking place with someone's finances, as well as possible abuse of a vulnerable woman. Would you have no powers whatever to investigate that under current legislation even if you suspected that criminal acts were taking place?

Andy Leigh: There is certainly a duty on us to investigate and to report if we have evidence to substantiate the suspicion. Often adults choose to live in relationships that we would consider to be inappropriate. We cannot get access into the house without a complaint; we need evidence to substantiate it. Often the information that we receive comes to us not as a direct result of an incident to which the police have been called but second or third-hand—the information is often hearsay, which makes it difficult for us to act. If we find that someone has a lack of capacity, we can use the provisions of the Adults with Incapacity (Scotland) Act 2000, but it can take several weeks for social workers to take action. That is a big gap in protection for people, so we need emergency

powers to allow us to get in and carry out an assessment.

14:15

Kate Maclean: Would amending the existing legislation to include emergency powers have the same effect as the bill?

Andy Leigh: Such an approach could close the gap for adults with incapacity.

The Convener: Do the witnesses from NHS Borders want to comment on that aspect of the bill? Will the bill enable action to be taken that could not be taken under the current arrangements?

Dr Sheena MacDonald (NHS Borders): I support the comments of Adrian Ward, who gave evidence to the committee last week. He said that some groups of people would fall between the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. Although an amendment of the 2000 act to provide for emergency powers would be helpful, some individuals would not fall within the definitions in that act.

The Convener: You mean the people who we heard were being sent to bed at 8 pm.

Dr MacDonald: That is possible. I listened to the discussion last week and I understand the committee's concerns. In general practice it is common to come across middle-aged adults who have been living with family members for many years and who never received assessments at school or in the workplace because such assessments were not available at the time. We become aware, often through anecdotes or because multidisciplinary teams share information, of levels of care that fall short of criminal activity. We need to broaden the gateway, as Adrian Ward said last week, but we also need to ensure that when we take action we are clear about the rationale for doing so.

The bill could support general practitioners as key individuals in the process. GPs are not employees of health boards; they are independent contractors and instructions to become engaged do not necessarily apply to them. We work in accordance with good medical practice and General Medical Council guidance when the risk to a patient outweighs issues of confidentiality. However, sometimes in the early stages of our involvement the situation is not clear, so it is useful to know that legislation underpins our involvement. There has been quite a change in the behaviour of independent contractors—the term includes not just GPs but general dental practitioners and other contractors who work in health—because they know that their approach is underpinned by legislation. The bottom line is that we might have to fall back on legislation but, short of that, people should feel that they have permission to get involved.

I support the suggestion that was made at last week's meeting that we need to be clearer about triggers when concerns escalate and about consent.

The Convener: We will come on to those matters. I do not want us to get sidetracked now.

I want to ask Eibhlin McHugh about removal orders. Where would we remove people to? Currently, areas of civil law can involve the removal of children at risk and I understand that informal prioritisation takes place because there are not enough places for children to be removed to. Will resources be made available to ensure that the approach in the bill works better?

Eibhlin McHugh: Resources are a major issue for the implementation of the bill and all work to do with adult protection. On the basis of work that we have done, we envisage that the removal provisions would be used infrequently, in a very small number of cases. Where we placed individuals would depend very much on their needs. We would use current respite facilities for some older people, as we have done when an individual has voluntarily moved out of the household for a period to allow work to be undertaken.

The Convener: That approach has a knock-on effect on the availability of respite facilities for the rest of the community.

Eibhlin McHugh: Yes, it does.

The Convener: That is a big issue. What other situations would you be talking about?

Eibhlin McHugh: Our respite facilities would also be used for adults with learning disabilities. In the past, we have had occasions on which we have had to set up emergency arrangements for individuals with learning disabilities. That has involved accessing housing through our homelessness section and putting in staff, 24/7, to support those individuals.

Again, the response would be similar to what we do at the moment when an emergency arises and we need to provide care to an individual.

The Convener: From a Borders perspective, could you give us a rough guess as to how many removal orders there would be in a year?

Eibhlin McHugh: It is difficult to say. There are probably one or two. We would probably want to find ways of supporting the individual to remain in their own home rather than issuing a removal order.

The Convener: What about an instance involving a banning order for the carer so that you were taking the carer away rather than the individual? Where would they go to, particularly if it was their own home?

Eibhlin McHugh: Again, we would need to access resources for individuals who are homeless and would need to work with our homelessness colleagues to ensure that that person was provided with accommodation.

We have come across a number of situations in which there have been issues with the carer. For example, there have been cases in which an older person has behaved in an abusive way towards a son or daughter who is living with them.

Obviously, we would use the powers that you are asking about only in situations in which there is no other alternative. We would explore every other option before we used them.

The Convener: However, the one or two banning orders and the one or two removal orders add up to two, three or four cases a year.

Eibhlin McHugh: That would be a maximum, I would say.

The Convener: That gives us an idea of the situation. It is difficult for us to gauge the likely number of cases across Scotland without finding out the number of cases in particular councils.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Will there be a significant additional call on your resources as a result of the new powers in the bill?

Eibhlin McHugh: Yes.

Mr McNeil: How?

Eibhlin McHugh: In a number of ways. The bill deals with the setting up of committees and so on. We have provided information on the cost of the vulnerable adult unit. I can make a judgment only on the basis of our experience over the past two years, in which time we have done a lot of work on training and awareness raising. As a consequence, there has been a rise in referrals and investigations. In that regard, the main cost has been in professional activity—in social work time to carry out the investigation and in management time to manage the investigation. Good communication and co-ordination require time.

The other areas in which there has been a significant increase in demand on resources have been to do with administration. We need competent administration staff who have skills in minute taking and are able to manage information systems and so on. From our annual report, you will see that, once the investigation is completed, the outcome in the majority of cases is an increase in the care package, which means that we put in more resources to address the needs that are identified for that individual. Further, the monitoring of that situation takes up more resources, in terms of professional time, if there are continuing risks.

Mr McNeil: Do you see the workload that you have identified as being on-going or do you think that, in the medium to long term, the risk assessment will reduce the need for that type of work?

Eibhlin McHugh: Are you talking about vulnerable adult investigations?

Mr McNeil: If your risk assessment is right, you should reduce the number of people who fall into that situation, which should reduce the need for investigation and so on.

Eibhlin McHugh: Once the investigation has been carried out, the risks identified and a risk management plan put in place, we need professionals to implement that and to deal with the on-going monitoring arrangements. Our experience over the past two years is that we have had a lot of activity involving people with learning disabilities and we have had an increase in activity with older people. We believe that the scope of the bill will mean that there will be an increase in activity with people who have physical disabilities. Therefore we think that we will see a continuing rise in activity.

Another important issue, which my colleagues mentioned earlier, is the trigger for a vulnerable adult investigation. Ultimately, social work activity is primarily about assessing risks and needs. That is our core business. Over the past year, we have had to do a lot of work on clarifying how we deal with lower-level concerns and ensuring that the process that we use is appropriate. In many situations, assessment and care management are the more appropriate vehicle for addressing those risks. A more intensive form of co-ordination is required for higher-level risks, in which criminal activity may be involved. We need the vulnerable adult investigation process for those risks.

Mr McNeil: My question was simply about the amount of resources that are associated with that work. Others may be able to pick up on and replicate the extensive work that you have done. The amount of work that has been put in is obvious from your report and the information that we have been given. Perhaps your work can be used as a model for others to produce that sort of impact.

The Convener: Ms McHugh mentioned the issue of the triggering of an investigation, on which Jean Turner has some questions. The issue has been raised, so Jean Turner will want to develop it.

Dr Turner: Everyone has touched on the issue of the trigger. As I understand it, the advantage of the measures in the bill is that the burden of proof that was previously required will be lighter. The lighter-weight trigger in the bill will allow you to sort out a situation that could eventually become criminal. I understand that the bill will give you the authority not only to enter people's homes but to go anywhere, such as into a hospital ward, if it is suspected that the way in which someone is being treated constitutes abuse in the broadest sense of the term, even though it is likely that in most cases there will be no criminal intent. Can you expand a little on that issue? Will the bill meet a need by changing the trigger that sets in motion a vulnerable adult investigation? How does that compare with what there has been in the past?

The Convener: I should clarify that our discussions last week highlighted the fact that, although we tend to think of such investigations being about entering people's homes in order to establish what the situation is, the power in question will not be confined to entering people's homes. It will also allow council officers to enter institutional premises, including hospitals and care homes. Given that such institutions have their own separate regimes, we are curious to know how that aspect will work.

Eileen Moir: With all the work and training that we have done in the Borders, I think that such abuse would be much less likely to remain undiscovered in a hospital environment. However, I am not sure how the bill will facilitate the process. Such investigations will not be held up in any way because of the bill, but I am not sure how it will facilitate them over and above the types of processes that hospitals have for raising such concerns.

Dr Turner: I am not sure that a local authority officer could enter a hospital and examine case notes to determine the situation in a ward. Normally, it would be for the NHS board to go through its own processes. Also, I am not sure that a local authority officer could arrive unannounced at a nursing home or whatever, given that nursing homes are inspected by the Scottish Commission for the Regulation of Care. There are overlaps. I can envisage a number of scenarios in which the main issue is that the bill will provide the opportunity to enter premises, whatever they are. Under the bill, the required burden of proof will not be as strong as was previously the case and seems to be less than what is required under, for example, mental health legislation.

Many such situations arise when people just do not get on with other people. What triggers might involve staff going in? Would general practitioners and carers going out into people's homes have more protection if it will be possible to step in to deal with a situation based on hearsay? Most such situations will involve people saying things without absolute proof.

14:30

Eibhlin McHugh: This bill will be able to help us with one of the areas. For many of the individuals we work with, there are considerable difficulties in providing the procurator fiscal's office with reliable evidence. Some of those individuals might have significant communication difficulties in that they are not readily able to describe what is happening to them.

We have had several cases that have gone to the procurator fiscal and been unable to proceed. That has often been because of the quality of the evidence.

The Convener: How will the bill change that? People who have severe communication difficulties will continue to have very severe communication difficulties.

Eibhlin McHugh: The bill would only change the situation in that it would give us powers. At the moment, if such individuals are not covered by the Adults with Incapacity (Scotland) Act 2000 or by the Mental Health (Care and Treatment) (Scotland) Act 2003, the only recourse is to common law. In many situations, we do not have adequate evidence for that.

Dr Turner: So you are really saying that you do not need substantial evidence to go into a situation. Could one person's expression of concern be a trigger? Would you act on one person's concern or would you need to have health visitors, district nurses, the general practitioner, the neighbours and so on involved? What would be the lightest trigger that would set things in motion? It is quite a serious thing to be able to walk into someone's home.

Eibhlin McHugh: We would act on all concerns, but our response would be different in each case, depending on the level of concern. When we receive an expression of concern from one individual, our first response is to seek more information about the situation. We would seek information from every other professional who is involved. We would then judge whether the situation can be managed and addressed using the normal processes or whether the concerns and risk are at a level that requires closer co-ordination.

If an older person with dementia alleged that a paid carer had hit them, we would consider that situation in relation to the employment of the carer as well as all the other evidence that might be around. The allegation might be part of a pattern that is related to the dementia, in which case we

would work with the care provider and use assessment and care management to ensure that the situation is continually monitored. Obviously, if there is more substantial evidence or if investigation and discussion with other professionals who go into the household show that there are grounds to do so, we would progress through a vulnerable adults investigation.

Dr Turner: Many people say that things have happened to them when they have not. We accept that we are here to protect vulnerable adults, but through our work in primary care, we all know that people come up with situations that are not true, for whatever ends, and also that some relatives do the same thing. It is quite a thing for a carer to be going into somebody's private space.

The Convener: Does anyone else want to come in on triggers? We are straying on to the next point and I want to bring Nanette Milne into the next part as well. The two issues start to become quite intertwined.

Dr MacDonald: The parallel that we discussed in relation to the pre-investigative case conference stage was with child protection. In the Borders, we have tried to encourage the multidisciplinary team to come together to bring all the little bits of information together in examining whether the situation is cause for concern. It might be that although there is one bit of evidence, someone at the case conference who has been going in daily has never seen any evidence of abuse and the person who has been seeing the individual weekly for her bath has never seen such evidence. We can seek guidance from the adult protection unit: we can say, "We're not actually sure about this. What do you think? This is the evidence to date." The key issue over the past year has been the absolute need for multidisciplinary discussion and sharing of anecdotes to see whether they build up a picture of evidence.

Andy Leigh: On thresholds and concerns that are based on information from only one person, I have found that we must take each case on its merits. We consider the nature of the alleged offence and the adult's vulnerability, and we then hold an initial referral discussion to consider other concerns and the information that we can bring together from the various disciplines. We mirror child protection guidelines in that respect. We might at first have only one concern or only one bit of information, but by the time we have pulled all the information together and looked at all the background information about the address, about the complainer and about the suspected abuse, we have a clearer picture and are able to make an informed decision. The burden of proof depends on whether we are talking about criminality, which would have to be established beyond all reasonable doubt, or about civil evidence on the balance of probabilities. The bill certainly seems to give us the option to consider using civil legislation powers.

The Convener: The biggest part of what you described seems to be about information sharing and about being able to bring it all together. Why on earth are you not doing that right now? What is stopping that?

Eibhlin McHugh: We are doing that.

The Convener: So why do you need the legislation?

Eibhlin McHugh: We do not—

The Convener: You do not need the legislation for the information sharing.

Eibhlin McHugh: I think Sheena MacDonald will have some comments to make about the participation of primary care professionals in information sharing.

Information sharing is happening at the moment. The bill will give us additional powers in a small minority of cases in which we do not have the powers to assess and to ensure the protection of the individual—cases that are not covered by the Adults with Incapacity (Scotland) Act 2000 and by mental health legislation. The bill will also extend intervention to people who do have capacity.

Eileen Moir: That is the case, but the bill will also add the support of the adult protection committee, the co-ordination of information and the coming together of professionals to provide an overarching strategy on protection and information, which is not in place in the meantime. Information sharing does happen in the Borders, but the co-ordination function is crucial.

Lesley Boal: I would like to add something from a police perspective. I know that the Borders situation is different, because it provides an example of co-located units working together with police, councils and health authorities. Other parts of the Lothian and Borders police area also have co-located units. However, we must remember that, although information sharing is working well in Lothian and Borders, child protection has been on the agenda for the past 15 years and every single public inquiry into the terrible tragedies that have occurred has highlighted failings in information sharing.

Kate Maclean: Is that because appropriate action has not been taken under the current legislation, or because of a lack of legislation? I have not read all the reports in depth, but it appears that, in some cases, appropriate action was not taken under the existing powers, rather than the legislation being inadequate.

Lesley Boal: You are probably right to suggest that some legislation has been misinterpreted or

misunderstood. However, I think that including in the bill a duty to co-operate would be beneficial.

Mrs Milne: A broad definition of "adults at risk" has been welcomed in the Executive's consultation. Are you content with the definition in the bill?

Dr MacDonald: I run the risk of boring you by saying that it is good to hear that there is consensus. I agree with what Orkney Islands Council has said about the use of the word "ageing". People who suffer from an infirmity or come under the other descriptions of "adults at risk" could include older people. To leave "ageing" in isolation is probably potentially discriminatory; it could be embraced by the other language that is used.

I would support a broader definition of "adults at risk"—one that goes beyond what some people might think is quite a narrow definition of people who could suffer abuse or harm. I am thinking in particular about adults who are at risk because of their circumstances—the environment or the people around them. We discussed that matter at great length on the way here in the car and have done so previously. A broader definition is required.

The Convener: There is concern about use of the word "abuse" because it carries the connotation that a deliberate act that has harmed somebody has taken place. However, much of what we discussed last week would fall into the category of neglect, or benign neglect. There are issues in that respect, particularly in long-standing family situations. Perhaps not all members of a family will be aware of the best ways of dealing with matters, so perhaps the word "abuse" is not the best word to use in such circumstances: people in such situations are frequently not intentionally abusive. However, what they are doing may not, for all sorts of reasons, be in an individual's best interests, which is not to say that they have deliberately set out to abuse the individual. Do you agree that that is an issue?

Dr MacDonald: Yes.

The Convener: Nanette, do you want to follow that up?

Mrs Milne: The matter has been dealt with.

The Convener: Helen—do you think all the issues to do with banning orders have been covered?

Helen Eadie (Dunfermline East) (Lab): More or less, but I was going to ask whether the witnesses want to add anything about whether the banning orders will be effective. One of the issues that arose most frequently in the submissions was the different orders that have been proposed.

The Convener: We should bear it in mind that it has been said that such orders would be expected to be used only once or twice a year.

Eibhlin McHugh: Banning orders would be used in a small minority of cases. We would always want to co-operate with everyone who is involved in a case. Especially where a parent and a young adult are involved, we would want to work with whatever good will remains in the relationship in order to secure the protection of the individual who requires it. The bill's principles are appropriate, and banning orders would be a last resort.

Let us consider the situation in which an older person who has lived in his or her own home for a long time has a son who has returned to that home, and whose behaviour is disruptive and may put the individual at significant risk. In such situations, the best option by which to secure the individual's well-being is to provide support to the son to move on, which can be done by using legislation.

The Convener: Why does that not happen now?

Eibhlin McHugh: It does happen, in the sense that we would work with such an individual, but we would have difficulties if an individual refused to move on or to leave the family home. The bill will allow us to take into consideration the undue pressure that the vulnerable individual may be under.

Mrs Milne: The bill seems to be similar to other legislation. Kate Maclean has raised the issue of amending legislation. Could what the bill is trying to achieve be done by amending the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003?

14:45

Eibhlin McHugh: The bill focuses on individuals who do not have a mental disorder and may have capacity, but who also require support and protection. It is the group in respect of whom we do not have statutory powers to intervene. The bill will give us those powers. I reiterate the importance of the section about undue pressure. Many individuals may be living in fear of an abuser, or the nature of their relationship is such that it is enmeshed and there is a need for us, as professionals, to create space to allow the individual to receive the help that they need.

Euan Robson (Roxburgh and Berwickshire) (LD): Are you satisfied with the general governance arrangements for adult protection committees, as set out in the bill? You have experience of how you need to operate and you have developed some of those governance

arrangements. Should anything be added to or taken out of the bill? What is particularly interesting is the duty that appears to exist for you to encourage the development of skills. Is that a departure from or growth of what you are doing at present?

Eileen Moir: The concept of the adult protection committee is welcome. Its great strengths are its co-ordination of all of the agencies and the fact that it has an independent chair. The bill says that the committee should lead on investigations. I have some discomfort about that because of the nature of the committee, which is about setting strategy and ensuring that training and skills development take place. The committee should take steps to ensure that significant incidents are investigated and take evidence to support that.

Euan Robson: How do you see the adult protection committee and the child protection committee co-operating? What is your experience of that, particularly in the context of someone who is passing from the child protection committee's remit into the adult protection committee's remit? Do you envisage common staff and so on?

Eileen Moir: I sit on both committees and I have deputies who are able to cover for me in both instances. The head of children and families sits on both committees. There are probably others, such as the police, who also do so. However, it is important that it is not just down to individuals; it is about ensuring we have in place the clear systems that will operate independent of any individuals.

Euan Robson: Should there be a requirement in the bill for co-operation, or is it sufficient to infer it or to be silent on it? As I read it, there is nothing to require co-operation.

Eileen Moir: It is important to require co-operation. As Dr MacDonald said, it would be helpful to support and enable others—for example, general practitioners—to contribute. There would be benefits to requiring co-operation. Perhaps some of my colleagues would like to add to that.

Eibhlin McHugh: Co-ordination of adult protection and child protection is important. In the Borders, we have seen the benefits of our vulnerable adult protection committee in furthering integrated working along those lines. The other matter that is particularly important is criminal justice representation on the committee. Many of the vulnerable adults or adults in need of protection and support with whom we work may also present risks to community safety, so it is important that we work closely with our criminal justice colleagues.

The Convener: You established in the Borders the vulnerable adult protection committee with criminal justice representation and co-operation, but you did not require legislation to do any of that.

Eibhlin McHugh: No.

Andy Leigh: To reinforce the point, it is incumbent on committees to ensure that they establish strong links with the other disciplines. Experience has shown that links with child protection services and criminal justice services are important, especially in relation to sex offenders. Multi-agency public protection assessments are now coming in, and we are identifying and establishing links with the different disciplines. It is important that, when committees come together, they bear that in mind.

The Convener: I thank all the witnesses for coming this afternoon. They are, of course, welcome to stay and listen to the evidence from the next panel of witnesses, if they so wish. We will take a couple of minutes to change over the witnesses.

14:52

Meeting suspended.

14:54

On resuming—

The Convener: I welcome the second panel to the meeting. From the far left, the witnesses are Sandra McDonald from the office of the public guardian; Liz Norton from the Scottish Commission for the Regulation of Care; Val de Souza from the Convention of Scottish Local Authorities; Harry Garland from Orkney Islands Council; Louis Skehal from North Ayrshire Council; Dr Donald Lyons from the Mental Welfare Commission for Scotland, who has previously appeared before us; and Glenda Cook from Greater Glasgow and Clyde NHS Board.

I want the discussion to be conducted more as a round table, although we are not set up in a round-table fashion. Members will have questions, but I want a bit of cross-questioning between witnesses. We will not just have a committee member asking a question that witnesses answer; we will try to have a more free-flowing discussion. It would help the official reporters if only one person spoke at a time; I know that that can sometimes be a bit difficult.

To open up the discussion, I ask the witnesses whether additional legislation is needed. Most respondents to our call for evidence were generally in favour of the bill's general principles, but you will have detected a note of scepticism in the committee about why the bill is required. Will you address that as specifically as possible without being too long winded?

Glenda Cook (NHS Greater Glasgow and Clyde): We confirm our broad support for the bill.

We expect it to be put into practice through our community health and care partnerships, which operate in partnership with the social work department, which we expect to be the lead agency.

We confirm our support on the basis that, as has been said, the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003 do not cover a number of people—people who have capacity but who could be vulnerable to abuse from carers. In several cases, we cannot help those people or improve their quality of life.

Dr Donny Lyons (Mental Welfare Commission for Scotland): I will make a general point and a specific point. The general point is about whether the bill is needed and whether existing legislation allows intervention. The same argument could have been mounted about the 2000 act. Instead of passing that act, Parliament could have amended existing legislation. However, the 2000 act set a tone and a direction and provided a general overview—Dr MacDonald said that about the bill. We think that that is needed. We have investigated some situations in which an intervention was made under existing legislation, but that is not always clear. The tone that the bill will set and the emphasis that it will place are important.

I will give a specific example, for which I thank my colleague Margaret Anne Gilbert, who is present. A man is injured in a road traffic accident and a relative of his contacts the local authority to say that his estranged wife has moved back in with him. The man has contacted the relative to say that his wife is not looking after him and alleges that she pushed him down the stairs, but he does not want the police to be involved. The wife does not want to let anybody into the house—she refuses to let other relatives, social workers or anybody else enter. We do not know whether the guy has a mental disorder, but we know that he is vulnerable. Nothing in existing legislation would give the local authority a clear steer on how to become involved. That came up when Kate Maclean asked for an example.

Kate Maclean: I would have thought that legislation covered the fact that people are not allowed to push others down the stairs, so the police could become involved. If somebody is concerned about a relative and a criminal act has been committed, they should ask the police to investigate.

Dr Lyons: Okay. If just the other allegations were made, it would be difficult to intervene. Existing law would not cover that.

Louis Skehal (North Ayrshire Council): We support the bill's general principles. It has been interesting to hear the debate this afternoon and the scepticism that is around, which the convener mentioned—the question is whether the bill takes a sledgehammer to crack a nut.

Balance is involved. There are people about whom we are concerned and for whom we cannot act. In your question to Scottish Borders Council, convener, you said that it had done all that it described without legislation, but the council acted on the back of a series of serious incidents.

The Convener: We do not want to discuss the series of incidents. The point that I made was that legislation was not required to achieve the result that everybody thought was better. We are talking about passing legislation to achieve something that, to many of us, is beginning to appear to be achievable by other methods.

Louis Skehal: I think that, like Borders council, we would say that a number of people live in complex circumstances in which we are unable to intervene. The bill would allow us to intervene.

Harry Garland (Orkney Islands Council): I am absolutely clear that we need additional legislation—we should not just build on other legislation. I agree with colleagues who have already spoken. The net needs to be closed. People have asked, "Why isn't this happening anyway?" and there has been a great deal of logic in their points. However, the new bill builds on what is good practice.

In Orkney Islands Council, we already have an adult protection committee—we do not have an adult protection unit but we do have a committee and it has been in place for almost a year now. That committee has allowed us, as professionals, to share information and to consider issues. That has been immensely helpful, but it has not allowed us to protect everyone in the way that we would like—or at least to go down the assessment route—because the legislative framework is not there.

My experience lies in local authorities, where there is huge pressure on resources—especially on social work resources. If there is not a duty to undertake certain actions, the resources in the pot will not go towards what we would all like to be doing—preventive work. The new legislation would clearly enable local authorities to focus on preventive work, which is an area of protection that society needs.

15:00

The Convener: What is the view of the Convention of Scottish Local Authorities on this?

Val de Souza (Convention of Scottish Local Authorities): COSLA represents 31 local authorities that are unanimous in their support for

the bill, for the reasons that my colleagues have outlined. The powers in the bill are not superfluous. All the local authorities have spent a long time looking into the bill and they support it.

The powers that will come with the adult protection committee relate to interagency co-operation and cannot be underplayed. When it comes to different responsibilities for adult protection, the net spreads very wide and covers many agencies. The adult protection committee will be a vehicle that will help us to standardise our approach and make it robust. We will be able to get things right—across the board and across the country.

Sandra McDonald (Public Guardian): In the office of the public guardian, our primary focus is on part 2 of the bill. I appreciate that the committee is probably more interested in part 1, which we also support, and which has a focus complementary to ours. We focus on incapable adults but, as we have heard already today, there are adults who are capable but nonetheless vulnerable.

I agree with Val de Souza. In our experience of working nationally—across all local authorities and various health boards—it is quite difficult to find a consistent or standard approach. It is difficult to know how people can act in a consistent, multidisciplinary and sharing fashion unless there is a duty in legislation.

Liz Norton (Scottish Commission for the Regulation of Care): I reiterate some of the comments made by my colleague from the office of the public guardian. The Scottish Commission for the Regulation of Care is a national organisation operating right across Scotland, and we find when we make referrals that there is no standard response for investigations into situations in which adults are at risk.

The Convener: What if the adult at risk is in a home that is inspected by the care commission?

Liz Norton: We have a statutory duty to investigate complaints. In the course of our investigations into adults at risk, we often uncover some elements of abuse. That happens not only in care homes, but in a range of different care settings. It would assist us tremendously if—as there is in child protection—there was absolute clarity about who was the lead agency, about what duty there was to share information with other agencies, and about who was taking forward the intervention. The situation in child protection matters is absolutely clear, but the same clarity does not exist in relation to the protection of adults who are at risk.

The Convener: We are talking about capable adults who are at risk. Is that what you mean?

Liz Norton: I am talking about some people with capacity and others who lack capacity. If people lack capacity, powers are available under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000, which make it easier to make a referral to social work as the lead agency for assessment. However, for people with capacity, it is not always easy to achieve clarity about which agency will take the lead in doing something about a difficult situation.

Although the care commission can investigate complaints, we have no powers of entry into people's homes. However, some people receive care-at-home services or housing support while living in their home. The powers of entry that the bill will confer on investigating agencies are important.

Mr McNeil: I am heartened by the support for the bill. I have an individual point. I believe that it is better that we are driving the changes through new legislation rather than as a result of a crisis, such as the one that drove Scottish Borders Council's ambition to put in place its current services. The present process will ensure better practice across the board as a result of new legislation, not a crisis.

Shona Robison (Dundee East) (SNP): Liz Norton talked about care that is provided in people's homes. At present, how would concerns in that setting be handled differently from how they would be handled in a care home and what will happen once the bill becomes law? What would happen differently in practical terms?

Liz Norton: At present, we have a statutory duty to investigate complaints. We can also inspect services at any time. We often investigate a complaint by carrying out inspections at any time of the day or night. There are two access points: through a complaint that is reported to us or through an inspection, which could be routine or prompted by an allegation. Under the Regulation of Care (Scotland) Act 2001, we can take a range of sanctions against a provider and we can take action to prevent abusive situations.

In situations in which a provider is not aware of the actions of individuals whom it employs or who might be visiting—there is a range of such situations—the powers in the bill will allow us to refer and make orders. To give just one example, a visitor to someone in a care home could carry out abusive actions. It would be difficult to use any sanction under the Regulation of Care (Scotland) Act 2001 to prevent that. However, some of the provisions in the bill will allow the protection of individuals from abusive visitors.

Shona Robison: For clarity, I understand your point about the application of the bill to situations

in people's homes, which is fairly straightforward, but you are saying that, although the bill will not add value to the inspection of problems that relate to care home providers, owners or staff, it may give additional protection in cases in which outside people come into care homes.

Liz Norton: That can lead to problems. For example, relatives or other visitors can carry out financial abuse on the premises. In that situation, the provider has no locus of control and there might not be sufficient evidence of criminality.

We believe that the bill's provisions could deal with certain complex situations in which providers have told the care commission that they cannot do anything—for example, having no power to prevent someone from visiting their mother, who has been subject to abuse. I think that the bill would bring added value for certain circumstances that arise in care homes. For people who live in their own homes, it would be useful to be able to refer some matters straight to the lead agency for investigation.

The Convener: Before we go on to the issue of definitions, Kate Maclean wants to come back in.

Kate Maclean: I want to pick up on something that Duncan McNeil said. Obviously, nobody wants vulnerable adults to be abused. I suppose we are trying to decide whether more legislation is necessary, or whether current legislation is adequate or should be amended. The high-profile cases did not happen because there was no appropriate legislation; they were the result of a failure to take appropriate action. Will the bill make people do their jobs so that appropriate action will be taken? I understand everybody's concerns; if we could legislate to make it impossible for people not to do their jobs properly, that would be fantastic—we would have cracked it. What in the bill will prevent failures from occurring in the future?

Dr Lyons: I will answer that, but I will first pick up on a previous point. Under the 2000 act and the 2003 act, we can intervene only in the case of a named individual; we cannot do so with anybody else, except for powers to restrict visitors under the 2003 act. For example, for someone in a care home, the 2000 act would allow us to get an order—presumably under the guardianship role—to restrict who a person may or may not consort with, but that would give us powers only in relation to a named individual and not to anybody else. It would be against the tone and spirit of the 2000 act and the 2003 act to try to change that position.

It is perhaps not the best thing to do to make legislation on the basis of high-profile cases.

Kate Maclean: I agree. I think that that is what we are doing today.

Dr Lyons: There are many other lower-profile cases that are much better guides.

You are partly right to question whether the bill is necessary. We have investigated cases in which we have identified opportunities to intervene under existing legislation. There is a new case on our website and in our annual report this year under the name of Mr H that I would encourage the committee to have a look at. However, there are cases that we have investigated where it has been unclear whether incapacity existed in relation to decisions an individual had to make or that had to be made for them. There was also difficulty in getting access to individuals to find out whether incapacity was present.

I think that there is a need for a bridging or some sort of breathing space between two different situations. On the one hand, there are individuals with capacity and autonomy who should make their own decisions without interference. I do not think that anyone around this table would argue that we should interfere with people's autonomy. On the other hand, there are people who are clearly incapable who would come under the remit of the 2000 act or the 2003 act. However, there is an in-between situation in which we cannot determine whether there is incapacity, either because we are not sure or because we cannot get access to the person to find out.

The advantage of the new bill is that it will give us a framework in which we can think about people's vulnerability in terms of the bill's definitions and principles. We would be able to use the bill's provisions to intervene, although perhaps only in the short term. I might come back to that because I am not sure what happens when the orders end after the seven days, six months or whatever.

The bill's provisions would give us the opportunity to intervene and would give us breathing space. We might have to decide in a particular situation whether it was necessary or more appropriate to use other legislation. Some of the other bits of legislation, especially the 2003 act, might be unnecessarily restrictive for the individual and removing them to hospital for treatment for a mental disorder might not be what is required.

15:15

Glenda Cook: Without the bill, we would probably have to do much adult protection work under the AWI act, which just does not apply to many of the people for whom we have multi-agency, vulnerable adult protection procedures. We might need some of the powers to assess whether the AWI act applies.

Mrs Milne: How do you feel about the use of the term "abuse" and its definition in the bill? Is the definition of an adult at risk of abuse broad enough to cover the people the bill is intended to protect?

Liz Norton: The definition is wide and can cover a range of situations. I concur with others who have expressed their concern about the absence of the word "neglect". Harm, whether intentional or not, needs to be encapsulated in the definition.

Dr Lyons: I am sure that the committee has heard a few people make this point, but I emphasise that age does not necessarily make people vulnerable; it is the illnesses and disabilities that go along with increasing age that do that.

We also have to consider self neglect. Let us not forget that people can become neglected because they do not have anybody, not because somebody is failing in their duty of care. One of the most difficult situations to deal with is the so-called Diogenes, or senile squalor, situation, whereby the person, without appearing to have any specific mental illness or dementia, ends up living in squalid, unsanitary conditions in old age. They are clearly neglecting themselves, but it is difficult to determine capacity or incapacity.

I also have to consider how to intervene to get care and treatment for people with a mental disorder who become physically unwell, but refuse to leave their own home. Perhaps we will revisit that issue.

The Convener: How do you stop adult support and protection becoming a lifestyle issue? How do the definitions prevent complaints being made or concerns being expressed about someone's lifestyle, rather than neglect or abuse?

Dr Lyons: There are people with lifelong strange patterns of behaviour.

The Convener: That depends on perception, does it not?

Dr Lyons: Yes, and we have to make fine, case-by-case judgments.

Val de Souza: Donny Lyons mentioned Diogenes. One of the most difficult cases that I dealt with as a social work practitioner was a situation where we suspected that a gentleman who lived not far from here was living in squalor, but we also had reports that he was quite well. Our problem was that we could not access him to make the judgment. The bill would have given us the power to do that quickly. I do not want to exaggerate, but the case was referred to us probably every two to three weeks for a year to a year and a half. A pattern built up, because of the amount of concern expressed, even though it might have been quite low-level concern. We had to consider whether the gentleman was just a wee bit eccentric and the issue was one of lifestyle. Our difficulty was that we could not get access to him. Eventually we used some of the other powers that you are talking about. I think that we got the police to knock down the door, but we were very reluctant to do that.

The Convener: I am glad to hear it.

Val de Souza: It took two years. Neighbours were phoning us with concerns.

The Convener: Was he well?

Val de Souza: He was not. The diagnosis was Diogenes syndrome. He was living in complete squalor. He was taken to the Edinburgh royal infirmary for a mental health assessment and was returned with support to his home. That was a good outcome, but the case frustrated the services and left us for a long time in a revolving-door situation, uncertain of how to approach it.

The Convener: I invite Janis Hughes to speak, as she would like to raise an issue that we raised last week.

Janis Hughes (Glasgow Rutherglen) (Lab): Your case study highlights the issue that I want to raise: human rights. Article 8 of the European convention on human rights protects a person's right to a private and family life. You say that you had suspicions about the welfare of the gentleman concerned, but that you had no powers to investigate the situation further. There is a very thin line between providing you with such powers and protecting a person's right to a private and family life. Do you think that the bill has the potential to breach that right, because it would give you more powers? In one way that would be a good thing, but would it conflict with the protection of someone's human rights?

Val de Souza: In such situations, professional judgment is important. There will always be tensions between people's right to be protected and their right to determine how they live their lives. The Human Rights Act 1998 provides us with guidance on that issue. When we reach the very fine line to which you refer, professional judgment must come into play, alongside the powers that the bill will give us. I do not think that people will say, "Now that we have the powers, we can go in a day after referral." There will still be a great deal of discussion and information gathering by different professions, people who know the person and the person's family. That is embedded in good practice, which we hope to support and promote along with the bill and the powers that it provides. None of us would say that there will not at times be tensions, but we will try to make good professional judgments in such situations and will record the reasons for our judgments.

Janis Hughes: I accept that you make such judgments in your daily lives as professionals.

Jean Turner said that the bill may provide you with the facility to have more lightweight triggers. Do you think that your professional judgment is challenged in respect of human rights?

Harry Garland: You are right to say that we must make professional judgments in such situations. We all operate under various codes of conduct, which take account of people's right to make choices, their right to run risks and their right to dignity. Those rights are embedded in the codes for each of the different professions. The advantage of the adult protection committees for which the bill provides is that they bunch together the different codes of professional ethics, which should produce a better outcome.

As the committee has heard, we should be enabled to make decisions more quickly. We may decide after two years that nothing needs to be done in a case. It is possible that we could make that decision after the first couple of people make a complaint, which might allow the person in question to enjoy a better quality of life. People would not be concerned about them because we could say that we have assessed the situation, that there is no need for intervention and that the person has the human right to live as they are living.

We are talking about the extremes. Unfortunately, we all too frequently come across grey areas, such as when people have capacity but are in abusive situations. That is where the net needs to be closed. We could all share many examples of such cases, but we do not want to provide details that might identify people.

The Convener: The orders that are provided for in the bill cannot be appealed against. Do you think that that is appropriate?

Dr Lyons: There may be an issue with article 5.

The Convener: Article 5 of the ECHR?

Dr Lyons: Yes. According to article 5 of the ECHR, anybody who is deprived of their liberty must be able to challenge that and have a decision made on it speedily by a competent court. That might be worth looking at.

The Convener: Making the orders non-appealable is, potentially, an ECHR issue.

Dr Lyons: It may be if the adult is deprived of his or her liberty as a result. I am thinking about some of the arguments that we have had over when to invoke the Adults with Incapacity (Scotland) Act 2000.

The Convener: Involving banning orders, removal orders, and so on.

Dr Lyons: Removals orders, certainly, although the short timescale might be an issue. We are not sure what will happen after one of the orders is made.

The Convener: Using the shortness of the timescale as a reason to deny an appeal process might, in itself, be an issue.

Dr Lyons: It may be. It is reminiscent of the arguments that we are having over when to invoke part 6 of the Adults with Incapacity (Scotland) Act 2000.

The Convener: Yes. Helen Eadie wants to ask about triggers.

Helen Eadie: Do you think that we should clarify in the bill what would constitute a trigger for an investigation to take place?

The Convener: We discussed this issue when we talked about the triggers not being as serious as they might have been in the past. The committee is slightly concerned—the examples that Adrian Ward used last week were a little alarming to us—because the matter gives rise to lifestyle issues rather than anything else. Helen Eadie is trying to establish a sense of what you would regard as an appropriate trigger.

Helen Eadie: It is about sharing information between agencies, as well. The question of what information it is appropriate to share between agencies came up last week.

Harry Garland: The benefit of the adult protection committees is that they can look at what the triggers might be in local situations. Scotland is a diverse place, and there is a wish to have consistency in protection and enablement throughout Scotland. There may be different issues in different areas. For example, a difficult situation on a remote island where there are no resident health visitors, doctors or social workers might trigger a protection committee to look at the issues earlier than a similar situation in a different area. I do not think that it would be wise to create blanket triggers. Each case has to be assessed individually, taking into account the circumstances around it.

Dr Lyons: The issue is perhaps more for the code of practice than for the bill.

Sandra McDonald: At the moment, there is nothing to say what triggers our investigations concerning incapable adults, as the issues can be far reaching. Inevitably, the matter has to be left fairly open.

Ms McHugh from Scottish Borders Council gave a good response to the question how best practice would risk assess and risk manage early on and escalate an investigation only when that was necessary. The convener was also correct in her summary of what was said—a lot of cases are to do not with abuse, but with omission and neglect. We are pleased to have early triggers in dealing with incapable adults.

We risk assess in the way that was described, and a lot of the work that we undertake at that point is coaching, mentoring and training people to do things a bit differently. They are absolutely mortified that they were doing something wrong in the first place. That early opportunity removes the need to have a higher-level trigger that can be used later. I therefore commend the opportunity to have wide-reaching, lower-level triggers as long as they are handled appropriately in the professional manner that has been described.

15:30

Louis Skehal: It is interesting to note in the Borders report that the highest level of reported abuse was financial. It is often difficult for us to access people's financial accounts because access is blocked massively. Human rights issues are involved in what is becoming an increasingly difficult and complex area. After the initial assessment, a judgment is made about whether a trigger is activated. At that stage we make the judgment about whether to leave things as they are or to enforce the duties and powers. Having the opportunity to investigate is the key to prevention.

The Convener: I have a final question, which relates to part 3, although it might not be for everyone on the panel. It arises from evidence we received from an individual who spoke about his experience of ordinary residence during transfer between a local authority in England and one in Scotland. One of his views was that transitional arrangements need to be put in place to ensure that any individual who is caught up in that way is supported while the various local authorities come to some agreement about the long-term resourcing of the services. The same issue arises in various contexts.

Does anybody have a view about whether the bill should provide for guidelines about transitional arrangements to ensure that people do not find themselves in limbo for X weeks or months while two local authorities argue with each other about who is responsible for what? Do not say that that does not happen, because it does.

Harry Garland: From Orkney's perspective, we all too frequently have inward migration by people who require services—even in some of the remote isles—which causes massive problems. There is value in having in the bill some specific recommendation about transition.

The Convener: Does Louis Skehal agree?

Louis Skehal: Yes. We need to develop a protocol. The Association of Directors of Social Work looked at developing an ordinary residence protocol to provide that somebody picks up the tab while negotiations go on.

Dr Lyons: It is to be the subject of my next inquiry.

The Convener: We very much want to see that happen.

Dr Lyons: It would be helpful.

Sandra McDonald: We have the same sort of issues with incapable adults. They might be clearly incapable, but because it is difficult to determine their ordinary residence, they feel as though they are left in the middle without knowing who is responsible. I support your suggestion.

The Convener: I thank all the witnesses for coming along this afternoon. You might have wished to say something else today, so if anything occurs to you as you go out the door, please do not hesitate to get in touch with the clerks. Your submissions will be circulated to all committee members.

Subordinate Legislation

Adults with Incapacity (Removal of Regenerative Tissue for Transplantation) (Form of Certificate) (Scotland) (No 2) Regulations 2006 (SSI 2006/368)

Human Tissue (Scotland) Act 2006 (Human Organ Transplants Act 1989 Transitional and Savings Provisions) Order 2006 (SSI 2006/420)

15:33

The Convener: We move to item 3 on the agenda. The committee is asked to consider two negative instruments. The Subordinate Legislation Committee raised no issues, no comments have been received from members and no motions to annul have been lodged. Are we agreed that the committee does not wish to make any recommendation on the regulations or the order?

Members *indicated agreement*.

European Issues

15:34

The Convener: We move to item 4. Members might recall that earlier this year we asked the minister to provide the committee with an update on the European Union work with which the Scottish Executive is currently engaged. Copies of the minister's response have been circulated with the papers.

Members might wish to note references to the Health Department's direct involvement in European Union initiatives and to areas where legislation might be required in Scotland to implement specific EU directives. For example, in relation to directive 2005/36/EC, on the recognition of professional qualifications, reference is made to possible consultation early in 2007. Reference is also made to the European policy on physical activity in Scottish school children—PASS—which is a Scotland-specific programme funded by NHS Health Scotland to investigate health-related outcomes associated with early activity patterns. Also, with regard to the European Council decision 2119/98/EC, which relates to surveillance and control of communicable diseases, the Health Department notes that legislation is proposed to update public health legislation in this area.

Are there any comments from members? Helen Eadie, I think that this was originally your idea, was it not?

Helen Eadie: I am deeply grateful to you, convener, and to the officials in our clerking team and the Scottish Executive for all the work that has been done on this paper. It highlights a number of key areas in which the Scottish Executive is heavily involved. It is good to see the direct link between the EU and ourselves when we see certain policies being translated into action. I was especially pleased to read that Scotland appears to have made unique progress in the e-health action plan. We might want to let the minister know that we value the fact that that is happening in our name in Scotland.

If you do not mind, convener, I will write to the committee clerk to ask whether I might have some more information on some of the issues.

The Convener: There is a possibility that we could ask for further briefing on certain issues.

Helen Eadie: I would like to have some further information on the issues around alcohol, which is an important issue for Scotland. I was particularly interested in the section on drugs. The fact that the bowel cancer screening programme will start in March 2007 is good, too.

Dr Turner: Could we also ask for more information on the implementation of the working time directive?

Euan Robson: The area relating to the recognition of qualifications and the potential for subsequent United Kingdom and Scottish regulation mentions that a number of new professions might be subject to regulation. Could we have some idea of what those might be?

The Convener: Do we agree to note the response from the Scottish Executive and ask for more extensive briefing on the issues that Helen Eadie, Jean Turner and Euan Robson have raised?

Members *indicated agreement.*

The Convener: That ends the public part of our meeting.

15:38

Meeting continued in private until 16:01.

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