JUSTICE 2 COMMITTEE

Tuesday 17 January 2006

Session 2

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JUSTICE 2 COMMITTEE
2nd Meeting 2006, Session 2

CONVENER

*Miss Annabel Goldie (West of Scotland) (Con)

DEPUTY CONVENER

*Bill Butler (Glasgow Anniesland) (Lab)

COMMITTEE MEMBERS

*Jackie Baillie (Dumbarton) (Lab)
Colin Fox (Lothians) (SSP)
*Maureen Macmillan (Highlands and Islands) (Lab)
*Mr Stewart Maxwell (West of Scotland) (SNP)
*Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD)

COMMITTEE SUBSTITUTES

Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*Carolyn Leckie (Central Scotland) (SSP)
Mr Kenny MacAskill (Lothians) (SNP)
Margaret Mitchell (Central Scotland) (Con)
Mike Pringle (Edinburgh South) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Hugh Henry (Deputy Minister for Justice)

THE FOLLOWING GAVE EVIDENCE:

Dr Jean Moller (Royal Alexandra Hospital)
Dr Michael Sheridan (Southern General Hospital)

CLERKS TO THE COMMITTEE

Gillian Baxendine
Tracey Hawe

SENIOR ASSISTANT CLERK

Anne Peat

ASSISTANT CLERK

Steven Tallach

LOCATION

Committee Room 6

Scottish Parliament

Justice 2 Committee

Tuesday 17 January 2006

[THE CONVENER *opened the meeting at 14:48*]

Violence and Knife Crime

The Convener (Miss Annabel Goldie): I welcome everyone to the second meeting in 2006 of the Justice 2 Committee. I have received no apologies. Carolyn Leckie is currently attending a Parliamentary Bureau meeting, but she will join us in the course of the afternoon.

Item 1 concerns violence and knife crime. On behalf of the committee, I welcome Dr Michael Sheridan, who is from the Southern general hospital in Glasgow, and Dr Jean Moller, of the Royal Alexandra hospital in Paisley. They are going to brief the committee on violence and knife crime. I am not a technical genius, but I can see that we are going to get a PowerPoint presentation.

Dr Michael Sheridan (Southern General Hospital): Good afternoon. My colleague Jean Moller and I are emergency registrars working in the west of Scotland. Emergency medicine became the new term for accident and emergency about two months ago, so I might use the two terms interchangeably.

Thank you for inviting us to speak to the committee. We are here to present a study on violence presentations to emergency departments, which was prompted by what happened on my return to Scotland after two years working in Australia. I worked in Melbourne in the emergency and intensive care trauma service in one of Australia's tertiary referral centres for trauma.

On my first shift after my return to the Southern general in January 2004, I met the gentleman who is shown in slide 2. He had been attacked in a public place with a knife, which had ripped through his face. He had also been stabbed in the chest and the leg. He was drunk and aggressive and required to be restrained by four policemen. He was spitting virally infected blood at those who were trying to help him—the nurses, doctors, ambulance staff and police. My repulsion at the vicious nature of the attack, the injury and the behaviour of the patient was compounded by the fact that in my two years working in Australasia, I had not seen anything like that. The rest of the A and E staff responded professionally, but with a resigned acceptance that the patient was, unfortunately, just another victim of an attack that they described as commonplace.

My experience was not unique. As the local evening paper noted and as one of my consultant colleagues with 25 years' experience said, there has been a problem for a considerable time. The west of Scotland, and Glasgow in particular, has an historical image of high levels of interpersonal violence. Despite previous initiatives such as operation blade, which was run 10 years ago, such violence has remained an on-going problem in the community and for the emergency services.

Statistics from the past year have highlighted the issue. There have been 137 murders—72 with a sharp implement. In Scotland there are 22 murder victims per million and in Glasgow there are 55 per million. In 2003, Strathclyde police noted 357 attempted murders, with 193—nearly 60 per cent—involving a knife. That is against a background of a knife culture, as it has been described.

Professor McKeganey's research on knife carrying among more than 3,000 11 to 16-year-olds in 20 Scottish schools, from a wide range of social backgrounds, showed that 34 per cent of males and 8.6 per cent of females had carried a blade in the previous year.

Our aim was to perform a prospective study to characterise the details of assaults and investigate the resources that are dedicated to the assessment and management of assaulted patients in emergency departments. The emergency departments involved were those at the Glasgow royal infirmary, the Victoria infirmary and the Southern general hospital. We conducted the study in April 2004, which was not an unusual month. My colleague and I considered cases that were documented on a two-page proforma when the person presented to the triage service. We considered the age and gender of the victim, the time of the alleged assault, involvement of psychoactive substances, the formal reporting of the incident, details of the assault, such as weapons used, the disposal from the department—where the patient went after our care—and the time that the victim spent in the department.

In that 30-day month, 484 information sheets were filled in. There were 153 in the Victoria infirmary, 113 in the Southern general, and 218 in the royal infirmary. The average time for victims to spend in the department was two hours. The times ranged from 15 minutes to five and a half hours, which obviously created a significant burden and pressure at the front door of the hospital and increased waiting times for those who had not come in with what is a preventable problem.

Slide 8 might be difficult to see from a distance, but I will explain all the numbers. Of the 484 victims, 82 per cent were male and 18 per cent were female. Fifteen to 24-year-olds accounted for

43 per cent; 25 to 34-year-olds accounted for 28 per cent; 35 to 44-year-olds accounted for 17 per cent; 45 to 54-year-olds accounted for 8 per cent; and those above the age of 54 accounted for 4 per cent. It is young males who are being assaulted.

The next two graphs show when victims presented to the emergency departments. As you can see, there is a gross distortion in the numbers presenting on a Friday, Saturday or Sunday night. The number of assaults then are statistically significant. Over four weekends, there were more than 250 assaults.

The time of presentation is also significant in that 41 per cent of victims presented between 8 pm and midnight and 26 per cent presented between midnight and 4 am. Overall, two thirds of those who had been assaulted presented between 8 pm and 4 am. That is often when emergency departments are at their busiest and when the level of staffing by senior and experienced staff is lower, which has a significant impact on those working at the time.

The statistics also show the weapons that were used to carry out the attacks. About 23 to 24 per cent of attacks, as described by the police, were made with a sharp implement or a knife. That is statistically significant, as those who had been attacked in that way sustained more serious injuries and more often required admission to a ward, intensive care unit or high-dependency unit or went straight to theatre. A firearm was used in only 1 per cent of attacks and, thankfully, such attacks remain a rarity in this part of the world.

Of the people who were seen in the emergency departments, 44 per cent could be treated and discharged home, but 56 per cent of cases had to be followed up: 32 per cent had to be followed up by a specialist clinic—an accident and emergency clinic, an orthopaedic clinic, a plastic surgery clinic or a maxillo-facial clinic—and 23 per cent required an in-patient admission.

I have here a typical picture of someone who has been assaulted. It is not unusual to see this sort of thing every weekend; indeed, over the weekend that I have just worked I saw somebody like this. Blood from a head injury is coming out. The injury must be cleaned, washed and sutured and it may require radiological investigation by a computed tomography scanner or a skull X-ray. The picture shows three small stab wounds. Such stab wounds can cause a disproportionate injury to the internal organs. The one on the left side of the chest—which you can see just below the lead—could have caused a pneumothorax or a punctured lung. The one just below the second lead could have caused injury to the bowel or to the heart. The one on the left-hand side could easily have perforated a bowel. Each stab wound could have required an operation and each was potentially fatal.

The figure of 357 attempted murders in Strathclyde, of which 193 were knife-related, is one of the most concerning. The potential for the murder figures to be much worse than they are and the seriousness of knife crime as a public health issue cannot be underestimated. The person who left their house with a knife on their person and who stabbed this patient had no idea of what injury they were going to cause. When such people plunge the knife, it is only by chance that more fatalities do not occur.

We asked those who were being treated in the accident and emergency department whether they were going to report the incidents to the police. Forty-seven per cent said that they were not going to report the incident to the police. That supports other figures that were gathered in Cardiff between 1995 and 2001, where it was found that fewer than 40 per cent of victims had reported the incident to the police after a case of violent assault.

We considered a one-month period in three accident and emergency departments. April was not an unusual month. Extrapolating those data, we could account for almost 5,800 such cases received annually in those three departments. That is not considering the other two accident and emergency departments in Glasgow and other emergency departments such as those in Paisley, Monklands, Wishaw, Hairmyres, and Ayrshire and Arran. The police agree that we really do not know how many people are being injured, as the statistics that they have are probably flawed. John Carnochan of the violence reduction unit agreed that the figures that we have probably reflect the picture more accurately.

I have mentioned some of the other departments. Knife attacks are a problem not just for accident and emergency departments but for general surgeons; orthopaedic departments; cardiothoracic departments; neurosurgeons; ear, nose and throat specialists; plastic surgeons; head injury wards; the blood bank; and radiology departments. Back in the community, after people have left hospital, the cases are passed on to general practitioners, psychiatric services and counselling services. I was brought up in Glasgow, and two of my contemporaries from school received significant facial injuries, which required them to have counselling for a time. The effect that that has had on the past 10 years of their lives, both socially and educationally, has been significant.

So, what are emergency departments doing about it? In Cardiff, Professor Jonathon Shepherd introduced the violence prevention unit, which collected anonymised information in emergency departments and shared it with the police. Hot spots were identified as a result of people who had

been assaulted telling the police, anonymously, where the assault on them had happened. Over a three-year study period, violent crime has been reduced by up to 20 per cent in Cardiff. Change has been implemented through police patrols, through the provision of bus services and through proprietors of licensed premises meeting police and accident and emergency consultants to see what is happening outside their establishments.

15:00

The Strathclyde violence reduction unit, which is headed by John Carnochan, and accident and emergency departments in the west of Scotland have been trying for over a year to implement a strategy such as this. The strategy has faced scrutiny by ethical committees. The plan is that anonymised violence assault data that are aimed at focusing policing on problem areas and allowing A and E staff to deal more effectively with violence victims will be introduced shortly in Glasgow royal infirmary. That data will no longer be anecdotal and will, we hope, be more authoritative.

In conclusion, knife injuries are a significant cause of mortality and morbidity, often requiring high-level in-patient care. Victims of knife assaults sustain more serious injuries than those who suffer trauma from blunt instruments. Knife crime commonly affects young men, who are generally a healthy sector. As such, it is a major public health concern. In our eyes, the public health problems are preventable and innovative legislation and clear sentencing deterrents are required to eradicate them. Assaulted patients create a considerable workload for emergency and in-patient services, especially at weekends and overnight, when departments are busy with other problems and less experienced staff are working. We hope that data that have been collected from emergency departments can provide valuable and accurate information about violent crime and give an insight into how to implement effective change.

The Convener: That has brought us to the stark reality of knife crime in Scotland, particularly in Glasgow and the west. I assume that we will be able to get copies of your presentation.

Dr Sheridan: They have been supplied.

The Convener: That is fine. Are there any questions?

Jackie Baillie (Dumbarton) (Lab): I found the presentation fascinating. However, I am slightly troubled. On a different day of the week, could the victims just as easily have been the perpetrators? I know that I am asking you to make assumptions.

Dr Sheridan: Dr Moller and I will try to answer all questions. What you suggest is a possibility. However, that is not to suggest that innocent people are not being injured and maimed for life.

Jackie Baillie: Sure, but the cohort that you described—15 to 24-year-old males—accounted for 82 per cent of the victims. I have seen similar statistics that describe most of the perpetrators as falling into that cohort. I pose the question because that connection could be made.

Is a trend in knife crime emerging? The use of swords is increasing, particularly on the streets of Glasgow. You have described a problem that we have talked about and on which we all agree and you have shown us newspaper headlines, yet it has taken a year to agree that one hospital will collect anonymous information. Is there a way of speeding up that process? Is there a duty on those who work in emergency care to report the incidents of violent crime that appear on their doorsteps?

Dr Jean Moller (Royal Alexandra Hospital): You saw in our presentation the picture of Michael holding a sword that someone had brought into his department. The person was sitting in the waiting room with a samurai sword. I work in Paisley and every Friday and Saturday night we see somebody who has been hacked with a machete. Therefore, I can say that knife injuries are common.

Returning to your first question, I think that the victims may be the perpetrators on other occasions. We often have to take knives off people, but that does not decrease the problem. Knife crime needs to be addressed on such a level that people are informed that it is not right to carry knives and get themselves into that position.

With regard to taking a year to implement change, we found it difficult to raise awareness for the strategy. The media are happy to splash the headlines, but it is difficult to implement change. There is the idea that we will breach confidentiality to report crime, but we are allowed to inform the police of injuries only if we have the patient's permission. You can see from our presentation that victims do not report the crime to the police. If an anonymised database falls into place at Glasgow royal infirmary, we will think about implementing a database in Paisley. I think that other departments would fall into line if a precedent were set. A Glasgow-wide database would help us to implement changes where they need to be made.

The Convener: Dr Sheridan, you said that the first patient whom you showed was in a state of intoxication. Is a state of intoxication common in victims?

Dr Sheridan: Approximately 73 per cent of those who had been assaulted suggested that alcohol had been a factor in their assault. Intoxication certainly seems to be an important factor before assaults occur. I think that

Strathclyde police's figures show that around 70 per cent of assaults are committed within 25m of public houses. Publicans and the alcohol trade therefore need to be aware that such things are happening in their environment and that alcohol seems to play an important role in assaults.

The Convener: Are your patients frequently under the influence of alcohol?

Dr Sheridan: Alcohol is frequently a component factor that leads to patients being admitted.

The Convener: Is it also thought to be an influence on the behaviour of perpetrators?

Dr Sheridan: That is difficult to say because the only people whom we see are the victims who have been sent to us.

The Convener: Okay.

Mr Stewart Maxwell (West of Scotland) (SNP): I echo what the convener said about the presentation, which will have enlightened colleagues. I am aware of your report, which I have read, and of the fact that only 53 per cent of assaults are reported to the police.

I have carried out my own survey of accident and emergency doctors and the figures that I found might surprise you. They suggest that the amount of information that goes to the police needs to be upped. I found that only 21 per cent of doctors would report knife injuries to the police—that figure excludes accidental knife injuries—and that only 63 per cent would report gun-related injuries. Do those figures surprise you? There is obviously some resistance to a mandatory reporting system among your colleagues.

Dr Sheridan: I read what you said in *The Sunday Times* at the weekend. The article suggested that that is the case. However, the issue of confidentiality always raises its head. If a person has an injury that is not thought to be life threatening and they do not want to raise the matter with the police, I understand why doctors will feel that they are in a difficult position with respect to whether the person should be reported to the police. I also understand that police officers have said that if giving information about individual incidents were mandatory, people would be less likely to present at accident and emergency departments. I am not sure whether that is the case; I think that somebody who has been injured probably will present, but some people may not do so.

Mr Maxwell: That was how some police officers reacted, although many police officers to whom I spoke, including some chief constables in Scotland, absolutely supported the idea and said exactly the opposite.

Given that we lack the intelligence to allow police officers and police forces to focus their resources effectively and given the resistance and problems that exist, could a mandatory system be rapidly implemented through legislation, guidance or directions from the Executive, for example, in the light of the experience from the Cardiff pilot and the local work that you have done in the west of Scotland and Glasgow, particularly on the anonymised reporting system? The issue is about intelligence rather than necessarily about individuals, and doctors would give their support.

Dr Sheridan: I think that they would. The police have presented to the accident and emergency consultants, of whom there are around 20 in the west of Scotland. The vast majority of those consultants think that using anonymised data is a good idea and that doing so would give us a bit more information to deal with the hot spots. However, one or two still raise issues relating to consent and confidentiality and therefore the proposals will probably not be implemented in their departments. Glasgow royal infirmary, led by Dr Ireland and Dr Rudy Crawford, and people in Paisley have been keen to get involved, but the south Glasgow hospitals are still discussing matters. If legislation were passed after discussions and the system were anonymised, the data could be very informative.

Bill Butler (Glasgow Anniesland) (Lab): None of us will forget this presentation in a hurry. The problem is obviously very serious. Dr Sheridan, you said that you and most doctors would see the benefit of having anonymised data. However, you spoke about the resistance of one or two institutions. Would you go so far as to say that if there is still resistance, the collection of anonymised data should be mandatory, for use in a focused way by police forces? Would you and your colleagues support that?

Dr Sheridan: I cannot speak on behalf of accident and emergency consultants.

Bill Butler: I accept that. You may answer just for yourself and surmise what the rest of your colleagues might think.

Dr Sheridan: There should be and would be no concern about anonymised data being used. The scheme has been implemented in Cardiff without great concern and with great improvements. The issues that Cardiff faces are slightly different from those that are faced in the west of Scotland. However, in Cardiff there was a significant decrease in knife crime over a three to four-year period of 20 to 25 per cent. If that happened in the west of Scotland, it would be important.

Bill Butler: Was there resistance in Cardiff before the violence prevention unit was set up and anonymised data were collected? Because of

what has happened in doctors' experience, has that resistance diminished markedly?

Dr Sheridan: I spoke to Professor Jonathon Shepherd, who led and implemented the scheme in Cardiff. He is a maxillofacial surgeon and deals with facial injuries. He said that initially there was resistance, which was based on the same issues of confidentiality, consent and concern that people would not present to A and E departments. Over time, that resistance has been smoothed out. Because of the results that they have had, people now think that the scheme is a good idea.

Bill Butler: You mentioned your two years in Australia and the fact that your experience in Scotland when you returned was remarkably different from your experience there. What makes the situation in Australia different? Is it a cultural issue? Is there a greater educational drive there?

Dr Sheridan: I will let my Australian colleague answer that question.

Dr Moller: The reason is cultural. The major difference between Scotland and Australia that I notice is the vast range in socioeconomic status here. In Glasgow, in particular, there is a huge population that is not happy with its standard of living, for good reasons. There is also a culture of violence that goes back years. In Australia there is not such a wide spread in socioeconomic status. Traditionally, we do not have a culture of violence, especially with implements. People do not tend to attack one another with knives.

Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD): Notwithstanding the socioeconomic and cultural aspects of the issue, the lack of consideration of the danger of carrying a knife and the lack of comprehension of the fact that putting a knife in one's pocket, taking it to a club or going out with it on a Friday night could lead—statistically, will lead—to very serious incidents, I was struck by the comparison with firearms. A very small number of attacks involved firearms. This is a legislature, and we are considering laws. What is your view on having knife crime laws aligned more closely with firearms legislation? That would not solve the socioeconomic or cultural problems, but it would send a signal that knives are very dangerous implements. I refer not only to means of accessing knives or swords but to sentences that the courts can issue for possession and for repossession, if there has been a previous conviction. In the case of firearms, those are much tougher.

Dr Sheridan: As you pointed out, and as I am sure you appreciate, thankfully gun crime in Scotland is not a big problem. In other parts of the United Kingdom, especially Nottingham, it is an increasing problem. In Scotland, the number of murders and attempted murders that are committed using knives—72 murders, which is just over 50 per cent of the total number of murders; and 60 per cent of the total number of attempted murders—is a far greater problem for emergency departments and for those who sustain injuries as a result. Tougher sentences, or greater awareness of the problems that knives can cause, would be better than the headlines that are associated with the one or two gun crimes that we have each year.

Jeremy Purvis: Dr Moller, do you agree?

Dr Moller: Absolutely. On a personal level, being at work is frightening. We see guys coming in who have been stabbed. When we take their trousers off, we find that they have massive knives in their pockets. They carry them all the time. I do not think that we have any idea of the level of knife use and knife carriage. It is frightening.

15:15

Jeremy Purvis: I know that your answer will be subjective, but will you comment on the degree of comprehension of the implications of carrying knives on the part of those who carry them, who are predominantly young men? In your professional experience, do you think that they are aware that carrying a knife is equivalent to—or more dangerous than—carrying a firearm? Are they aware of the significance of what they are doing?

Dr Sheridan: I do not think so. They do not realise that the person who puts a knife in his pocket along with his iPod might, later that day, be a murderer or an attempted murderer. The Scottish Executive could hammer home that message through education and advertising.

Carolyn Leckie (Central Scotland) (SSP): I am sorry that I was late. I was at another meeting, so I missed your presentation. I apologise for that.

I come from a health background, so I am interested in the dilemmas to do with patient confidentiality and consent. I suppose that I would like to hear the arguments of the people who are objecting. I imagine that even anonymised data could be identified to a locality and given to the police who, with even limited intelligence, could identify where the incident took place. Obviously, there would be concerns about repercussions. I suppose that it is a precedent—

The Convener: May I intervene for a moment, Carolyn? We are pretty pushed for time. That is an important matter, but I appreciate that the witnesses will not have the answer at their fingertips. Could a response be submitted to us in writing?

Dr Sheridan: Indeed.

The Convener: That would be helpful.

Carolyn Leckie: I just want to get the other side of it, because I think it is an ethical minefield.

The Convener: Thank you for that suggestion.

On behalf of the committee, I thank the witnesses for giving us a chilling indication of the situation that confronts them in the real world of emergency departments, as we now have to call them. I will find that difficult, being an almost lifelong resident of Bishopton. Your presentation was extremely instructive. Thank you for taking the time to come before us. The committee found the information invaluable.

15:17

Meeting suspended.

15:23

On resuming—

Subordinate Legislation

Police Act 1997 Amendment (Scotland) Order 2006 (draft)

The Convener: We move on to agenda item 2, which is consideration of an affirmative instrument. I welcome the Deputy Minister for Justice, Hugh Henry, and I invite him to speak to the draft order.

The Deputy Minister for Justice (Hugh Henry): Part V of the Police Act 1997 allows Scottish ministers to carry out criminal record checks for employment and other purposes. The draft Police Act 1997 Amendment (Scotland) Order 2006 makes supplemental provision in part V of the 1997 act in consequence of amendments that were made to the 1997 act by the Serious Organised Crime and Police Act 2005.

The draft order adjusts delegated powers in three sections of the 1997 act, corrects some typographical errors in sections 113C(3)(e) and 125(6) and clarifies the meaning of "police force" in section 120A(6). Articles 2(1), 2(3) and 2(4) of the draft order affect section 112(1) on the basic disclosure, section 114(1) on the standard disclosure for Crown employment and section 116(1) on the enhanced disclosure for judicial appointments or Crown employment.

The amendments will mean, first, that Scottish ministers will be able to prescribe the manner in which applications are made. It is intended that that power will be exercised such that both paper-based and electronic applications are acceptable. Secondly, Scottish ministers will be able to prescribe the ways in which payments can be made for those applications.

Similar changes are being made for the usual standard and enhanced applications by the 2005 act. The amendment that the draft order makes will ensure that these other types of applications are treated in the same way. We plan to lay the relevant regulations, which are subject to the negative procedure, before the Parliament in late February. The changes in articles 2(1), 2(3) and 2(4) are therefore closely linked to the amendments that the 2005 act makes to the 1997 act.

The Subordinate Legislation Committee reported the draft order to the lead committee and to the Parliament in relation to those amendments. In that committee's view, it is unusual to use a power to make supplemental provision in primary legislation to grant the Scottish ministers further powers to make subordinate legislation.

The Scottish Executive disagrees with that view. The powers that Scottish ministers have under section 173 of the 2005 act are sufficiently broad to allow the amendments to be made. The legislation permits the power to make supplemental provision to be used to amend primary legislation. The manner in which the power is being exercised results in amendments that mirror amendments made by the 2005 act. Further, the amendments affect sections of the 1997 act in which powers are already delegated to Scottish ministers. The amendments are very closely related to the existing powers that we have. We therefore take the view that such a use of those enabling powers was within the contemplation of the legislature when it approved them.

I will also explain briefly the remaining three amendments in the draft order. Articles 2(2) and 2(5) each correct an error made by the 2005 act's amendments to the 1997 act as it applies in Scotland. Article 2(2) inserts the words "the law of" into section 113C(3)(e) of the 1997 act, as amended by section 163 of the 2005 act. That will make clear the intention of the legislature—namely, that regard must be had to the laws of countries outwith the United Kingdom if we decide to consider any list of persons unsuitable to work with children held in such a country during an assessment of a person's suitability to work with children in Scotland. A similar amendment was made to the vulnerable adult provisions by the 2005 act. Article 2(2) brings a consistent approach to assessing information about the suitability of people to work with children or adults. Article 2(5) corrects a minor typographical error in section 125(6) of the 1997 act as it will apply in Scotland. The original amendment was inserted into the 1997 act by the 2005 act, and the correction changes "(3)" to "(4)" in section 125(6). The UK Parliament has made changes to the 1997 act as it applies in England and Wales that are similar to those made in articles 2(2) and 2(5).

Article 2(6) amends section 120A(6) of the 1997 act to make it clear that the Scottish ministers may request information from a number of further bodies that are covered by the 2005 act in the same way as information can be requested from chief officers of police forces in England and Wales. Therefore, the amendment clarifies the meaning of section 120A(6) of the 1997 act.

I hope that that rather convoluted explanation covers all the justifications for why I recommend that the draft Police Act 1997 Amendment (Scotland) Order 2006 be approved.

The Convener: Thank you for those comments. Reference has been made to the comments that the Subordinate Legislation Committee made when it considered the draft order. Indeed, our papers include an explanation of those comments. Stewart Maxwell is a member of that committee, so I ask him whether he would like to make any further comment.

Mr Maxwell: I ask the minister to expand on what he has said, because there is obviously a disagreement between the Executive and the Subordinate Legislation Committee. I have been on that committee since I was elected in 2003, and it certainly seemed to me—as it did to the other members of that committee—to be unusual to use one piece of subordinate legislation to create another. That just seemed odd, and I had certainly not come across the procedure before. Will the minister expand on the reasons why that power has been used? Is it due to an error? Should there have been another power in the first place and is the draft order simply rectifying that error? Alternatively, is there some other reason? The matter certainly seemed very unusual to the Subordinate Legislation Committee.

15:30

The Convener: Before the minister responds, I should make members aware of the fact that the draft order will amend a piece of Westminster, rather than Scottish Parliament, primary legislation.

I will allow the minister to address Stewart Maxwell's question in a moment, but let me first ask a general question that the minister's advisers might be able to answer. Given that the use of the procedure seems slightly unusual, does the Executive consider that such a mechanism is likely to be used again or, as Mr Maxwell suggested, is the procedure being used simply to cure a few difficulties that have emanated from Westminster legislation?

Hugh Henry: Given that the draft order will correct changes to legislation that were made at Westminster, I cannot say whether such a procedure will be used again. It is hoped that any such changes that were made here or elsewhere would be consistent, so I would always hope that we could avoid using such a procedure. However, it would be foolish of me to give a guarantee on that.

In response to Stewart Maxwell's question, I suggest that the proposed amendments are exactly the sort of thing for which the power exists. As the convener said, the amendments have been necessitated by changes that were made at Westminster. We are simply mirroring those provisions so that we ensure consistency and do not create any loopholes. I am not sure that it would be best if such inconsistencies were addressed or excised by primary legislation. The mechanism that is being used enables us to make the changes quickly to the provisions concerned,

which I believe are important enough to justify speedy action.

The Convener: Do members have any other factual questions for the minister?

Bill Butler: I accept what the minister has said, but as I was a member of the Subordinate Legislation Committee some years ago, I have a further question. Having said that the power was not unusual, the minister explained why the power in section 173(1)(a) of the 2005 act exists and why it is appropriate to use it in this circumstance. However, how unusual is the use of such a power? Is this a one-off, or have similar circumstances arisen a few times? I know that the minister cannot predict the future, but how does the use of the power in the draft order relate to past experience?

Hugh Henry: I can certainly write to the committee on whether such a provision has been used before. It would be wrong of me to say that the use of the power is not unusual, as it is clear that it is unusual. We do not use such powers frequently, but the use of the power in the draft order is competent. This is exactly the type of situation that such provisions were created to address. The proposed power is also closely linked to powers that ministers already have. However, I will certainly check whether and how frequently such provisions have been used on previous occasions. As I said, and as Bill Butler confirmed, I cannot anticipate the future. I would hope to avoid such use of ministerial powers if at all possible, but such things are sometimes unavoidable.

Bill Butler: I would be grateful to the minister for that information.

The Convener: I have a final factual question. If the draft order was not approved under the affirmative procedure, would there continue to be deficiencies and legislative gaps in the Scottish legislative framework?

Hugh Henry: The draft order seeks to address inaccuracies and errors that are largely typographical. As I said earlier, the draft order will also allow people to make electronic applications and will address the way in which payments can be made for such applications. While the errors may be relatively small in the larger scheme of things, it is best that they are dealt with. As far as making electronic as well as paper applications is concerned, it is a sensible provision, given the way in which we now operate.

The Convener: Technically, I must now ask you to move the motion, so that we can debate it.

Motion moved,

That the Justice 2 Committee recommends that the draft Police Act 1997 Amendment (Scotland) Order 2006 be approved.—*[Hugh Henry.]*

Mr Maxwell: I accept everything that the minister has said about policy—it is right to tidy up the matter and to do so quickly, and I am sure that we all welcome that. However, there was some unease among members of the Subordinate Legislation Committee about the way in which the power has been used, although the committee did not go so far as to say that it felt that it was totally inappropriate. Research by the Subordinate Legislation Committee did not unearth similar examples, although there may well be some. However, given that the circumstances are unusual or almost unique, I have some concerns about the use of the power in this way. The concern that I share with the rest of the Subordinate Legislation Committee was that the Executive might push at the boundaries of such powers because they are a kind of vague catch-all that appears at the end of bills. There is a reasonable concern that the Executive might pursue a line of using those powers to add bits in when the drafting of the legislation was not tight enough in the first place.

Bill Butler: Having heard the minister's detailed explanation of section 173 of the 2005 act, I am content. I will be interested to hear what comes back from him when a search for similar occurrences is carried out. However, the power is there to deal with exceptional—or "unusual", as the Subordinate Legislation Committee said—occurrences such as this and I am content.

The Convener: I do not want to draw this out. Does anyone else have anything to add?

Maureen Macmillan (Highlands and Islands) (Lab): I was just going to remark that we are too young a Parliament to be relying on precedent. Even if such a use of ministerial powers has not happened before, that does not make it a worry. As long as it is competent, as the minister assures us it is, I am perfectly happy.

The Convener: There is a feeling on the part of the committee that we are not here to obstruct the legitimate desire of the Executive to make complete the Scottish version of legislation that has been enacted at Westminster. The report from the Subordinate Legislation Committee signals that this is an interesting use of the procedure.

The Justice 2 Committee, while having no desire to obstruct the legitimate use of delegated legislation in the Parliament, is expressing the concern that we do not think that this is necessarily an ideal model. We would not want it to be regarded by the Executive as an acceptable modus operandi for the future. We appreciate that it may arise in exceptional circumstances but it is perhaps not a model of good delegated legislative practice.

Hugh Henry: The Executive would not see this as a model that it would want to use frequently. However, we believe that there can be circumstances that would justify its use, particularly when we are seeking to rectify very quickly something that has happened elsewhere and over which we do not have total control. It is not about correcting errors that have been made in the Parliament per se, but about considering something that has happened elsewhere and which impacts on us. In the circumstances, therefore, using the procedure is entirely appropriate. It is not necessary to consider primary legislation or to delay unduly. I can assure the committee that the Executive's use of the procedure will not become a weekly or a monthly occurrence. Equally, however, it would be wrong of me to rule out our having to use it at some point in future.

The Convener: The question is, that motion S2M-3803 be agreed to.

Motion agreed to.

That the Justice 2 Committee recommends that the draft Police Act 1997 Amendment (Scotland) Order 2006 be approved.

The Convener: I thank the minister and his advisers for attending this afternoon.

Adults with Incapacity (Supervision of Welfare Guardians etc by Local Authorities) (Scotland) Amendment Regulations 2005 (SSI 2005/630)

The Convener: The next two instruments are subject to the negative procedure. As there are no questions about the first set of regulations, is the committee content to make no recommendation to the Parliament?

Members *indicated agreement*.

Adults with Incapacity (Countersignatories of Applications for Authority to Intromit) (Scotland) Amendment Regulations 2005 (SSI 2005/631)

The Convener: As there are no questions about the second set of regulations, is the committee content is the committee content to make no recommendation to the Parliament?

Members *indicated agreement*.

The Convener: We will now consider in private the committee's stage 1 report on the Police, Public Order and Criminal Justice (Scotland) Bill.

15:41

Meeting continued in private until 16:52.

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