JUSTICE AND HOME AFFAIRS COMMITTEE

Wednesday 3 November 1999
(*Morning*)

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8TH MEETING

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*Roseanna Cunningham (Perth) (SNP)

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*Pauline McNeill (Glasgow Kelvin) (Lab)
*Tricia Marwick (Mid Scotland and Fife) (SNP)
*Euan Robson (Roxburgh and Berwickshire) (LD)

*attended

THE FOLLOWING MEMBER ALSO ATTENDED:

Michael Matheson (Central Scotland) (SNP)

WITNESSES:

Ms Kay Barton (Scottish Executive Justice Department)
Mrs Micheline Brannan (Scottish Executive Justice Department)
Jim Brown (Scottish Executive Health Department)
Dr James Dyer (Mental Welfare Commission for Scotland)
George Kappler (Mental Welfare Commission for Scotland)
Mrs Liz Lewis (Scottish Executive Health Department)
Mrs Lynda Towers (Office of the Solicitor to the Scottish Executive)
Adrian Ward (Law Society of Scotland)

COMMITTEE CLERK:

Andrew Mylne

SENIOR ASSISTANT CLERK:

Richard Walsh

ASSISTANT CLERK:

Fiona Groves

Scottish Parliament

Justice and Home Affairs Committee

Wednesday 3 November 1999

(*Morning*)

[THE CONVENER *opened the meeting at 10:07*]

Adults with Incapacity (Scotland) Bill: Stage 1

The Convener (Roseanna Cunningham): We have quite a lot of business to get through this morning, and I want to press ahead as quickly as possible. The first item on the agenda is the Adults with Incapacity (Scotland) Bill. We will be taking evidence, and I want to indicate a rough time scale for this part of the agenda. Although we have not put times on the agenda, I want to try to deal with this aspect of the agenda by 11.55 am. As three groups of witnesses are giving evidence this morning, my intention is that each will get half an hour.

In those circumstances, I am asking the witnesses to keep any opening remarks extremely brief, to give committee members the maximum opportunity to ask questions. If it appears that we will fall short of the half-hour, witnesses can return with any further statements that they wish to make. However, I do not want to take up each of the half-hours with long opening statements that make it difficult for people to ask questions.

The three people who are here from the Executive are accompanied by others from the Executive, who may wish to answer specific questions that arise. We have a difficulty with the microphones, and if it is necessary for one of the other three to answer a question, they will be required to swap seats with those in front of the microphone so that the official reporters can hear clearly what is being said. That might be a little awkward, but I ask people to bear with us.

Our first witnesses are Ms Kay Barton and Mrs Micheline Brannan from the civil law division in the justice department and Alan Williams from the office of the solicitor in the Scottish Executive. As the paper that has been given to me is a bit long, could one of the witnesses summarise it?

Mrs Micheline Brannan (Scottish Executive Justice Department): I will condense it as best as I can. I have overall responsibility for the bill, Kay Barton is the bill team manager and Alan Williams is our legal adviser. The other Scottish Executive colleagues who are here are specialists in the area of care establishment and medical matters and, with permission, I will refer questions on those subjects to them.

You already have copies of the bill. The substantial memorandums that were provided with it explain its contents in great detail. We are here to answer any supplementary questions that may arise out of the memorandums. I stress that since the Scottish Law Commission started its deliberations in 1991, the bill has been subject to wide consultation. We believe that there is wide support for the bill as it stands, subject to various detailed comments.

I also stress that the bill is based on general principles that govern anything done for an adult under its provisions. Those are stated explicitly in section 1 of the bill and underlie the other provisions. My colleagues and I will be happy to explain any detailed points that members of the committee would like to have clarified.

The Convener: Thank you. I should have said that Michael Matheson, an MSP who is not a member of the Justice and Home Affairs Committee, has asked to be present. He will be taking part in the deliberations.

We have had many briefings on the bill, and took informal evidence at the end of the recess. Committee members already have a fair amount of information and understanding about how the bill is intended to work. Many of the submissions that we have received since the end of the recess express a degree of alarm about some aspects of what is being proposed. Most of that concern relates to decisions about the provision of medical treatment. I expect that a lot of the questions this morning will relate specifically to that aspect.

I open up the meeting to questions by members to the Scottish Executive witnesses. Do not be shy.

Phil Gallie (South of Scotland) (Con): If there is an absolute silence—

The Convener: Phil will always fill it.

Phil Gallie: ENABLE and others have expressed concern about the definition of mental health in the bill. The original definition of mental health suggests total incapacity. There is a feeling that people with mental health problems have a range of incapacities—not always total incapacity.

Mrs Brannan: It is one of the general principles underlying the bill that an adult should be encouraged to exercise whatever capacity they have. The bill recognises that mental incapacity is not an all-or-nothing concept, that there are degrees of incapacity and that an adult can be capable of one type of decision but not another.

Ms Kay Barton (Scottish Executive Justice Department): It might be helpful to spell out that the bill has two threshold criteria for assessing incapacity. One is mental disorder, broadly in terms of the Mental Health (Scotland) Act 1984. The other is an inability to communicate because of a physical disability. Beyond those two threshold criteria, the bill sets out further criteria as to whether someone is incapable of acting, making or communicating a decision, or remembering that they have made a decision. Mental disorder on its own is not a passport to the provisions of a bill. There is a further incapacity test.

Phil Gallie: Can we, therefore, assure ENABLE that it should not continue to be concerned about the definition that will be retained from the Mental Health (Scotland) Act 1984?

Ms Barton: I have read ENABLE's submission, and think that it could be reassured that there is no presumption that someone suffering from a mental disorder, whether it be a mental handicap—a learning disability—which is where ENABLE's interests lie, or any form of mental illness, is incapable of any particular decision or of decisions in general.

The Convener: I have a more general question, which relates to points raised by ENABLE and the Mental Welfare Commission, about the interaction of this bill and the Millan committee's review of mental health. What consideration was given to the Millan committee when this bill was being drawn up? How will the decisions of the Millan committee impact on this bill? There might be two things going on that are more conjoined than seems at first to be the case.

Mrs Brannan: The reason why this bill has been brought forward now, rather than waiting for the Millan review, is that it is recognised that reform of the law on mental incapacity is urgently needed. It is thought correct to improve the situation as soon as possible, rather than to wait for a more wide-ranging reform. We feel that there is a wide consensus on the timing and content of the bill, including the agreement of the Millan committee, which was asked whether it was content for us to proceed. The Millan committee has certain detailed reservations about the content of the bill, but not about the general principle of proceeding with the bill, or about the timing.

The people whose interests are protected by the bill are not necessarily the same as those who are covered by mental health legislation. As Ms Barton explained, mental disorder is one of the threshold criteria in the bill for assessing incapacity, but not everyone with a mental disorder will have an incapacity. We accept that there is an overlap, but do not feel that that is a reason for not proceeding now.

Tricia Marwick (Mid Scotland and Fife) (SNP): As Roseanna said, we have had a great number of submissions. I want to ask specifically about nutrition and hydration, which are covered in section 44. The Society for the Protection of Unborn Children has sent us a submission, in which it claims that the effect of subsection (2) would be to allow doctors to withdraw nutrition and hydration by assisted means for patients who are not dying, with the express intention of bringing about their death.

Mrs Brannan: At this point we shall have an uncomfortable shuffling of chairs because my colleague Mr Brown is more expert in this area than I am.

10:15

Jim Brown (Scottish Executive Health Department): It has been suggested that the bill will legalise, or otherwise make possible, euthanasia on a voluntary or legal basis. Euthanasia is a criminal offence under the existing law and nothing in the bill will alter that. The Executive has been at pains to make clear that it remains opposed to any legalisation of euthanasia.

Fears have been expressed by a number of interest groups that guardians or welfare attorneys acting in their own financial interest, and perhaps in collusion with doctors, may seek the withdrawal of treatment, in some cases leading to the patient's death. The bill contains a number of safeguards designed to prevent that.

Part 1 of the bill requires all interventions to be of benefit to the patient and to be the least restrictive option available. Part 5, which contains section 44, allows the person responsible for medical treatment of an adult to seek authority from the Court of Session to give treatment in the event of refusal of consent by a guardian or welfare attorney.

Guardians and welfare attorneys also have a duty at common law to act in good faith and in the interests of those on whose behalf they make decisions. There is a range of safeguards designed to forestall the situation envisaged in your question.

The Convener: Could you address the point more specifically? Is withdrawal of hydration and sustenance possible under this bill?

Mrs Lynda Towers (Office of the Solicitor to the Scottish Executive): That is currently dealt with under the common law by application to the Court of Session. It is understood that that will continue to be the position. If somebody seeks to withdraw nutrition and hydration, that will still have to be dealt with by petition to the Court of Session.

While medical treatment includes ventilation, nutrition and hydration, our understanding is that it still would not allow somebody to withdraw treatment.

Tricia Marwick: If that is the case, why have you specifically included it in the bill? If there are safeguards at common law, why have you taken the opportunity to specifically include it in a bill dealing with adults with incapacity?

Jim Brown: That follows the Law Commission's report. It is designed to clarify that doctors can, within the general scope of their authority to treat, give ventilation, nutrition and hydration by artificial means. It clarifies the law as it currently stands.

Tricia Marwick: It also allows them not to provide nutrition and hydration.

Mrs Towers: This is authorising carrying out of treatment under this provision. It allows them to carry out that treatment. The provision does not allow them to not carry that out; it is authorising them to carry it out. It is a more positive approach.

Tricia Marwick: On a more general question, section 44(2) in the draft bill also makes reference to the inclusion of nursing. That has raised concern as medical treatment and nursing care are quite different disciplines. There is a concern that, for example, pain relief should be provided to all patients regardless of their condition. Will you give me an explanation for the inclusion of nursing within this bill?

Jim Brown: Yes, that is for clarification. Any fears that nursing care might be terminated are unfounded. There is a duty of care on the medical profession to provide what is necessary for the comfort and sustenance of patients in circumstances such as cases of terminal illness.

Tricia Marwick: I am concerned that the witnesses see the provisions in the bill as positive, but the majority of representations by organisations made to this committee express the view that they are not positive. Those organisations think the bill increases the chances of withdrawal of treatment.

Mrs Towers: To an extent, the bill sets out a statutory framework for what is already happening. Patients will receive surgical, medical, nursing and various other treatments. The person who decides whether a person has the capacity to give consent will still be the doctor. It is not envisaged that a nurse will decide whether a person is properly able to give consent. Nurses will give the caring treatment that the care team considers is appropriate for a particular patient.

The Convener: The difficulty is that, while it might not be envisaged that that is the case, if it is put down in statute in black and white it might still have that effect. We have all experienced legislation that has an effect that was not envisaged. Is it your view that the proposed legislation is not capable of the construction that is suggested by some potential witnesses?

Mrs Towers: As a lawyer, I would certainly not say that one could argue for different constructions. The person who is ultimately responsible for the medical treatment will be the medical practitioner. He will authorise treatment by the various other elements of the care team. It will not be open to a nurse to decide that a patient should not be given nutrition and hydration. No additional door is being opened.

Kate MacLean (Dundee West) (Lab): I am particularly interested in intervention and in when a person can be delegated to make decisions about an individual's health and welfare. What safeguards are being put in place to ensure that an incapable adult's previous wishes are taken into consideration, and when would the views of nearest relatives or primary carers be sought or taken into account? I am thinking particularly about same-sex relationships, which an incapable adult's family might disapprove of. Will there be any safeguards or reassurances that the partner's views will be sought or taken into account and not just the views of the family, which might have had no contact with the incapable adult for a number of years?

Ms Barton: The bill says a number of things about consulting everyone with an interest before decisions are made or actions are taken on behalf of someone who does not have the capacity to decide for themselves.

The bill uses the Mental Health (Scotland) Act 1984 definition of nearest relative. The act identifies a sequence of people whose views are to be considered. That includes the spouse and can include someone who lives with the adult as though they are husband and wife. Our advice is that the definition does not include a same-sex partner. There are other ways in which the bill will ensure that those who are close to the adult and who are involved in looking after them have their views taken into account—their views will be given equal status to the views of the nearest relative.

Mrs Towers: May I add one further point? The definition of nearest relative is as Kay suggested. It includes the catch-all that if a person has resided with someone who is not a relative for a certain period of time, that person can assume particular status, but only if there is no one else under the nearest relative list.

The Convener: So it would be possible, theoretically, for a nearest relative who has not been seen for 20 years to be involved in the direct decision making about care?

Ms Barton: It would be possible for that person

to be involved, but theirs would not be the only view to be taken into account. The bill will ensure that anyone else who is looking after the adult, or is close to them, has the right to have their views heard. The bill does not distinguish between the status that is given to the different views.

Kate MacLean: That is a highly unsatisfactory state of affairs—could anything be added to tighten it up? As Roseanna said, in a lot of cases a relative who has not been involved for 20 years could have more influence than a partner of 20 or 30 years' standing.

Ms Barton: The Millan committee is considering the definition of nearest relative—which originates in mental health legislation—and consulting on changes to it. If that committee decides to recommend changes in the mental health legislation, perhaps the definition in this bill should also be changed.

Christine Grahame (South of Scotland) (SNP): My point has been made by Kate; during an informal briefing, the Law Society of Scotland also mentioned its concerns about the definition of nearest relative. Does the bill include provision for an interim appointment for cases where there is conflicting input from various parties? Is there a case for that when intervention has to be made fairly urgently?

Ms Barton: Section 3(2)(d) contains a general provision that the sheriff can make an interim order to suit the circumstances. He has complete flexibility as to how quickly he can make that order and what sort of evidence he decides that he needs or can dispense with.

Christine Grahame: So the sheriff could deal with a conflict about who was the nearest relative by calling for a hearing?

Ms Barton: He could decide whom he wanted to hear evidence from in any decision in front of the court.

Mrs Towers: The Mental Health (Scotland) Act 1984 also makes provision whereby, in certain circumstances, an application can be made to the sheriff to change who is regarded as the nearest relative. However, those circumstances are very limited and I do not think that the provision is used very often. The Millan committee will examine all these matters.

Christine Grahame: It is obvious that we must consider this matter as linked to the Mental Health (Scotland) Act 1984.

Ms Barton: Some of the underlying definitions in the incapacity bill are certainly linked to that act. The Executive consulted Mr Millan about it. His view was that it was a good idea to have consistency of underlying definitions, provided that they are used appropriately and that the use of Mental Health (Scotland) Act 1984 definitions in the incapacity legislation can be reviewed, and perhaps amended, once his committee has reported.

Euan Robson (Roxburgh and Berwickshire) (LD): I want to clarify my understanding of section 44. On subsection (1), the explanatory memorandum states:

"The general authority to treat will extend to the medical practitioner assessing capacity, and to any person acting under the instructions of that medical practitioner."

The memorandum states that the effect of subsection (2)

"will be to enable doctors, nurses, dentists, and others to seek to improve the health of adult patients with incapacity by giving treatment without fear of legal challenge."

Let us imagine that I am a nurse. I am treating someone under the instructions of the medical practitioner, but I decide to do something in addition. If I do something in addition without seeking the authority of the medical practitioner, am I then open to legal challenge? That could be an interpretation.

10:30

Mrs Towers: I do not think that the intention behind the legislation would be to protect any nurse or other medical person who acted beyond the instructions that they had been given on an individual's care. That would also be the common law position. Currently, any nurse would have the protection of saying, "I was doing what the doctor was telling me." Technically, that would not prevent somebody from suing the doctor and the nurse.

Euan Robson: The explanatory memorandum says on subsection (2):

"The effect of this section will be to enable doctors, nurses, and others to seek to improve the health of adult patients with incapacity by giving treatment without fear of legal challenges."

That text must be construed with the original.

Mrs Towers: Indeed.

Gordon Jackson (Glasgow Govan) (Lab): I am out of sequence. I am still thinking about the point that Tricia Marwick made on section 44.

I did not understand why you felt it a good idea to include subsection (2)—the definition—at all. Experience teaches that, in legislation, small is beautiful. When definitions are included, that gives lawyers an opportunity to play games with them.

You have conceded the possibility of another argument—any lawyer will concede that. Responsible people have been writing in with their perception of other arguments. Why were you against leaving subsection (1) as it was, on the

commonsense basis? Subsection (2) defines medical treatment, but medical treatment is surely what people do to look after the welfare of other people, including giving them water, air and whatever else is needed. A legal definition creates words for people to play with, so why bother with it at all?

Jim Brown: Essentially, we were following the recommendations of the Scottish Law Commission's report, on which we consulted. There was no overwhelming argument against defining medical treatment—possibly the converse. That has shaped our thinking in including this provision in the bill, which is intended as clarification.

Gordon Jackson: Would you accept that it would not do a huge despite to the bill not to include the definition? That would avoid the minefield but not undermine the bill's integrity.

Jim Brown: I see that argument. Conversely, the medical and nursing professions may welcome the clarification.

Mrs Towers: The additional factor is that, although medical treatment is easily argued to consist of surgical, medical and nursing treatment, it is perhaps not always obvious that it would include optical and dental procedures or treatments. Leaving the definition in a wide format allows for developments of other professions and for other treatments in the future. It would be a flexible provision—but you are right.

Gordon Jackson: I see the difficulty—after "medical treatment" one might want to insert "including optical or dental". However, a definition may, in future, leave some treatments—physiotherapy or whatever—slightly outside the terms of the bill. If the definition is not specific, however, it will, through common sense, include everything. Once a definition is put in, anything that is not within the definition is excluded. Does that not create the problem that you are trying to avoid?

Jim Brown: By your argument, section 44(2)(c) would fit the bill.

Gordon Jackson: That is already included in paragraphs (a) and (b); it would be there anyway. I do not want to go on about it; I am just curious about why you did it.

Mrs Towers: There is an historical factor. It was considered to be a sensible approach by those whom we consulted.

The Convener: I thank the Scottish Executive representatives for coming along. I would ask some of you to stay on if you were not already intending to. We may ask you to come back for five minutes as part of the wind-up.

I ask Adrian Ward, convener of the mental health and disability committee of the Law Society of Scotland and spokesperson for the alliance for promotion of the incapable adults bill, to come to the table now.

Mr Ward, welcome to the committee again. You came before us during our informal briefings in the recess. We will go straight to questions, unless you feel an overwhelming need to make another statement. If you do, could you make it no more than two minutes long?

Adrian Ward (Law Society of Scotland): I outlined the background when I came to the committee before and I am happy to take questions now.

The Convener: Do members have any questions to put to Adrian Ward, who is here in two capacities?

Adrian Ward: I am convener of the mental health and disability committee of the Law Society of Scotland—that is the capacity in which I appeared before. I am also principal spokesperson for the alliance in favour of the bill.

Gordon Jackson: You have heard us talking about the definition of medical treatment and whether it should include details. Do you have a view on that?

Adrian Ward: Yes. It is important to step back and see the context. Medical treatment is authorised in four different ways. Most forms of treatment that intervene physically would be classed as assault unless the treatment was authorised. The authorisation criteria are: the consent of the patient; the consent of someone who has legal power to consent for the patient; the principle of necessity—if I am reeled into hospital in a state of unconsciousness, the doctor does not need my consent; and where medical treatment is authorised by statute. In our law, that last criterion is limited to compulsory treatment for mental disorder under the Mental Health (Scotland) Act 1984.

The problem with the present law is the doubt about whether some circumstances are not covered by those criteria. Consent is obvious: either it is given or it is not. However, there is doubt about the extent of the principle of necessity. Case law in England gives a broad interpretation of necessity, but England has no equivalent of our tutors dative who can be given authority to give medical consent for the treatment of another adult—that is the only form of proxy consent that is authorised at present.

There is concern about whether treatment that is clearly not necessary to preserve life—such as dental treatment and optical treatment—is covered. If the owners of a care home ask a

dentist to inspect the teeth of a person who cannot make a decision, there would be a question about whether that was authorised by law.

To the best of my belief, all the interest groups that we have consulted on the matter—and the alliance has been careful to consult a broad range of opinion—believe that we need an additional ground of authority to cover that situation. Section 44 makes it clear that that would be in addition to the other forms of authorisation. The four that I have listed will still stand, but we need an additional statutory authority. I expect that it will cover routine things and will not be necessary in a case of obvious necessity, such as when someone has been knocked down by a car.

There is a flaw in section 44. At the moment, it differs from the guidance, as it allows

"any person who is responsible"

to give certification. I understood, from the guidance, that it was intended that only a medical practitioner would be able to do that. The first sentence should specify that certification should be made by a medical practitioner; as drafted, it implies that it could be done by someone who may not even be qualified—a manager could be responsible for treatment.

Once authority has been given, it is important to signal that it covers a broad range of things, such as going to the optician or the dentist. I have heard the comments about subsection (2). My concern is that, if it was taken out, there could be doubt as to whether something outwith the fringes of care were covered. It is important that the provision is broad and covers things that involve care rather than treatment. Some legal systems make a clear division between the two—French law does, for example—but ours does not: care and treatment merge into each other.

Gordon Jackson: Is there not a danger that, if you make the definition and worry about things at the fringe, you will create the problem? You will find things at the fringe that are not covered by section 44. Eventually something will turn up and, because it is not specifically included, the argument will be that, as the section is inclusive, that thing is specifically excluded—you could exclude things by specifically including things.

Adrian Ward: I would have no objection if subsection 44(2) started with paragraph (c), which is already very broad. The other parts of the definition could be included without prejudicing that generality. In other words, we should have the broadest possible definition—which is similar to that in paragraph (c)–and anything specific, such as paragraphs (a) and (b), should be given as examples that do not limit the definition. I would have no problem with the section being adjusted in that way.

Gordon Jackson: The emphasis could be moved round?

Adrian Ward: Yes.

On a related point, does this new authority to treat create a new authority not to treat? My answer is that, clearly, it does not. It does not take anything away from the ethical or other obligations of doctors; it confers a positive authority to give treatment where there may be doubt about whether such treatment is authorised under the law as it stands.

The Convener: I ask a more general question. You heard us discussing the impact of the Millan review. You have talked about mental health legislation. What is your general impression of the way in which this bill and the Millan review interact? Are there matters that you would prefer to leave to the review, or do you feel that we might require this bill to be amended when Millan reports?

Adrian Ward: The bill is necessary; the Millan review is very necessary, and I welcome it. When, in 1986, I first suggested a comprehensive review to the Scottish Law Commission, I said that that review should encompass both incapacity and mental health law. However, the two can be dealt with separately without problem, as they deal with different, although related, areas. Mental health law is essentially concerned with issues of compulsion, such as when it is appropriate to deprive people of their liberty or to give them treatment that they would otherwise refuse to accept because of the characteristics of their mental disorders. That is the core of mental health law.

This legislation covers a far wider range of people. You will have heard the estimate that it would probably be relevant to 100,000 people in Scotland at any given time. There are certainly not 100,000 people who would come under the Mental Health Act (Scotland) 1984 provisions at any given time, and the people who would have different needs. This bill concerns decision making about such people's finances and health care.

Mental health law is much more specific. I am concerned that parts of mental health law, which we all know need to be reviewed and are going to be changed, might nevertheless be referred to. I would prefer this bill to give a definition of incapacity that is clearly suitable for its purposes. Any definition in mental health law will serve a different purpose—it will concern the issues of compulsion that I have described.

I am delighted that the Millan committee is doing the job. I hope that it conducts a wide-ranging review and challenges everything, as much needs to be changed. However, let us not wait for that; let us formulate the right definitions in this bill. I do

not think that, after Millan has reported, we will want the definition in mental health law to be included in this bill, which serves a different purpose.

The same applies to the question of the nearest relative. We are concerned that there is no mechanism to displace an unsuitable nearest relative. A father may be abusing a daughter, but if he is the nearest relative, we cannot get rid of him. Everybody knows that that problem must be addressed and I see no need for the bill not to deal with it.

10:45

Christine Grahame: Going back to Millan's letter, I note that, for the procedures in the sheriff court, the Millan committee is looking for nominated sheriffs. I would like your comments on that. In the Court of Session, we seem to be moving towards specialist judges. In the sheriff court, we have nominated sheriffs for family law, which I think would be a good idea for incapacity and mental health law.

My second point concerns the way in which the hearings are conducted. I see that it comes under the heading of summary application. Would you like the hearings to work along the same lines as child welfare hearings? They will be dealing with some sensitive family issues, so perhaps there should be more consultative and interventionist hearings for certain matters at an intermediate stage.

Some cases require frequent returns to court. In one case that I handled, a tutor dative was appointed; we had to keep going back for more powers but were resisted. It was a cumbersome case in the Court of Session and, because it concerned a young woman with anorexia nervosa, it was very urgent indeed. I wonder whether something could be done about the sheriff court procedures to make special provision for such cases.

Adrian Ward: On your first point, when my committee of the Law Society of Scotland was considering its response to the Scottish Law Commission's consultation in 1991, we looked at what forum would be appropriate for handling jurisdiction under such legislation as is now proposed in the bill. We did not start by looking at sheriffs at all. We considered a number of models, including children's panels and industrial tribunals. We then created a list of all the attributes that we thought would be necessary. Somewhat to our surprise, we came to the conclusion that, because of the question of basic rights, these matters should be within a sheriff's jurisdiction. One way or another, albeit with good reason, the process involves taking away somebody's right to do things for themselves and putting in place another mechanism for making those decisions.

We also felt that, where there was dispute or the possibility of an appeal, we needed someone who was competent to state very clearly, in a way that an appeal court could address, how he or she came to his or her decision and the grounds in law and in fact. We concluded that a sheriff was probably the best person to do that.

We were firmly of the view, and we remain so, that it would be helpful for designated sheriffs to become familiar with this jurisdiction. As far as I am aware, those who practise in mental health and mental incapacity matters entirely support that. This area of law requires a rather different approach from the one for much of the work that a sheriff usually does.

In answer to your second point, I have seen models and paperwork for procedures in other countries. One of the Australian states kindly sent me all the relevant documentation: all the procedures were user friendly; in many cases, a lawyer would not be needed; and people could read the guidance, fill in the form and then go along for the hearing.

The two questions are related. There were many arguments for having a format similar to that of a children's panel but, as a case is to go to a sheriff, the atmosphere should be closer to that format. That is a matter not for primary legislation, but for the rules within legislation. I strongly favour the approach that you have described, but recognise that some hard issues will have to be confronted. Legislation will not remove the problems; it will provide a better framework for addressing them.

The Convener: It would be interesting to hear your comments on a couple of points that have been raised with the committee by the Mental Welfare Commission, which will be giving evidence later. Concern has been expressed about the conflict of interest that could arise in the financial management of patients' funds when NHS trusts want to spend the money on goods and services that the health service would otherwise provide. How will that be monitored? Who is going to monitor whether the money that is being spent is over and above the money that should be getting spent anyway? You did not really address that issue in your submission.

Adrian Ward: We have already experienced such a pattern under section 94 of the Mental Health (Scotland) Act 1984, which gives hospitals the ability to manage patients' funds. This provision of the bill widens and updates that measure to allow a form of management to be available in other settings.

Although I am not aware of any substantial body of complaint—apart from that from the Mental

Welfare Commission—about whether the existing system uses an individual's money to pay for things that the NHS should be paying for, there could be a problem there. However, I have seen many cases where people's money has accumulated and no one has been able to get to grips with the issue of whether that money could be used to their benefit. It is a question of balance. Although we need the controls, we have to get away from a situation where people's money is not being spent for their benefit.

The Convener: The concern is that, as the bill gives the health boards a supervisory role, their relationship with various NHS trusts will become more complex if it looks as though money is being spent inappropriately. Are health boards in the strongest position to do anything about such a situation? Are there sufficient resources for supervision?

Adrian Ward: I do not think that I can answer that question on behalf of the bodies that I represent. The Mental Welfare Commission might be able to help you more, as it has better hands-on experience of monitoring that situation.

Gordon Jackson: I want to follow up a point that I did not fully understand. When you were asked about the bill's relationship with the Mental Health (Scotland) Act 1984, you said that different definitions might be appropriate. The bill's definition of incapable includes the two thresholds by reason of mental disorder, but mental disorder is then simply defined under the terms of the Mental Health (Scotland) Act 1984. The bill also contains an odd bit about promiscuity and sexual deviancy, with which I will not burden you. If you do not want the Mental Health (Scotland) Act 1984 definition of mental disorder in the bill, how would you want mental disorder defined?

Adrian Ward: Why are we not happy with that definition? Mental disorder is defined in the Mental Health (Scotland) Act 1984 as

"mental illness or mental handicap however caused or manifested."

It was defined in that way until very recently. This Parliament has now added the qualification that the definition includes personality disorder. I have to say in passing that I have never heard anybody else suggest that personality disorder is a mental illness. A Westminster Government paper published in July explicitly stated that personality disorder is not a mental illness.

Gordon Jackson: You are preaching to the converted on that one.

Adrian Ward: I not preaching; I am reporting what the paper said. However, here in Scotland personality disorder is defined in that way. We have real concerns over whether that definition covers conditions such as brain damage acquired traumatically in an accident. Is that a mental illness or a mental handicap? It is doubtful. Does it cover brain damage caused by a stroke? We in the alliance and the Law Society of Scotland have real concerns over whether the definition—even with the recent adjustment to it—adequately covers what is meant.

The simple answer to your question is to quote the definition that the alliance proposed:

"any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning, or inability to communicate because of physical or other disability."

That is a wider definition. We have to be careful; this is one of the problems that I have with the Mental Health (Scotland) Act 1984. If we are talking about people whom it is appropriate to treat against their will, and who should lose their liberty, we need a narrow definition.

If we are talking about the initial gateway into the legislation, there are—as a previous witness said—two levels. The first is: are you potentially in this jurisdiction at all? We need to be careful that we do not exclude anybody, such as those with acquired brain damage. We need a broad definition. Secondly, once we are in, we have to be careful, and we must have tight general principles. If people are potentially within the jurisdiction, will we, for example, make things better for them if we apply a particular remedy? Is it the minimum necessary intervention?

Those are the two levels of decisions. It would be a great shame for the legislation to go on the statute book with any doubts as to whether the people whom we all think ought to be covered—for example, someone who had brain damage in a road accident at the age of 20 and cannot make financial decisions—are potentially within the jurisdiction.

The Convener: In the submission from the alliance, you made some powerful points about why aspects of the bill were absolutely necessary. Although the committee has focused a little on some of the concerns and problems that might arise, will you comment on some of the points on pages 3 and 4? At first glance, they appear to be hypothetical case studies of present situations. You discuss how the bill would improve them. Were those cases actual and not hypothetical? Will you take two minutes to explain why those are the circumstances that require fixing? What problems will be resolved by the bill?

Adrian Ward: About 10 case studies have appeared frequently in alliance literature, and I will give you their background. At an early stage, we decided that we ought to provide explicit examples and, off the top of my head, I gave 10 examples

from my own experience. Some were typical of many and others were more individual, but they are either specific cases that have happened or a generalisation of many specific cases.

The Convener: Some of that is because of current banking practices that have evolved and created even more difficulties.

Adrian Ward: We have the problem of joint accounts. People put an account in joint names believing that there will be no problems if one of them dies. However, if one loses capacity, there are problems. If the banks become aware of the loss of capacity of one joint holder, they freeze the account.

The Convener: The whole account?

11:00

Adrian Ward: Yes. Broader issues arise from curator bonis. People have found that all their funds have been exhausted because of the costs of curator bonis. They have had to pay massive sums in damages and have been living on less than state benefits. I am talking about people I know personally.

The Convener: Are those real examples?

Adrian Ward: Yes. I will not go through them, but they are all based on actual cases. Some are based on many cases of a similar nature.

The Convener: Thank you, Mr Ward. You are welcome to stay, if you can find a spare seat.

I ask Dr James Dyer and George Kappler to come forward. They are, respectively, the director and the social work officer of the Mental Welfare Commission for Scotland.

I welcome Dr Dyer and Mr Kappler. You have been listening to the evidence that has been given so far, and you may anticipate what some of the questions will be. I would like to open the discussion by asking you to comment specifically on the issue that I raised—the concern that you expressed in your written submission about the possible conflict of interests caused by health boards overseeing the management of these funds. You make some specific comments based on information of which the Mental Welfare Commission is aware.

Dr James Dyer (Mental Welfare Commission for Scotland): That is one of a number of comments in our submission concerning the erosion of the role of the public guardian, which was proposed in the Scottish Law Commission report of 1995. Under that proposal, the management of funds of incapable people in hospital would have been supervised by a public guardian, rather than by the Mental Welfare Commission, as at present. Under the bill, health boards would have that supervisory function.

We have mixed feelings about taking that responsibility away from the Mental Welfare Commission. As I say in our submission, it would, on the one hand, remove an area of work from us and allow us to concentrate on other important aspects of our role. On the other hand—as your question indicates—we worry about a potential conflict of interests arising from one NHS organisation monitoring another NHS organisation.

We sometimes come across problematic cases. In one such case, a hospital wanted to pay for a patio area outside a ward with the funds of an incapable patient. Because the patio would be expected to last far longer than the patient, that proposal seemed to us inappropriate.

We sometimes have to adjudicate in such cases. They are not frequent, but it can be difficult to decide whether something should be provided by the NHS or out of a patient's funds—for example, a more luxurious bed or more luxurious furniture. We are hampered by a lack of clear guidance from the NHS in such circumstances as to what it should provide. One has to make commonsense decisions.

If health boards are to monitor trusts—and, of course, trusts are funded via health boards—there is the potential for a conflict of interests. They do not have the same independence that the commission is able to exercise at present in scrutinising these cases.

The Convener: Do members of the committee have any specific questions?

Christine Grahame: Earlier I raised the question of interim orders. In your submission, you comment that the bill

"does not appear to make provision for real emergencies which require very urgent intervention."

I have already referred to that twice. In one case in which I was involved, we had to go back to the courts constantly. What would you like to see here?

Dr Dyer: We are particularly concerned about welfare functions. We know that the sheriff has the power to make interim orders, but that requires an application to be made to the sheriff. There might be very urgent situations, in which someone's welfare needs to be protected, that are not dealt with by the current bill. That may be because the Law Commission report on vulnerable adults, which was produced after the report on incapable adults, proposed emergency intervention powers for vulnerable people, including people with mental disorder. That would address such a situation.

We simply point out that there could be a gap. Of course, the Mental Health (Scotland) Act 1984

can also be used in emergency situations. If someone needs immediate protection, a section of that act allows people to be taken to a place of safety, and so on. It would be interesting to ask what the Executive envisages when somebody's welfare requires immediate protection, even beyond the terms of the interim order.

George Kappler (Mental Welfare Commission for Scotland): The ability to proceed quickly to provide the care—particularly, residential and nursing care—that someone is assessed as needing, on an emergency basis has come up consistently over the years from social workers and mental health officers to the Mental Welfare Commission. Although the Mental Health (Scotland) Act 1984 allows someone to be put in a place of safety for 72 hours, it is difficult to get an application through, even with the proper paperwork, and to get it adjudicated, even on an interim basis, within 72 hours.

Christine Grahame: May I come back to the court procedures that might be used? Should there be a different structure? I concur with the sheriff being involved. As rights are being taken away, that level of jurisdiction and authority is needed, which would then, perhaps, be subject to review by the Court of Session and so on.

It seems to me that, if a different system operated, we could resolve some problems. Rather than people making the usual applications to court and trying to arrange a hearing in the course of the day, a system would be in place which envisaged that in the first place.

Dr Dyer: We started off by being fairly firmly in favour of the sheriff court system, but we now have a more open view. The Millan committee is discussing what the appropriate procedures should be in relation to new mental health legislation. I am a member of the Millan committee, but am not speaking in that capacity today. It will examine the merits of the sheriff court versus a new tribunal system. An argument in favour of a tribunal system is that there could be more expertise about medical and welfare matters than is available under the sheriff court system. One member of a three-person tribunal could have such professional expertise, which could be immediately available.

Both sheriff courts and tribunals have pros and cons. We have simply said in our submission that it is worth considering those options, but we do not have a fixed view on which is preferable.

The Convener: I come back to the issue of money. I understand that the bill gives the Mental Welfare Commission additional functions. Have you made any assessment of the implications for your budget of the additional functions? Do you have concerns about the resourcing of aspects of this bill?

Dr Dyer: Yes. We noted that the financial memorandum quotes figures for updating our computer system and adding to our staff to enable us to cope with the fairly extensive extra responsibilities that the bill gives us, but we are not aware of any consultation taking place prior to arriving at those figures.

The Convener: Nicely put.

Dr Dyer: Can I express a willingness to discuss with the Executive a costing of the extra work, so that an accurate figure can calculated? We are very strained at present as our work is statutorily determined under the Mental Health (Scotland) Act 1984, and our work load keeps going up. Despite community care, detentions keep going up. Requests for review of detentions are going up disproportionately to detentions—a welcome form of user empowerment—and other aspects of our work are increasing. We are seeking extra funds to keep that work going at present. We would certainly need significant extra funds to meet the new responsibilities in the legislation.

Pauline McNeill (Glasgow Kelvin) (Lab): We have heard evidence on some of the controversial aspects of the bill concerning medical treatment. Can you briefly outline the benefits and dangers of authorising medical treatment without a patient's consent?

Dr Dyer: As Adrian Ward explained, it is necessary to give a clear statutory authority to treat. Currently, that is given under common law. In Scotland, common law is seen through a glass darkly. It is very unclear because, unlike south of the border, there has been a lack of court cases clarifying common law.

We welcome a general statutory authority to treat. Of course, that will be qualified and we were surprised to find that those qualifications will be made through regulations rather than in the bill. We are not clear about the procedure that will be followed. We understand that the negative procedure will be used, whereby regulations are debated only if someone objects to them.

The regulations will include matters that are considered to be controversial, such as psychiatric treatments. Treatments such as drugs for a psychotic disorder and electro-convulsive therapy are likely to be exclusions to the general authority to treat, requiring special safeguards. It is important that there is adequate discussion of such matters.

In regard to the previous discussion about whether including certain treatments covers withdrawal, I would point out that one of the underlying principles of the bill is that any intervention should be required to produce a

benefit for the adult. It would be against the principles of the bill to give any treatment that was not conferring benefit.

Tricia Marwick: Or not giving treatment?

Dr Dyer: I simply say that it is against the principles to give treatment that would not confer benefit. The bill does not say anything about withdrawing treatment. That was in the Law Commission proposals, but the Executive has chosen to leave out of the bill any specific proposals for withdrawal or withholding of treatment.

Pauline McNeill: Are you saying that if more positive language was used, the controversy surrounding that might be avoided? Some organisations—I have had many letters—are suggesting that the Executive is about to legalise euthanasia. I can see that that is not the case.

Dr Dyer: I am aware that there are some very vigilant and vocal organisations with strong views about that. However, it is clear to us that the purpose of the bill is to give a statutory authority for treatment, with various safeguards for more controversial or irreversible treatments.

Pauline McNeill: I want to ask about what constitutes treatment and care. Chemotherapy, for example, is a treatment that could be interpreted as a benefit, or not as the case may be. Would that be covered by "medical treatment"?

Dr Dyer: I imagine that it would, although that is not within the expertise of the Mental Welfare Commission.

I would like to comment on Mr Jackson's question about definition. It is necessary to give some guidance as to the definition of medical treatment—to know whether it is a narrow definition or a broad one. Without such guidance, there would be endless arguments in relation to individual cases. We need to know whether it means what people often think about, such as pills and surgical operations, or wider matters, such as nursing care. Such issues have been relevant in appeals against detention under the Mental Health (Scotland) Act 1984. In the cases of Alexander Reid and Noel Ruddle, the breadth of the definition of treatment was crucial.

If there were no guidance, the definition would have to be arrived at through individual court cases. I am not necessarily saying that I am satisfied with the current guidance, because it goes part of the way to being more specific, without going the whole way. It mentions surgical and medical treatment, for example, but does not mention psychiatric or psychological treatment. Furthermore, it does not specifically mention investigations to aid diagnosis, or blood tests to check the safety of medication—although that could conceivably come under procedure in section 44(2)(c). If the definition is to be explicit, it should be more explicit; if it is not to be explicit, it should be less explicit, but accompanied by some form of guidance.

11:15

Gordon Jackson: I am still not clear why we want ventilation, nutrition and hydration to be specified as medical treatment. Surely we are not envisaging a doctor saying that although he is entitled to treat a person medically, he cannot give them air, water or food. That would be an absurdity—those must come under medical treatment. I fear that if that is not the case, that area would become a battlefield rather than something that is, as a matter of common sense, included in any medical treatment.

Dr Dyer: I understand and am sympathetic to the argument about making that a battleground. On the other hand, there is an argument that there could be uncertainty about whether feeding and giving water to someone is treatment. I can conceive of that being argued in court.

Gordon Jackson: It is conceivable that a doctor who has the authority to treat someone medically might say that he will not feed the patient or give the patient water because he does not have permission to do that. I have heard some weird arguments in my time—I have put some forward myself—but that sounds pretty weird to me.

Dr Dyer: I am not saying that a doctor would refuse to do that because it is not permitted, but there might be an argument about whether that is treatment or something else, such as the general duty of care.

Gordon Jackson: I was sympathetic to Christine Grahame's view that the sheriff should deal with that. It seems right to me that that should be a judicial decision. You have mentioned the other side of the coin—that there could be technical arguments. Is this a case for procedure being put into the law of Scotland—and this is rarely done—to give a sheriff an assessor for such purposes? Would there be value in a sheriff having technical help?

Dr Dyer: That would be worth exploring. The sheriff could have the benefit of expert advice. We, too, are sympathetic to the idea of nominated sheriffs—sheriffs who build up expertise in this area. The Sheriffs Association will tell you, however, that it does not think that that would be viable outwith the main centres of population, because it would be more difficult to get sheriffs in rural areas to specialise. However, that seems to us to raise issues about the training of sheriffs and appraisal of them. Why should not rural sheriffs benefit from the same training as everyone else?

What Mr Jackson suggests about expert, independent and professional advice is an idea that is well worth exploring.

Scott Barrie (Dunfermline West) (Lab): I am slightly confused by the answer given in response to Pauline McNeill's question. Did I understand correctly that what was said was that treatment could be withdrawn when there was no obvious benefit to the person receiving it?

Dr Dyer: I would not put it in those terms.

Scott Barrie: That is how I understood it.

Dr Dyer: It is not what I said—I said that one of the basic principles of the bill is that any intervention under the authority of the proposed legislation should provide benefit to the adult. Under the bill it might, therefore, seem inappropriate to offer intervention to an incapable adult, which conferred no benefit on that adult.

The Convener: How is benefit to be assessed in those circumstances?

Dr Dyer: That would be the judgment of the person who could offer the treatment. If there were controversy, it would be necessary to take the case to the courts, so that a decision could be made there.

Tricia Marwick: Do you agree that feeding and hydration would always benefit a patient?

Dr Dyer: It is highly likely that that would be the case. I am not expert in conditions such as persistent vegetative state, and which are not within the remit of the Mental Welfare Commission, so I am not fully competent to answer that question.

Pauline McNeill: You said that you are not an expert on the whole subject of medical treatment, but it strikes me that some of the evidence that we have heard today suggests that there are implications for the whole medical profession.

I know a wee bit about the nursing profession; in my view, it is clear that it is within the duties and legal responsibilities of any nurse to include sustenance and so on in the provision of care. That is part of the professional code of conduct of nurses. If we were to put 100 nurses in front of the committee, they would all say that. The demarcation between doctors and nurses is, in reality, completely clear.

You said earlier that the medical practitioner would decide what intervention would be required, and whether the matter would be referred to court. Do you think that there are legal implications for the medical profession?

Dr Dyer: Yes. The bill will make the situation clearer. At the moment, doctors and others who are involved in treatment are not sure about the legal authority to treat incapable patients. The bill will clarify that, with the general statutory authority to treat in fairly ordinary circumstances. Those people will know that there is a statutory authority. Provisions in the bill will cover situations in which a welfare attorney or guardian disagrees, and there will be a court procedure for resolving those disagreements. There will be special safeguards for treatments that are considered more serious or more controversial. However, I have expressed concern that those will be dealt with by regulations instead of being debated with the sections of the bill.

The Convener: A recent court ruling endorsed the argument that nutrition and hydration can be withdrawn without implications of ill treatment or neglect. The bill may enable that argument to be made without reference to court scrutiny. Do you think that that would be possible?

Dr Dyer: I agree with Adrian Ward's comments. The purpose of the bill is to provide a statutory authority for treatment—it is about giving treatment—and it does not contain sections that are concerned with withdrawing or withholding treatment. The basic principle is that treatment should be for the benefit of the person. It could be argued, in certain drastic situations, that the maintenance, with food and hydration, of a person's existence is not to that person's benefit, as they have no prospect of recovery. An intervention, under the bill, might not be appropriate in such a situation. However, in discussing such matters, I am straying beyond the remit of the Mental Welfare Commission.

The Convener: Do members want to raise any other points or questions?

Dr Dyer: We have some concerns about welfare guardianship.

The Convener: Let us decide whether members have any further questions. We have five minutes in hand. If there are no more questions, we will invite the witnesses to make further statements.

Gordon, you look eager.

Gordon Jackson: I wondered whether we might ask one further question of the Scottish Executive.

The Convener: We will ask it to return, Gordon.

Gordon Jackson: On another day?

The Convener: No—now. We have sorted all that out.

Gordon Jackson: Sorry. That is my fault for coming in late.

The Convener: Members have no more questions specifically for the Mental Welfare Commission. Therefore, our witnesses may raise specific issues with us, although that might prompt

more questions.

Dr Dyer: Mr Kappler would like to comment on the welfare aspects of the guardianship that is provided for in the bill.

George Kappler: Guardianship will be removed from the Mental Health (Scotland) Act 1984, and included in the Adults with Incapacity (Scotland) Bill. There will be many benefits from that. The three existing powers of guardianship are quite limiting. In spite of that, guardianship has more than doubled in the past three to four years. There are probably about 200 people in guardianship, under the Mental Health (Scotland) Act 1984.

I have some concerns about the transitional arrangements. The period for which guardianship is granted, under the Mental Health (Scotland) Act 1984, is six months initially, which is renewable yearly. The period that will be granted under the Adults with Incapacity (Scotland) Bill will be three years or longer, which will be renewable for periods of five years or longer. Basic rights are at issue. We often talk of compulsion, which is a key issue in the management of a person's care. Quite often, a power of residence is used specifically to provide a level of care in the community, albeit often in a residential or nursing home. It is required to protect a person's safety and welfare.

People often ask us to exercise our power to discharge guardianship, which we do in the periods during which they can appeal to the sheriff court. Many people who are in guardianship would feel aggrieved if that period of approval were extended to the extent that the legislation suggests.

The Convener: Do you view that as a potential burden on individuals?

George Kappler: I believe that many individuals will perceive it to be a burden.

The Convener: Does that raise any further questions?

Gordon Jackson: Are you saying, Mr Kappler, that the period is too long?

George Kappler: The period is longer than it is under the Mental Health (Scotland) Act 1984.

Gordon Jackson: Should the period stay the same or should it be in between?

George Kappler: For people whose incapacity is related to mental disorder, there is an argument that the period should remain the same. To do otherwise would be to erode the rights that they have, especially for those who are in guardianship under the Mental Health (Scotland) Act 1984. To change the period would be to move the goalposts quite considerably for people with the same condition for whom guardianship will be used in the future.

Tricia Marwick: What time scale would you suggest?

George Kappler: We have suggested both six-monthly and yearly renewals, as we have at present. Additional safeguards are built into the legislation, which are quite good, such as renewals being done not by filling in forms, but by reaffirming that the grounds exist by going back to the sheriff court. That is a positive move. There might be a trade-off, to some extent, with the periods for which guardianship is approved and can be renewed. As it stands, the difference in the length of the period is quite dramatic for a number of people.

Phil Gallie: Will you comment on the costs to the individuals whose interests are being looked after? I am told that the curator bonis system is fairly costly and that guardianship should improve the situation considerably.

George Kappler: There is no doubt that curators bonis are expensive. There is also a gap in the system for people who need some intervention in their financial affairs but who cannot afford a curator bonis. Undoubtedly, the bill will be quite helpful to families and professionals who are involved in managing people's care. The cost should be much more manageable as the system is much more streamlined.

Dr Dyer: I have two comments to add. First, there is a gap. The Scottish Law Commission proposed that it should be possible for the accountant of court, in his role as public guardian, to be appointed as financial guardian if there was no other way of looking after a person's finances. The Executive rejected that view. We can envisage situations in which there is nobody else to look after people's affairs, especially those with modest estates, and in which a low-cost system is necessary to protect their finances. For example, somebody with incapacity who is not in residential accommodation, but who is living at home with a lot of support, might need the public guardian to be a financial guardian of last resort.

Secondly, it is important that people who have things done to them because of their incapacity have adequate legal representation. The policy document says that legal aid will be available in the normal way. We do not believe that that is sufficient. We have successfully argued the case with the Executive that the situation in Scotland should be brought into line with that in England and Wales, where means-testing was abolished some time ago for legal aid in relation to mental health hearings and appeals under the Mental Health Act 1983. The Executive has told us that regulations will soon be laid that permit the abolition of means-testing for legal aid in relation to part V of the Mental Health (Scotland) Act 1984.

We think that there is an even stronger argument, where people have been assessed as being incapable, that there should be no inhibition on their legal representation through cost if they are not within the current legal aid threshold. It is not through their actions that they seek legal assistance. We are keen to see the abolition of means-testing for legal aid, and at least for advice by way of representation, under this legislation as well as under the Mental Health (Scotland) Act 1984.

Christine Grahame: I will go for the Legal Aid Board anytime on any subject.

Your submission states:

"In addition, the Bill does not appear to specify how often appeal can be made to the Sheriff against Guardianship."

Would there not be a general right to appeal against any order of the sheriff, if one were dissatisfied with it or if the sheriff were to misdirect himself in relation to the law or the facts? Why do you want a specific reference to that?

George Kappler: We are not clear about the bill's proposals. In existing mental health legislation, it is clear that someone can appeal against the decision to renew guardianship once during the period of renewal.

Christine Grahame: So you are concerned about renewal rather than about the decision itself?

George Kappler: That is correct, although the decision could be challenged on a point of law. The renewal that is allowed under the Mental Health (Scotland) Act 1984—

Christine Grahame: The note does not make that position clear as it refers only to how an appeal against guardianship can be made to the sheriff.

Dr Dyer: Under the bill, there might not be any renewal, as guardianship can be allowed for an indefinite period. An individual might want to appeal every week or every month. The Mental Health (Scotland) Act 1984 limits that by allowing one appeal in every period of renewal, which seems to be a reasonable balance.

George Kappler: That may be reasonable if an appeal is allowed after six months or a year. It may not seem reasonable if the renewal period is five years or is an indefinite period

11:30

Gordon Jackson: Would you make it an annual period?

Dr Dyer: Yes, something like that.

The Convener: Pauline, please ask your question quickly.

Pauline McNeill: For the record, why do you think that means-testing for legal aid should be removed for this group of people?

Dr Dyer: They are incapable through mental disorder and are in a vulnerable position where their control over their finances is taken away as well as, perhaps, control over where they live. It is important that the arguments for such action are explored as fully as possible and the justification for it tested. Therefore, such people need legal representation and, if they are of modest means, they may be inhibited from obtaining adequate legal representation if they have to pay for it.

The situation has not been brought about through their actions. In fact, some of those people are likely to be incapable of forming a view as to whether to instruct legal representation because of their incapacity. It seems right to remove any such inhibition by making legal aid available to everyone, at least for advice by way of representation, so that they can be legally represented in these important matters without the cost falling on them.

The Convener: Thank you, Dr Dyer and Mr Kappler. We are grateful for the information that you have given us today.

We are running pretty much to time. I have succeeded in allowing a period of 20 to 25 minutes for the committee to discuss what we have heard and what we are likely to hear in future. That will help us when it comes to making decisions about the stage 1 report.

While I will be more specific later about future business, I remind members that we are working towards the preparation of a stage 1 report on the principles of the bill. That report has to be laid before Parliament and forms the basis upon which there will be a stage 1 debate. We are working towards holding that debate before Christmas, probably on Wednesday 8 December. The stage 1 debate on the Abolition of Feudal Tenure etc. (Scotland) Bill will take place the following week. While that business is not fixed, it is expected that the stage 1 debate on the Adults with Incapacity (Scotland) Bill will take place prior to the Christmas recess, and we must have a report on the principles of the bill by then.

A lot of information has come before us on specific parts of the bill, including, in many of the written submissions, suggestions for amendments, but we will not reach that stage until after the stage 1 debate. Therefore, when we listen to evidence, discuss the bill and consider the direction in which we are going, we must try to remember that we will report on the general principles rather than on specific issues.

With that in mind, I advise members that, next week, we will hear evidence from representatives of those organisations, including the Catholic Church and related organisations, that have grave concerns about some aspects of the bill and that have given us submissions on the subject of medical treatment. Members will be aware of those concerns, which we will have the opportunity to canvass with the organisations, particularly in the light of the assurances that we received this morning, and which I hope will be, by that stage, part of the official record. Also, members of the Health and Community Care Committee will be invited to attend next week's meeting. We are required to take their input into account before we draft the report.

It might be useful to have a brief discussion about the generality of the bill, to get a feeling of where any remaining concerns may lie. Bearing in mind the fact that at this stage we are working towards a report on the principles of the bill rather than specific details, do members want to raise any points?

Gordon Jackson: Like everyone else, I have never seen a stage 1 report or been at a stage 1 debate, so I am not quite sure what it is like. How detailed is it? It is easy for me to say that, in principle, this bill is a good thing. I suspect that nobody will disagree with that. Is that as far as we go in discussing the principles of the bill? We need a little bit of guidance on when one crosses the line into detail.

The Convener: As you say, nobody has seen a stage 1 report. A stage 1 debate is the equivalent of the second reading debate in the House of Commons. A second reading debate has no parliamentary procedure running up to it but, in this Parliament, there are procedures running up to a stage 1 debate. We are expected to report rather more fully than simply to say that the bill is great, full stop.

There may be issues that the committee thinks have not been fully considered. I am thinking of the concerns that Gordon expressed about the definition of medical treatment. At this stage, we should not say how we think that the relevant sections should be amended. We should be expressing the committee's concerns, or the concerns of a number of committee members, that some areas of the issue have not been considered fully enough and that the definitions may be too detailed in some areas and not detailed enough in others.

It would be appropriate to indicate that, although we are generally sympathetic to the principles, we recognise the areas in which there are real concerns that need to be dealt with now, but that there may nevertheless be aspects of the bill about which we have some lingering concerns, notwithstanding the assurances that we have had. That would indicate clearly where the concerns of the Justice and Home Affairs Committee lie and that would inform the stage 1 debate. As far as I can see, that is the whole point of this part of the procedure. Our report will also flag up an early indication of where some of the hot spots might be when it comes to debating the bill.

Phil Gallie: I have two points to make. First, I would like some clarification of your comparison with second reading in the House of Commons. At second reading, members contribute to the debate and a committee to take the bill through its stages is established from among those who have contributed. Here the committee is already in place and has considered many of the issues. For that reason, it might be better if committee members stepped back from the stage 1 debate when the bill comes to the chamber, to allow others to participate. I seek your views on that.

Secondly, with respect to reservations there seems to be some difference of opinion between the Scottish Executive and other witnesses whom we have heard today on the definition of mental disorder. We should put down a marker on that with the Scottish Executive.

The Convener: Because we are running on time, I hope that we will have five minutes at the end of this part of the meeting to ask some of the Scottish Executive representatives to come back to address briefly some of the issues that are of concern.

Christine Grahame: I want to return to the fundamental definitions of nearest relative and primary carer. Those may create conflicts, particularly in today's society, in which relationships are so different from what they were before.

We also need to consider tightening up emergency procedures—it is not clear here that we might be dealing with very difficult cases—and to flag up the procedures that will be used for this kind of application under the bill. In due course, regulations and sheriff court rules may need to be changed. That would eradicate some of the problems that lie ahead, in terms of procedures getting in the way.

The Convener: I want to pick up on Phil's point about the role of committee members in the stage 1 debate. Phil is quite right about the difference between a stage 1 debate and a second reading. A second reading debate in the House of Commons provides members with an opportunity to express specific interests and gives an indication of what the standing committee's composition will be. I cannot say to people on this committee that the advice is for them not to speak in the debate, because there is a countervailing

argument that that would mean the people with most to contribute to the debate standing back from it.

Individual members will have to make a judgment. Presumably, within members' parliamentary groups there will be discussions about who should participate, and groups may arrive at different views. I do not want to bar those people who have done most work on the bill and have most to contribute from making points in debate. It may be that committee members will be able to focus their points more clearly and take less time than they otherwise would take.

Euan Robson: As a veteran of the Public Finance and Accountability (Scotland) Bill, which has had its stage 1 debate, I should point out that, during that debate, members from across the chamber, including members of the Finance Committee and the Audit Committee, made both philosophical and technical points. The debate seemed to go very well with a mix of the two. I do not think that members of the committees to which I referred were inhibited in any way from taking part in that debate.

The Convener: This is a judgment that members will have to make. Let us not forget that the Health and Community Care Committee has a big input into this bill, and that many members of that committee with specific expertise will want to comment. We could flag up that a significant number of us still have concerns about medical aspects of the bill.

Tricia Marwick: In the stage 1 debate, would it be in order for us to raise questions about matters that are not included in the bill, such as the Mental Welfare Commission's concern about the fact that some treatments will be defined by regulation, rather than in the bill? Those include psychiatric treatment and electric shock treatment.

The Convener: As far as I am aware, the stage 1 report that we return to the Scottish Executive could cover the areas where we feel that the bill has remained silent on things which should, in our view, be there. Equally, it covers concerns about how things have been drafted in the bill as presented.

The difficulty is that this is the first stage 1 report and debate on such a bill. The extent of the report is entirely up to us to decide. How widely, generally or specifically we focus it is something that this committee has entirely within its hands. Nobody else is telling us how to do this; there is no pro forma report that we must comply with. It is entirely our decision what the report will include.

11:45

In my view, we should include the areas of the bill on which we are in total agreement; the areas about which a significant number of us have a real concern—that will flag up a concern in the chamber as a whole; we are not likely to be completely unrepresentative of the chamber—and the areas to which we feel more attention should have been given: more information supplied and more issues covered. It is entirely in our hands how we approach this stage 1 report.

When we are getting evidence from individuals, we need to remember that we are discussing principles rather than specifics at this stage. The bill will come back to us for line-by-line consideration.

Pauline McNeill: We have heard a lot of evidence over two days. I still have questions about things in the bill on which I have an open mind. If I have an open mind about those points because of the evidence that I have heard, I am sure that that will be replicated around the chamber. Ultimately, we are all legislators in the chamber and we must hear all the evidence to decide on the right thing to do. At the moment, there are eight specific points that I am concerned about, but on which I am not coming down on one side or the other.

Because of that, we must ensure that we get this right. We have heard that this is an important piece of legislation. There is a demand for it, and it will be good legislation if we get it right. We need to make absolutely certain of ironing out the detail; otherwise, it could all go wrong. My feeling is that this committee needs to identify the areas of agreement where they exist and a list of all the outstanding matters that need resolved. We should flag up our concerns, whatever that list turns out to be, and at the earliest possible time, so that other members can consider their view. That is our role.

The Health and Community Care Committee has perhaps paid more attention to the bill, because it is their work, but I am sure that everyone else is very busy with other committee work. Even if we have a list of 15 areas—I have eight, so if other people have more—

Christine Grahame: Pauline is allowing the rest of us seven. [*Laughter.*]

Pauline McNeill: Some of them fall into categories of agreement; some are "Let's have another look".

The Convener: It is also important to remember that flagging up all the areas of concern at this stage will give us very good information when it comes to timetabling stage 2. It indicates to the Executive and to the Parliamentary Bureau that, in the light of the number of concerns, the timetabling of stage 2 is appropriate.

At the moment, we are operating on the basis that two committee meetings would be required for finalising a draft report. A first meeting would examine it, and we would go round the table to take views and concerns and judge the bill. It would then come back to a second meeting, if it was allowed. We have allowed flexibility to do that. Pauline is right. Everybody should have an opportunity and we should make sure that we canvas all the areas of concern and ensure that they are all dealt with. Nobody on the committee should feel that, if they have a significant concern, it has somehow been left out of the draft report.

It is our duty to flag up those concerns as early as possible, whether or not we are unanimous on every one of those issues. I suspect that there will be some issues on which we are unanimous and others on which members have different concerns. Given that, I invite Pauline to tell us what her eight concerns are now. Other committee members will then know whether they agree with these concerns.

Pauline McNeill: My first point is about broadening the definition of mental disorder to include brain damage and so on, as proposed by the alliance. We should clear up the issue as to whether the bill legalises euthanasia and the withdrawal of treatment. We should ensure that the bill is clear. As Christine and Kate have said, the nearest relative is not a modern approach, and I want to examine that issue in detail. We should examine whether having a different definition from the Millan commission is desirable.

We should consider the training of sheriffs, designated sheriffs and courts versus tribunals. We should examine the role of health boards and trusts in relation to patient's funds. On authority to treat, Gordon made the point as to whether section 44(2)(c) can be merged with subsection 44(2)(b). We should also consider the point that the commission made about access to legal representation without being means-tested for legal aid.

The Convener: That is probably a fair summary of the concerns that many members have. We might be more unanimous in our concerns, at this stage, than we thought.

That has been useful. Will members of the Scottish Executive team now come back up for a few minutes, so that they can comment on some of the issues that have been raised? We hope to move on to the next item on the agenda soon.

Mrs Brannan: We have not had the opportunity to confer. That creates some difficulties for us as we will all have our own list of points. I will start with mine and invite my colleagues to correct anything that they do not agree with and to add their own points.

The points that we were implicitly invited to comment on were: what to do about emergency situations; rules of court; guardian of last resort; and appeal against renewal of guardianship. Colleagues may want to mention others.

On emergency situations, we do not have a perfect answer yet. It relates to rules of court, which I will now cover. In terms of the summary application, there will be new rules of court as to how this is to be done. The Sheriff Court Rules Council has already had one meeting. It is a consultative body, which draws up draft rules and consults on those. Everybody who has been involved in the consultation process about the bill will have the opportunity to be involved in considering the rules of court as well.

I do not know whether the rules of court can prescribe special procedures for emergency situations. If so, they can be covered in that way. If that is not the case, there is the Law Commission's report on vulnerable adults. I must confess that the Scottish Executive has not had the opportunity to take stock of that report and decide how to take it forward. We will examine it now in the context of the emergency situation. We do not think that there are other existing statutory provisions that deal with adults with incapacity in emergency situations to which we can refer members. We will examine that again.

On the issue of guardian of last resort, we recognise that the Scottish Law Commission recommended that the public guardian should be available as guardian of last resort. The policy memorandum discusses in detail why we have departed from that, as did the white paper "Making the Right Moves". There are a number of reasons why we do not want to go down that route. One is that where there is only a small estate, the public guardian would either have to manage that estate at public expense or withdraw fees from it. We could get into the situation that we are in with curators bonis at the moment and a small estate could be exhausted by charges being levied.

Another reason is that we believe that the bill already provides a degree of flexibility with regard to the measures that can be taken in cases where a person's funds are limited; for example, permission may be sought to withdraw money from the person's bank account—which would be supervised by the public guardian—or to obtain an intervention order from a sheriff. There is the possibility also that, if a person with limited means foresaw their own incapacity, they could appoint a continuing attorney with financial powers at a suitable stage. So other measures are available to deal with modest estates, which we hope will mean that there will be little need for a guardian of last resort as envisaged by the Scottish Law Commission; therefore we have not introduced

that measure.

On the matter of appeals against the renewal of guardianship, the bill places no limit on the number of times that a person can appeal against a guardianship order that was made for an indefinite period. I presume that someone would take legal advice on behalf of the person who is the subject of the order as to whether it was worth appealing on a regular basis, but they could appeal more than once, unlike the situation under the Mental Health (Scotland) Act 1984.

Ms Barton: If I may pick up that point and one or two of the commission's—

The Convener: We have only five minutes left.

Ms Barton: I just wish to add to what Mrs Brannan said. The provisions in the bill with regard to guardians, who will replace curators bonis and others, are much more flexible than are those in the Mental Health (Scotland) Act 1984. That is one of the main reasons for needing to change the law, so that periods of appointment can be designed to suit an individual's circumstances. The duration of periods of appointment will not be prescribed; each individual must be considered by the sheriff.

The bill also makes it possible to challenge at any time, not just at prescribed intervals, anything that is being done, for example orders that are being put in place by the courts or anything that is being done on behalf of an adult by someone appointed to act for them. There is a lot more flexibility under the bill than under the Mental Health (Scotland) Act 1984, with regard to the discharge of guardians, which can be considered by the statutory authorities and the courts at any time when the adult does not need the help any more, rather than only at prescribed intervals.

The Convener: Are there any other issues that you wish to return to?

Mrs Liz Lewis (Scottish Executive Justice Department): I have policy responsibility for the section of the bill that deals with the management of residents' finances. My point concerns health boards being the regulatory bodies for trust hospitals. There are a number of things to be said, and I shall rattle through them, because I appreciate that we are running out of time.

The bill introduces controls that do not exist currently. The controls that apply at the moment are narrow, yet hospitals are managing the funds of long-stay residents with incapacity. Under the bill, hospitals should only manage residents' funds as a last resort when no one else is available to do it. That is a considerable safeguard. The policy statement said that there should be a £5,000 upper limit on the funds that can be managed. The amount that can be managed will be prescribed by regulation. That means that hospitals cannot get access to large estates.

As you will be aware, there are statutory controls in section 39 of the bill over what can be managed: heritable property, stocks and shares cannot be managed. The management of funds must be for the benefit of the resident. I wish to draw to your attention section 39(1)(h) of the bill, which prohibits the manager from spending a resident's money on items or services that should be provided as part of a normal service. That should address some of the concerns that were raised.

Finally, the managers are liable for any losses as a result of any breach of duty or misuse of funds, and they must make provisions to indemnify residents for that. We feel that that package of provisions introduces considerably more safeguards than exist under the present system to protect residents in long-stay hospitals.

12:00

The Convener: That concludes our discussion on the Adults with Incapacity (Scotland) Bill.

I have allowed two brief sessions for us to discuss other items. I will allow a maximum of 15 minutes—we do not need to use the whole 15 minutes—to discuss the general issue of prisons.

Christine Grahame: I am sorry to interrupt, but I would like to clarify something about the regulations. Have we accepted them?

The Convener: No. The regulations will appear later.

Christine Grahame: It seems to me that they are quite important.

The Convener: Perhaps we could ask what stage the regulations are at and for financial information.

Christine Grahame: I think so. They concern financial limits and other important things.

The Convener: We will write to the Executive and ask it what stage it has reached in drafting the regulations that will appear after the bill.

Prisons

The Convener: We have a maximum of 15 minutes for this item on Scottish prisons. It was on last week's agenda, but the evidence session on the Carbeth hutters was much more involved than we expected, so we did not reach the item on prisons. It was never certain that we would discuss prisons—the item was included as prisons will be a long-running issue for the committee, and there had been an announcement about a budget cut of £13 million, followed by a great deal of speculation as to the impact of that shortfall. I suspect that the

announcement resulted in many local press releases, seeking assurances that the local prison would not close down.

Since then, I have been advised—although I have not been able to confirm this—that at the Scottish Executive Cabinet briefing yesterday, references were made to a consideration of the way in which young offenders are dealt with. As a result of our interest in prisons, the committee is considering taking on the issues of young offenders and women offenders. My understanding is that there is a steer that the treatment of young offenders is to move away from custody and towards non-custodial disposals. That would be in keeping with the direction in which things have been moving in Scotland over a period of years, and obviously it impacts on our discussions on prisons over the longer term. I want to allow the committee a brief opportunity to discuss some of the issues arising from the £13 million budget cut and in respect of young offenders.

Christine Grahame: I was most concerned to learn of the threats to close Penninghame open prison. I know that that is only speculation, but I have a constituency interest. The prison is in the south of Scotland and I lived quite close to it for a long time—in a village called Minnigaff. The prison is very well respected. I have a paper from it—I will be happy to let members see it if they do not have copies—which contains submissions from the prison officers and from local communities. It is a successful prison, which has a very low cost per prisoner. If it were to close, it would be serious for the Scottish Prison Service.

Unique to Penninghame are what are known as independent units. Twenty independent unit places are available—prisoners have to work and to budget for their food. Forty per cent of the prisoners are on outwork placements—they used to work in Minnigaff, on pensioners' gardens. The social mixing is important.

The impact on the local economy would be noticeable. The area needs the employment that the prison provides. Its cost to the Prison Service is well below the target for other prisons.

The main point is the prison's success as the gateway to release for all levels of prisoners, from those sentenced to short terms to those who are serving sentences for murder. It has a good drug rehabilitation programme. I have a letter from the head teacher of Douglas Ewart High, the local school, praising what the Prison Service does for the school, and similar letters from various voluntary organisations. It is a successful open prison, and I want the committee to be aware of that.

Phil Gallie: We recently heard from the Scottish prisons inspectorate, which boasted of the reduction in prison overcrowding. Any reduction in staffing numbers or in the number of prisons would affect that.

The report from the inspectorate suggested that Longriggend, which some members of the committee visited, was under threat. I understood that other options that would reduce overcrowding in the prison might be considered.

The £13 million reduction seemed to come out of the blue. It should have been announced in the statement on funding that the Minister for Finance gave to the chamber a few days before the announcement.

The policy on young offenders is totally separate from the argument on the £13 million reduction. The Parliament must make a decision on how to deal with the reduction. I do not believe that those policies can be introduced immediately; they will have to be discussed. I have great concerns about any thought of reducing the number of warders or the number of prison spaces.

The Convener: I advise the committee that I have seen, and have a copy of, the internal Scottish Prison Service document that was sent round after the announcement of the £13 million reduction. It takes the form of three pages of hypothetical questions and answers and is on the basis that there will now be an increase in overcrowding. Assurances are given that the Scottish Prison Service will be able to handle overcrowding.

I will ensure that copies of the document are circulated to all members.

Scott Barrie: To some extent, you have pre-empted what I was going to say.

Given the way in which we first heard of the announcement in the popular press, it is difficult to know the details. If numbers of prisoners were falling—as they seem to be—and there were no problems about the fabric of our prisons or about overcrowding, I would have no problem with the reduction in the budget. However, prisons are overcrowded and the buildings are poor.

As one who is interested in the young offenders strategy—or lack of such—I echo Roseanna's points. The conditions in which young people were held in Longriggend were appalling. No wonder we have people who spend their lives going in and out of prison. I have no problems about the proposed closure of Longriggend, but the committee should return to the issue of young offenders later. We need to develop a coherent strategy to deal with the problem. Incarceration, though necessary in some cases, should not be the first option when dealing with young offenders.

Pauline McNeill: Phil Gallie made the point that

we were satisfied that overcrowding was not an issue, because of the opening of the prison in Kilmarnock, and that the key issue was drugs in prisons. We have an overwhelming responsibility to ask the Executive about that issue. It is not acceptable if the committee is not satisfied, so we might go back to the issue of overcrowding.

The question of the rehabilitation of offenders in institutions and what we do with people in prison has never genuinely been considered. We have an opportunity to examine progressive ways of dealing with people in prison—I agree that there should be a separate strategy for young offenders, and I agree with what is being done there. The committee must not lose sight of the issue of rehabilitation.

I do not know how we came to decide that we would consider prisons. The committee has a lot of work. I know that this will overburden us, but I do not think that we can let it go.

The Convener: That is why it is on the agenda today. Whatever else we do, I want us to keep visiting the issue.

Pauline McNeill is right. It is vital that you all see copies of the internal Scottish Prison Service document, as it specifically refers to an expectation of overcrowding as a result of the budget reduction.

Maureen Macmillan (Highlands and Islands) (Lab): I will say what everybody else has said. The announcement came out of the blue. Having just visited prisons and seen the appalling conditions at Longriggend, I could not believe that it was happening, and I want to know why.

I have had representations from MSPs with prisons in their constituencies. I received a representation from the MSP whose constituency contains Cornton Vale. She spoke to the governor of Cornton Vale, who is most concerned. She said that the prisons had made efficiency gains, but were not getting the benefit, as those gains were passed somewhere else. The Prison Service feels that it is down to the minimum. As Scott Barrie, Pauline McNeill and others have said, we need to take this further.

Euan Robson: I am interested in what the figure of £13 million constitutes. I have heard various descriptions of it, including accumulated underspends. What has the Scottish Prison Service not being doing to achieve several years' worth of underspend?

I have done further research. Apparently, the service will be allowed to keep £11 million of last year's underspend.

We need to ask the Executive and the Scottish Prison Service what those sums are. If the underspends were accumulated over a number of financial years, why, given the state of places such as Longriggend, has the money not been spent? Also, why was it decided to reallocate the £13 million?

The Convener: I understand that those sums were achieved through efficiency savings within the Prison Service specifically so that they could be spent on the prison estate. The efficiency savings were a way in which the service could accumulate money, to deal with things such as ending slopping out.

If the service cannot benefit by spending the money on the prison estate, there is not a great incentive to find future efficiency savings.

Euan Robson: Why have those savings not been used? What prevented the Prison Service from using them?

The Convener: Nothing prevented the Prison Service. It was trying to accrue enough money to make a substantial difference.

Mrs Lyndsay McIntosh (Central Scotland) (Con): What is the point of the Prison Service making such an effort if it does not benefit?

The Convener: That is a broader issue.

Kate MacLean: Can we have that clarified? It seems strange that the service could accrue contingencies or balances from revenue and then be able to spend them on capital projects.

The Convener: We need clarification, as we are all operating on the basis of newspaper reports that gave us nothing more than a figure, followed by a great deal of speculation. It is difficult to know whether that speculation is informed.

I suggest that we write directly to Tony Cameron, the chief executive of the Scottish Prison Service, requesting clarification on where the £13 million came from, what the money was originally to have been spent on, what the position is now, given that the money has been taken away, and what the result will be. We can refer him specifically to the internal memorandum circulated by the Scottish Prison Service. We should also write to the Deputy First Minister and Minister for Justice asking how the decision was made, where he thinks the £13 million came from and what justification there can be for taking it away.

If that is agreed, we can take the issue forward both with the chief executive of the Scottish Prison Service and with the justice minister. That might shed some light on the matter; I am aware that, at the moment, we are operating in an area of speculation. I would also like to ask for clarification of the Cabinet briefing that I understand took place yesterday, so that we can establish what the proposals are. We would want to include those

proposals in any future examination of the young offenders strategy by the committee.

Future Business

12:15

The Convener: As we move to the next item on the agenda, I note that we are absolutely bang on time, which is astonishing. All members have had a provisional forward programme of business circulated to them, but I have some additional comments to make.

I was at the Parliamentary Bureau meeting yesterday. It was the third meeting that I have attended and it continued the rolling discussion about timetabling. This morning's business bulletin contains a motion in Tom McCabe's name—motion S1M-243—which concerns the designation of lead committees. This committee is designated as the lead committee for the Abolition of Feudal Tenure etc. (Scotland) Bill and for the Adults with Incapacity (Scotland) Bill, with the proviso that we should also take into account the views of the Health and Community Care Committee. We have already been designated as the lead committee for the Abolition of Poindings and Warrant Sales Bill, but motion S1M-243 states that the Social Inclusion, Housing and Voluntary Sector Committee and the Local Government Committee are also to report to this committee on that bill.

There are no specific timetabling dates in the motion, but that does not mean that we do not have a timetable. The provisional forward programme was designed with a particular set of circumstances in mind. Those circumstances are now changed. Notwithstanding the fact that there are no specific dates in the motion concerning the Adults with Incapacity (Scotland) Bill and the Abolition of Feudal Tenure etc. (Scotland) Bill, both bills are expected be ready for stage 1 debate before Christmas.

I understand that the stage 1 debate for the Adults with Incapacity (Scotland) Bill is expected to take place in the week beginning Monday 6 December. The stage 1 debate for the Abolition of Feudal Tenure etc. (Scotland) Bill is expected to take place in the week beginning 13 December, the final week before the Christmas recess. It is expected that both debates will take place on a Wednesday afternoon. That may change to Thursday morning, but it is felt that Wednesday afternoon will afford the longest period for dealing with the bills.

It was originally expected that we would try to get the member's bill on warrant sales to the same stage at about the same time, although it was unlikely that the stage 1 debate would take place before Christmas. That has changed as a result of the decision to involve the Social Inclusion, Housing and Voluntary Sector Committee and the Local Government Committee in the stage 1 report on the bill. Both committees have indicated that they are so overburdened with work—[*Laughter.*]

Mrs McIntosh: Will that appear as "laughter" in the report?

The Convener: The committees are so overburdened with work that they are highly unlikely to be able to report to the Justice and Home Affairs Committee before the end of January at the earliest. That means that we would not be able to make our stage 1 report on the Abolition of Poindings and Warrant Sales Bill until February at the earliest.

I have a slight problem with that; although we are the lead committee, we are not being allowed to set the pace. I flag up the timetabling of bills because I have been asked to go back to the bureau before Christmas to discuss that issue in general. When I do, I want to make the point that when a committee is designated the lead committee, it should have greater control of the timetable, in consultation with other committees.

We drafted a forward business programme—which involved a great deal of work—and discussed the possibility that we might have to meet more than once a week on one or two occasions. We are now not quite back to square one, but we are certainly in a slightly different position—that concerns me. I am also concerned about the interesting scenario in which we find ourselves as a result of dates not being included in some of the motions. In effect, there is no parliamentary imposition on us in respect of any of these bills, albeit that there is a sort of back letter that is an agreement about when we will do the work.

Gordon Jackson: Why are there no dates? Should there be?

The Convener: I understood that there would be timetabling motions before Parliament, but to be fair to everyone—including the bureau—this is brand new for all of us. The bureau may be trying to find a more flexible way of working. The problem is that we are designated a lead committee but find that our work is being held back by other committees that are not lead committees. That is why our programme is perhaps even more provisional than it was originally. We will try to keep members updated when we revise the forward programme, but it has already been added to. Next week, for example, in addition to taking evidence on adults with incapacity, we will hear evidence on the Abolition of Feudal Tenure etc. (Scotland) Bill from the Scottish Executive, the Royal Institution of Chartered Surveyors and the Law Society of

Scotland. We may also hear from Scottish Environment LINK and Land Reform, Scotland.

The following week, on Wednesday 17 November, we are due to hear evidence on poindings and warrant sales. Notwithstanding the revised programme, I think that we should go ahead with that, as we have started to put invitations out. In addition, it has been flagged up that the Scottish Landowners Federation could come on that day to talk about Carbeth. Members will remember some of the rather inflammatory statements that were made about the position of the Scottish Landowners Federation; we felt it only fair to ask the federation if it was interested in coming to talk to us. That is provisional at the moment; the rest of the programme holds, although if we are going to be held to the timetable of the Social Inclusion, Housing and Voluntary Sector Committee and the Local Government Committee, perhaps we can open up our forward programme a little. That may allow us, for example, to return to prisons or domestic violence in more detail.

Phil Gallie: By just before the recess, we will have had the equivalent of second reading of the bills in the chamber. That means that, in January, two bills will be put back in our court. In my view, that is where our real work will lie. The bills will take up a great deal of our time, as there will be a lot of detail to consider. It might be beyond our means to cope with three bills, which would be the situation if stage 1 of the Abolition of Poindings and Warrant Sales Bill happened before Christmas.

The Convener: That is something that I, as convener, would want to manage. This is an extremely hard-working committee and I want us to be as bullish as possible about our capacity to absorb this work load. There is an element of truth in what Phil says. In principle, I am not happy about the lead committee being held back by the timetable of other committees, but the fact that that is going to happen allows us a more deliberate staging of bills. In those circumstances, stage 2 of the Abolition of Poindings and Warrant Sales Bill will be further down the line.

There are huge timetabling issues with respect to stage 2 times. My concern is that the bureau will want to foreshorten those as well. There was an attempt to get us to report even earlier on the land reform and incapacity bills. A suggestion was wafted past my nose that we might be able to report on both of them by the end of November, but I said that there was no way that I could guarantee that. There is a desire to cut short the timetable. All committees scrutinising bills will have to deal with that. We will want the maximum time, the Executive will want the minimum time, and we will have to reach some kind of compromise.

Phil Gallie: I hear what you say, convener, but it is one thing to be bullish, and another to recognise the importance of this legislation. I accept that we have some legal minds on the committee, who may be able to cope much better with the detail of these bills than laypeople can. However, to be perfectly honest, I think that it will be extremely difficult for us to deal with the detail of one bill at a time, never mind two at once. There is a heck of a lot to absorb and to pick up, and I am concerned about my capacity to deal with two bills at once. This Scottish Parliament has to get the legislation right. It is pointless rushing it through for the sake of it. I want to put down a marker on that.

The Convener: Notwithstanding that, we will have to produce a stage 1 report on the land reform bill some time after Christmas. There are issues relating to how we will handle all this, but I think that we can manage it if we timetable things sensibly, and if we accept that we may have to schedule in extra meetings.

Phil Gallie: I do not mind extended times.

The Convener: We may have to schedule in the odd extra meeting. I do not want to do that as a matter of course, but it may be necessary. We may not need a whole extra meeting, but we could squeeze something in even in an hour and a half.

Kate MacLean: I give notice that the Equal Opportunities Committee may also want to comment on the Adults with Incapacity (Scotland) Bill. At the moment, I am trying to find out how the committee fits into the process formally, as that has not yet been made clear. The Equal Opportunities Committee has a heavy work load, but it is in the process of timetabling. I will try to ensure that that fits in with what we are doing here.

The Convener: The Health and Community Care Committee has been asked to report to us by 22 November so that we can take its views into account for 23 November.

Kate MacLean: The Equal Opportunities Committee's remit is to scrutinise everything, but it has not been designated the lead committee for anything because the power to legislate in that area is reserved to Westminster. I think that there should be a more formal procedure for our involvement, but we will try to fit in with your timetable.

Gordon Jackson: I want to flag up my concern, which partially covers Phil's concern. I accept what you say, convener, about being bullish and about wanting this committee to be one that does things. However, there is a danger that we will end up taking too much work as the lead committee, because we are the legal committee—that is, the

Justice and Home Affairs Committee. By that argument, all legislation would be passed to us, as it all has to do with legal matters. The danger is that we will get everything. I am not persuaded that we should have been the lead committee for the Abolition of Poindings and Warrant Sales Bill. There is an argument that another committee could have been the lead committee for that bill, albeit that there are legal aspects to it. I am not persuaded that we need to be the lead committee on the land reform bill, if we are busy, because aspects of that bill should be dealt with by other committees.

I am on Phil's side. I would rather that we did one piece of work at a time, week after week, so that we could concentrate on it, rather than have a constant overlap between bills. I am legally qualified, but I find that overlap quite difficult. I am just flagging up the idea that perhaps we should not allow everything to come to us—

The Convener: That is not our decision.

12:30

Gordon Jackson: It may not be our decision but, as you say, you are bullish about it. We can have an influence. We can say, "It's not our decision." However, rather than saying, "We want this," we could say, "Hey, we've got enough. Get someone else to do that."

Christine Grahame: We do not have an agenda item for any other competent business, but I want to suggest one, so that we can cover letters that we receive from individuals on relevant matters. We all received a letter from Mr and Mrs Watson, whose daughter was murdered. We should consider whether we should take a view on such matters as a committee or whether we should deal with them as individuals. Mrs Watson raised the issue of the victims' notification scheme, which appears to have let her down and which we should consider on another date.

I want to make another point, although I do not know whether it is relevant. I was horrified to read in the papers about the judgment placed on Deputy Chief Constable Tom Wood following leaks about allegations that are not even under investigation. Does the committee want to make any comment about the manner in which that was done?

The Convener: I remind members that we decided that we were not going to consider items of new business until the first meeting after the Easter recess. However, that does not prevent individual committee members from putting in writing an issue that they wish to have on a list for consideration. I invite members who have such issues to remember that our meeting then will entirely be taken up with examination of what will be, by that stage, a variety of issues—there are already half a dozen. Members should not feel that they cannot flag up further items for consideration, although they should bear in mind the fact that we will not discuss future priorities until that first meeting after the Easter recess.

Christine Grahame: I will write to you, convener.

The Convener: At next week's meeting, we will consider a small draft report on our work so far on prisons issues. I ask the committee to agree that, as with the draft report on the statutory instrument, we should deal with it in private as, until we sign off on the draft, the report is not public. It should be possible to circulate the report to members in a draft form before next week's meeting. We will work out timings for that.

As a result of this morning's exercise, I have a general question. Would members find it useful to have a brief five-minute meeting in private before an evidence-taking meeting starts? That would allow me to go around the table and establish the points that members wish to raise. I know that members cannot be absolutely certain—sometimes questions occur to one only halfway through. For example, it would have been useful if I had been aware of all the members who wanted to raise points about medical treatment. I could have brought them into the discussion one after the other and avoided some of the jumping about. Such an approach would involve a quick five-minute discussion before a meeting, to allow people to identify the points that they are going to raise. Do members agree to that approach when we are taking evidence?

Phil Gallie: Roseanna, I think that the less we meet in private, the better. I recognise that your suggestion is purely administrative and I accept your comments about the draft report, which I go along with. However, apart from those circumstances, I think that we are better simply remaining in open meeting. In any event, there is nothing to prevent members from having such a discussion before the meeting opens.

Scott Barrie: I appreciate what Phil is getting at and I concur with some of what he says. However, if we are trying to get the most out of witnesses, it is incumbent on us to be more disciplined in our approach. I do not think that there is anything wrong with your suggestion, convener, if that is what it was designed to do. Certainly, that procedure has worked successfully for other committees.

The Convener: We can hold those discussions either in private or in public. I have to keep in mind the advice that was given to conveners to try to find ways of avoiding burdening the Parliament's resources. We were asked to have such

discussions when dealing with purely housekeeping issues.

Scott Barrie: If we are talking about five minutes and we are disciplined enough, it will not cause too much concern. People get suspicious only when committees meet in private for three quarters of an hour and then say that nothing was discussed.

The Convener: We can take the view that such a discussion need not be held in private—in the sense that the public is not present—but we could tell the official reporters that they do not need to record it as part of the *Official Report*.

Members *indicated agreement.*

The Convener: I think that I have covered absolutely everything that I needed to cover.

I close the meeting at only five minutes over time. I am grateful to everyone—the meeting went well this morning.

Meeting closed at 12:35.

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