PUBLIC PETITIONS COMMITTEE

Wednesday 8 December 2004

Session 2

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19th Meeting 2004, Session 2

CONVENER

*Michael McMahon (Hamilton North and Bellshill) (Lab)

DEPUTY CONVENER

*John Scott (Ayr) (Con)

COMMITTEE MEMBERS

*Jackie Baillie (Dumbarton) (Lab)
*Helen Eadie (Dunfermline East) (Lab)
*Rosie Kane (Glasgow) (SSP)
*Campbell Martin (West of Scotland) (Ind)
*John Farquhar Munro (Ross, Skye and Inverness West) (LD)
*Mike Watson (Glasgow Cathcart) (Lab)
*Ms Sandra White (Glasgow) (SNP)

COMMITTEE SUBSTITUTES

Frances Curran (West of Scotland) (SSP)
Susan Deacon (Edinburgh East and Musselburgh) (Lab)
Phil Gallie (South of Scotland) (Con)
Rob Gibson (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Eric Brown
Linda Fabiani (Central Scotland) (SNP)
Mr John Home Robertson (East Lothian) (Lab)
Brian McAlorum
Annmarie McDonald (Justice for the Innocents)
Alex Neil (Central Scotland) (SNP)
Lydia Reid (Justice for the Innocents)
Dr David Reilly
Stewart Stevenson (Banff and Buchan) (SNP)

CLERK TO THE COMMITTEE

Jim Johnston

ASSISTANT CLERK

Joanne Clinton

LOCATION

Committee Room 1

Scottish Parliament

Public Petitions Committee

Wednesday 8 December 2004

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

New Petitions

Methadone Prescriptions (PE789)

The Convener (Michael McMahon): Good morning. I welcome everyone to the 19th meeting in 2004 of the Public Petitions Committee. I have not received any apologies this morning, so perhaps the members who are not yet here will arrive at some point.

The first agenda item is consideration of new petitions, the first of which is PE789, in the name of Eric Brown. This petition calls on the Scottish Parliament to take a view on the need for regulation to ensure that methadone prescriptions are taken by the patient while supervised by a suitably qualified medical practitioner. I welcome to the meeting Mr Brown, who is accompanied by Billy Clelland. Mr Brown, you have three minutes to give a brief statement to the committee after which we will discuss the issue.

Eric Brown: First, I want to say that giving such a large quantity of methadone to addicts is like giving a bottle of whisky to an alcoholic and expecting him to take two nips of it a day. Because of the nature of addiction, it is highly unlikely that a drug addict would take the prescribed amount.

I have spoken to numerous doctors and health officials, who freely admit that methadone gets sold on. Last year, figures from the General Register Office for Scotland showed that there were 87 deaths from methadone. That is absolutely shocking. In a previous inquiry into methadone-related deaths in Scotland, 30 of the 56 deaths referred to it had methadone cited on the death certificate and 45 per cent of those 56 people were not even on a methadone prescription. The way in which methadone is prescribed is shocking. Doctors freely admit that it is getting sold on and yet they prescribe quantities like 700ml a week. Some doctors will even prescribe a month's supply in one go.

I lost my son through methadone that had gone into the illicit market. Two individuals were arrested for supplying the drug to my son, but the fiscal's office seems to be dragging its heels on taking them to court. The figures speak for themselves: 87 lives have been lost.

The East Lothian drug and alcohol action team's objective is to cut drug-related deaths by 25 per cent by 2004-05. This year, up to June, there have been six deaths in East Lothian. That figure should be compared with the total of only two deaths last year. If we want to cut the number of deaths, methadone should be prescribed only on a daily basis and consumed at a pharmacy. We have to find a way in which to do that. It would help the addict to stabilise, as they would not be able to take more than their daily dose. I imagine that that would make it easier to reduce their intake and, hopefully, to get them to become drug free.

The figures speak for themselves. I have taken them from the Scottish Executive website and from the information and statistics division of the NHS. I cannot say much more than that, although I should perhaps mention some of the reports on the subject and the meetings that I have had with Jim Sherval of the national health service and the community drug-problem service—everybody admits that there is a problem with the present set-up.

Lives would be saved if methadone were prescribed on a daily-dose basis and consumed on pharmacy premises. It would have helped to prevent the 87 deaths that occurred last year because of methadone.

The Convener: Thanks, Mr Brown. I open the meeting up to questions from members of the committee.

Ms Sandra White (Glasgow) (SNP): Good morning, Eric. My sympathies go out to you and your family and to all the other people who have lost kids to methadone and drug overdoses. From the committee papers on your petition, I see that the Scottish Executive guidance on the dispensing of drugs sets out that some patients' consumption of methadone should be supervised. Your suggestion is that all those who are prescribed methadone should be supervised by a pharmacist or in some other way.

Eric Brown: As far as I know, no doctor dispenses methadone in their surgery, yet doctors are paid £350 just to take a drug addict on to their books. The payment is meant to be an incentive to doctors to take on drug addicts, but as far as I can see it is a bribe. If a doctor is getting £350, why does he not dispense methadone in his surgery? After all, it is the doctor who prescribes the methadone.

Ms White: The Scottish Executive guidance says that some patients should be supervised in that way. It also mentions that people with a disability can get someone else to collect a prescription for them. The biggest problems seem to stem from prescriptions to cover holiday times. What is the background to the figure of 87 deaths? Do the biggest problems lie with the people who can get a month's supply and take an overdose or sell it on?

Eric Brown: Generally, that is where the problem lies, as that is where large quantities are prescribed and dispensed in one go. When a larger quantity of methadone leaves a pharmacy, it is hard to get an accurate figure as to what happens to it. It was only recently that I was able to get the 2003 figures from the Registrar General of Scotland. Numerous advisory council reports have recommended that those on methadone should undergo a period of six months' supervision—indeed, that was a recommendation in the 2000-01 report I mentioned. Those recommendations were made by advisory councils but as yet they have not been implemented. Confidential inquiry reports, some of which date from 2000, have asked for action to be taken.

As far as I can see, none of the recommended measures have been implemented and the deaths are still happening. I can understand it if someone dies when they inject heroin, but although doctors freely admit that methadone is being sold on, they still prescribe large amounts of it. The nature of addiction is that those people have trouble controlling what they are taking and the amounts they are taking. It is common knowledge that people sell methadone on to enable them to buy heroin. The report produced by Professor Neil McKeganey states that six out of 10 addicts are asking for detoxification rather than methadone prescriptions.

Mike Watson (Glasgow Cathcart) (Lab): I know from experience that in Glasgow the whole question of methadone prescriptions is controversial. I hear what you say. Your experience from the east of Scotland backs up our experience in the west.

I am aware that how methadone is dispensed is controversial. A comment that you made earlier left me unclear about your position. You talked about doctors at their surgeries. I assume that the prescription is issued to someone who has been put on a course of methadone treatment and that that person takes the prescription to a chemist or a pharmacy where the methadone is issued. I know that there are all sorts of issues about whether it should be consumed on the premises or whether its consumption should be supervised.

Some pharmacies in my constituency have a special booth so that methadone can be taken with an element of privacy. The problem is that there is evidence that some people put it into their mouth, leave the pharmacy, and immediately spit it into a receptacle so that it can be used by somebody else. As has been said, the Executive has told us that

> "for some patients, supervised consumption should be arranged with the most appropriate health professional, e.g. clinical nurse or community pharmacist".

You state in your petition that you want there to be supervision by

> "a suitably qualified medical practitioner".

By "medical practitioner" do you mean a doctor, or do you mean someone such as a clinical nurse or a community pharmacist?

Eric Brown: I mean anyone who is qualified to dispense medicines. I do not have sufficient knowledge to know who is qualified to do that. I believe that nurses can dispense medicines.

The figures that I have come across for Glasgow suggest that methadone deaths are dropping as a result of supervised consumption. I would like such a measure to be introduced not only Scotland-wide, but nationwide. I feel strongly that if a drug addict is put on a daily dose, it helps them. A drug addict who gets a prescription of 700ml can take as much of it as they want. Some people get a month's supply and they can take as much of it as they like. They use various tricks to get a reissue of a prescription. They might break a bottle of methadone in a brown paper bag and drain it through that. I am aware that people spit the methadone out into a receptacle. I have family who work in the Royal Edinburgh hospital. They use a stalling tactic when they dispense a daily dose of methadone. They say to the addict, "Hold on: we have a form for you to fill in." Or they check the person's mouth to make sure it is empty.

Mike Watson: That is fine. That answers my question. You want supervision to be carried out by somebody who is properly medically qualified to certify that the methadone has been consumed. There are currently no guidelines, but we could perhaps decide that we want the Executive to introduce guidelines on the matter.

10:15

Rosie Kane (Glasgow) (SSP): I say hello to Eric Brown and to Billy Clelland. Like Sandra White, I offer Eric my condolences for his experiences with his son. A lot of your expertise comes from that terrible reality.

Like Mike Watson, I am aware from my area of Glasgow of what became known as methadone spit: people were spitting the methadone out into crisp pokes and selling it on when they left the pharmacy. My pharmacy sets aside a place for people to collect their methadone and take it with supervision. When I have been in there, I have always thought about what that means for a pharmacy in an area such as mine, which has quite a high dependency rate. It must place a strain on a business and on that pharmacy.

Guidelines and proper, qualified staff to administer the methadone must be required. The guidelines that you suggest would cure many problems. For example, the pharmacy I mentioned is inundated at 10 in the morning by a queue of people who require their methadone. That must be difficult to oversee.

When people are given a methadone prescription, do they have any support for gradual reduction? If a qualified individual administered methadone in a health centre, would that provide the possibility of supported reduction and the ability to leave a programme?

Eric Brown: I have never come across anybody who does that. Most people who take methadone and the drug addicts to whom I have spoken are put on a prescription and stick there. If their records were checked for a couple of years, they might have had a reduction for so many months.

Doctors have clinical guidelines in what is referred to as the orange book. I spoke to my doctor just on Friday. His practice would happily support supervised consumption. I asked him why he did not prescribe methadone daily. The previous Deputy Minister for Health and Community Care, Tom McCabe, wrote to me because John Home Robertson asked a question in Parliament. The letter said that how to prescribe methadone was up to a doctor and that a doctor can prescribe it to be consumed daily on pharmacy premises if he likes.

However, my doctor says that if doctors did that, there would be no way that pharmacists or doctors could cope. He said that Department of Health policy prevents doctors from following guidelines in the clinical management guide for doctors—the orange book. The guidelines say that doctors should take adequate precautions to ensure that the methadone that they prescribe does not filter on to the illicit market. In the present situation, it is impossible for a doctor to ensure that.

Rosie Kane: You said that GPs receive £350 when somebody registers. Is that an annual sum?

Eric Brown: Yes.

Rosie Kane: Is it for each registered individual?

Eric Brown: It is for each drug addict. Jim Sherval of the Department of Health’s policy department gave me the figures in a meeting.

Mr John Home Robertson (East Lothian) (Lab): The meeting was with NHS Lothian.

Rosie Kane: Is that money given with a reason? Is it to establish something?

Eric Brown: It is an incentive for a doctor to take on a drug addict. The money is not spent on building a wee room in a practice to dispense methadone; it is like a bonus. The money could be better spent. The doctors and pharmacists to whom I have spoken would like a clinic to be established to deal with the problem. The problem used to be prevalent in areas that were considered to be bad, such as Niddrie and Bingham, but now it is everywhere, including small villages.

Gone are the days when somebody obtained a methadone prescription because they were hooked on heroin. They are prescribed methadone because they are hooked on pills or street methadone. That is a vicious circle.

I repeat that if methadone was dispensed and consumed daily in pharmacies, drug addicts would benefit because they would not be able to take any extra, the drug would not get on to the street and methadone deaths would be virtually wiped out.

John Scott (Ayr) (Con): Good morning, Eric. I too offer my condolences on the loss of your son. I am aware of the problem in Ayrshire, where methadone prescription is twice the national average, which is a worrying statistic. I am aware that there are guidelines on clinical management, but you say that in the real world pharmacists cannot follow them. How is the problem addressed elsewhere in the world? You talked about local clinics in which people could be supervised when they take methadone. Is that possible solution to the problem used in England and Wales? Are you aware of best practice that is taking place anywhere?

Eric Brown: When I first approached my doctor, Dr Clubb, he could not understand why we do not take the approach that is taken in Amsterdam, where what people call the methadone bus travels round schemes. Addicts have to meet the bus at a certain time in the morning and if they miss the bus they do not get their prescription for the day. They are given their daily dose on board the bus.

If we are throwing £100 million at the problem in one year and putting aside £160 million, we should be spending the money wisely to reduce deaths. It is no good stabilising someone on methadone if no attempt is made to reduce their dependence and make them drug free.

Doctors and pharmacists want clinics to be established. The pharmacists I have spoken to want clinics because when they dispense methadone there is increased shoplifting on their premises. We hear that the figures for drug crime are going down. Given that stealing is the most common offence that drug addicts commit, if a pharmacist keeps handing over bottles of methadone, the crime rate for thieving will go down because addicts sell on the methadone and do not have to steal as much. I have spoken to a police inspector in Musselburgh and to numerous other policemen, who say that it is well known that methadone is used as a currency. That says it all.

John Scott: From your knowledge of what goes on on the street, do you think that a travelling clinic would be a good idea? Should we look into that?

Eric Brown: Any type of clinic would do. For example, if there is a community centre in an area that has a problem, the centre could be used. I support the use of any place, if it means that we can deal with and reduce methadone use. Edenhall hospital in Musselburgh would have been ideal for serving Tranent, Prestonpans and other areas close by, but it has been shut down. We have been promised a new clinic, but the Edenhall hospital building is already there. Some organisations argue that we must protect drug addicts' dignity and treat them as though they were normal patients with a normal illness, but drug addiction is a self-inflicted illness, if it is an illness at all.

Campbell Martin (West of Scotland) (Ind): I am seeking clarification on a matter that you mentioned in your answer to Rosie Kane. You were talking about what currently happens and who decides that an addict must take their methadone in front of the dispensing pharmacist. If the doctor who writes the prescription does not write on it that the drug must be taken in front of the pharmacist, can the person just collect the drug and go?

Eric Brown: That is exactly what happens. According to the letter from Tom McCabe, the former Deputy Minister for Health and Community Care—I did not bring it with me—it is for the doctor to direct that the methadone be taken under supervision. The doctors I have spoken to say that they cannot possibly do that. It seems to me that the Health Department's policy simply stops doctors following that way, even if they wanted to. The funding is not there. People would not be paid.

Campbell Martin: So arrangements are basically haphazard, which is why you are asking for regulation.

Eric Brown: Definitely.

The Convener: Mr Brown's MSP, John Home Robertson, has joined the committee. I invite him to add any comments or information.

Mr Home Robertson: As I am Eric Brown's constituency MSP, I would like to make a quick summary. First, I am grateful to the committee for considering this extremely important issue, which Eric Brown has raised. Secondly, I express my admiration for the dignified and positive way in which he and his family have pursued the issue in order to minimise the risks that other families will suffer. His family has already suffered. The Scottish Parliament and the petitions system are here to ensure that the Government listens to the real problems of real people, and we could not discuss a more urgent example.

Eric Brown's son died because somebody gave him prescription methadone. That has happened in his community of Musselburgh and, as he has told us, it has happened on 87 other occasions around Scotland. No part of Scotland is safe. Any of our families could be affected by the issue, which could not be more serious. That the use of what is meant to be a medicine turns out to be as lethal as the original cause of the problem—illegal drugs—is especially alarming.

A fundamental point is that methadone is extremely dangerous. There is alarming evidence that a significant amount of prescription methadone is finding its way to the wrong people in the wrong places. It is being traded. That has tragic and fatal consequences, as Eric Brown has told us. I fully appreciate that it might not be possible to get every dose consumed in controlled circumstances, but that should surely be the objective.

Eric Brown has made a powerful and logical case that we need to be far more vigilant with methadone. Therefore, I hope that the committee and the Executive will seriously consider the points that he has made. I am grateful to the committee for giving me an opportunity to register my support for him.

The Convener: Do members have recommendations on what we should do with the petition?

Mike Watson: As I said earlier, the Executive has carried out a review of drug treatment and rehabilitation services. Despite that, I understand that there is still no regulation at all that applies to methadone prescription and consumption. The Executive will read the *Official Report* of the meeting. We should write to it and ask what steps it intends to take to deal with the matter. I hope that we can say that the committee's view is that something must be done to bring in regulation so that what Mr Brown has outlined does not happen more widely throughout Scotland.

The Convener: I do not disagree, but I was going to suggest that, on a practical level, it might be worth consulting the people who dispense methadone. Therefore, it might be worth writing to the Royal Pharmaceutical Society of Great Britain to find out whether it has a perspective on the matter from the other side of the divide, if you like. Is that a good idea?

Ms White: I was going to say exactly what Mike Watson said. I appreciate what you are saying, too, convener, and support it.

John Scott: I wonder whether we should write to the British Medical Association, given that we are going to write to the Royal Pharmaceutical

Society of Great Britain.

The Convener: We could get as wide a perspective as possible on the issue.

John Farquhar Munro (Ross, Skye and Inverness West) (LD): It might also be appropriate to pick up on Mr Brown's suggestion about establishing a clinic that is separate from the pharmacy or the doctor's surgery. That might be cost effective and more appropriate.

The Convener: We could ask the Executive for its views on that suggestion.

Rosie Kane: I do not know whether this is the right stage at which to ask this question, but I am interested in the £350 payment. I do not mean to be pedantic. I think that John Home Robertson mentioned NHS Lothian.

Mr Home Robertson: There was a meeting that we arranged with NHS Lothian.

Rosie Kane: To get a bigger picture, I wonder whether there is any way of finding out whether that payment is made across the health boards.

Eric Brown: It is negotiated differently with different health boards. The payment is £350 in Musselburgh, but it could be £250 elsewhere. Pharmacists get an allowance as well, but I have not been able to get that figure.

Rosie Kane: It would be interesting to see what that incentive looks like at a national level.

The Convener: For the record, it is worth pointing out that the laws relating to the misuse of drugs and the regulation of their sale and supply as medicinal products are reserved matters. Of course, that does not stop us asking how the Executive deals with the matter in the NHS.

10:30

Eric Brown: The clinical management guide that I referred to—the orange book—gives figures that show that withdrawals from methadone are more severe and take a longer time than withdrawals from heroin do. That makes me question why people are being prescribed methadone. Edinburgh is starting to introduce a drug called Subutex, which is in the form of a tablet that dissolves under the tongue and can be taken three times a week instead of daily. Issues like that have to be considered as well. The main thing, however, is to save lives that are lost to methadone.

Dihydrocodeine is prescribed along with methadone and it is not even licensed for the treatment of drug dependency. That is stated in the clinical management guide as well. I find it strange that a drug is being used to treat drug dependency when it is not licensed for that purpose.

The Convener: Thank you for that information and for bringing the petition to the committee. Again, on behalf of the committee, I express our condolences in relation to the situation that led you to lodge the petition. We will let you know what the Executive and the other organisations advise us in relation to the issue.

As the petitioners who will speak to PE790 have not yet arrived, I ask the committee to agree to deal with PE791 now and to come back to PE790 later. Do we agree to do that?

Members *indicated agreement.*

NHS Scotland (National Specialist Services) (PE791)

The Convener: Petition PE791, by Brian McAlorum, calls on the Parliament to review the criteria and funding mechanisms for national specialist services that are provided to NHS Scotland by individual health boards as, currently, they are neither transparent nor effective, as witnessed by the situation that has arisen with regard to the centre for integrative care at Glasgow homoeopathic hospital.

Brian McAlorum is here to make a brief statement to the committee in support of his petition. He is accompanied by Dr David Reilly.

Brian McAlorum: We are here to ask the committee for its help and support in our call for a review of the criteria for national funding that would enable the Glasgow homoeopathic hospital, as an example, to become a national specialist service in its own right, with proper funding that would secure its future. The model of care that the Glasgow homoeopathic hospital provides for the Scottish people should be built upon and not dismembered. The hospital needs financial stability and security for its patients and staff and should be a beacon of light for the NHS in Scotland. In November, the Minister for Health and Community Care, Andy Kerr, responded to a letter that Robert Brown MSP had written on the subject of the Glasgow homoeopathic hospital becoming a national specialist service and said that the hospital was relatively inexpensive because it does not require the multidisciplinary teams and technology that are commonly required for a national specialist service. Dr Reilly will elaborate on that point later.

The Glasgow homoeopathic hospital might not require extensive technology but, nevertheless, it is a lifeline for the approximately 500 patients who suffer from a wide range of complex chronic illnesses who come through the in-patient doors every year. I was first admitted only 18 months ago, but I can say honestly that I may well have been dead if my general practitioner had not referred me to the Glasgow homoeopathic hospital at that time.

Professor Kerr, the chairman of the advisory group on service change in NHS Scotland, has said:

> "specialist centres offer the best outcomes for patients, we have to be able to deliver that."

Without a doubt, the Glasgow homoeopathic hospital's in-patient facility is a specialist centre. It treats patients from throughout Scotland—more than half of the patients come from outwith Glasgow. The hospital is the only integrative care facility in Scotland that combines conventional and complementary treatments and care that are tailored to patients' needs. One hundred per cent of patients who are admitted have received some form of conventional care, which, for one reason or another, has failed them. Nothing could be done for them or offered to them. For the majority of patients, the hospital is a lifeline in the true sense of the word, because there is no alternative.

Professor Kerr talked about the shortage of specialist staff, but the Glasgow homoeopathic hospital has specialist staff in abundance. In a July board paper, NHS Greater Glasgow said:

> "In addition to orthodox and advanced homeopathy, Glasgow Homeopathic staff have a range of specialist skills enabling the Hospital to provide additional specialist services".

Professor Kerr said:

> "There is a great deal about NHS Scotland that works extremely well, and we must build on that."

I could not agree more, but we need help to secure the facilities and we should not let them be at the mercy of an individual health board's financial whims.

NHS Greater Glasgow proposes to close the in-patient ward to claw back part of its £58 million deficit. The Scottish Executive gave the health board an additional £12.06 million earlier this year, but the proposals to close the ward are still in place. The approximate short-term saving would be in the region of £100,000 to £300,000. On the one hand, Andy Kerr is saying that the hospital is too cheap, and on the other hand NHS Greater Glasgow is saying that it is too dear. The true financial facts are stated in the Glasgow homoeopathic hospital report, of which members have a copy. The hospital has proven to be cost effective to the NHS. Regardless of that, I believe that the cost effectiveness is in human terms, not just economic ones.

Rosie Kane: I express an interest: I am a supporter of the campaign and have attended meetings and demonstrations on the subject.

The letter from Andy Kerr states:

> "Any service designated as a national service will be highly specialised"

and "uncommon". Surely, that is just how one would describe the homoeopathic hospital. It is highly specialised and, given that it is the only hospital of its kind and has been around for a long time, it is a national service. I draw the committee's attention to the fact that, as both the witnesses will know, when the national health service was set up in the 1940s, it was stated that homoeopathic hospitals would continue to be available as long as there were patients who needed the treatment and doctors who were willing to provide it. I believe that we have both of those and I take issue with Andy Kerr's reply. Do you agree that the hospital is a national service and therefore should be funded appropriately?

Dr David Reilly: I thank the committee for allowing us to give evidence. The petition has been produced by patients, led by Brian McAlorum, not by me. I acknowledge that and thank the patient group.

Uniqueness is certainly one characteristic of the hospital and there are three elements to it. One is that the hospital uniquely combines a hospital environment with a fundamentally holistic model. In a sense, it is almost a synthesis of the knowledge of primary and secondary care. Secondly, the hospital is unique in that its function is to tackle people's problems when conventional evidence-based medicine has failed. We often correctly hear of the importance of evidence-based medicine. I am an advocate of that and, as a consultant physician, a user of it. However, what is not commonly discussed is what should be done when such medicines have been applied and have not worked. Where do we go with conventional care then? The homoeopathic hospital provides another pathway.

Finally, we are unusual and unique in synthesising the best of orthodox and complementary medicines. In our in-patients, we tackle a small group of patients who are particularly disabled and distressed. For example, typically after the pain-relief clinics have failed, about 70 per cent of people show signs of post-traumatic stress disorder, background histories of sexual abuse and other complicated traumatic mixtures of physical and psychological illness.

As the name of the unit may not have let people understand our function, this is a good opportunity to highlight our new subtitle—"The centre for integrative care"—which more accurately transmits what we do.

Rosie Kane: I think that patients who attend the homoeopathic hospital make fewer subsequent visits to their GP and need less treatment afterwards. Do you have figures on that?

Dr Reilly: A critically important issue is that the centre is the development of a new model of care. Everyone recognises that the NHS has become too fragmented. According to our survey of all of Scotland's GPs, which had a remarkable 62 per cent response rate, only 20 per cent of GPs believe that they succeed in giving adequate holistic care. Some 70 per cent believe that there are unnecessary investigations and unnecessary prescribing. Another reason for the health board overspend is the fact that the drug bill has increased by 50 per cent in three years, which is a stunning and unsustainable figure. Health care needs the development of less drug-based models.

To answer your question, health economic arguments focus on the cost of patient incidents rather than patient journeys. What that means is almost a farce. People compare the relative costs of a visit to an orthopaedic specialist and a visit to a chiropractor, but what they do not consider is whether the same patient had to visit the orthopaedic specialist, the chiropractor, the psychiatrist and the pain-relief clinic. That is a typical journey that patients might make before we see them.

We find that the holistic model, which is founded on people's own capacity and on the need to bring together treatments, makes remarkable cost-effective savings. When we tracked people over two to five years, we found a 50 per cent reduction in drug use, a 45 per cent reduction in hospital admissions and a 60 per cent reduction in GP visits. However, when we try to argue the case to our colleagues in the division, they explain that the health service is not costed in that way. Things are costed year on year. The fact that we might break those expensive cost cycles does not impact on the health board because it must balance the budget for the current year.

Given such an overheated system, which is driven by fragmentation, over-prescribing and over-specialisation, I think that the health service needs the sort of innovative development that we are trying to lead.

John Scott: It is obvious that the homoeopathic hospital provides a national specialist service, but how many patients does the hospital treat? Perhaps Rosie Kane is aware of the numbers, but I am not.

Given that the hospital already provides a de facto national specialist service, what change would be required to the guidelines to allow it to qualify in the eyes of the Scottish Executive as a national specialist service?

Dr Reilly: I will deal with the first question on numbers. Fifteen years ago, we adopted a policy of trying to make the hospital as small as possible. Before managed care networks existed, we had the idea of establishing regional clinics in 10 health boards throughout Scotland. We have also innovated in day-care development and we have managed to reduce the number of beds from 30 some years ago to 15 today. We have now reached a critical mass for the core group of patients who, at certain moments in their journey, simply cannot be tackled as out-patients and day cases. The 15-bed unit receives between 400 and 500 admissions per year from that group of individuals, but we have a policy of trying to move them as quickly as possible into day care and out-patient care.

On the second issue, to be honest, I am unsure how we would match up. I welcome the dialogue that Brian McAlorum and the patients have led because it is a learning exercise for us. The crisis that hit us in April threatened our very existence and the patients have taken the initiative to try to address the question that you have raised. When we look through the nine criteria, we think that we match them pretty well across the board, so we are unsure.

10:45

John Scott: You could reasonably argue that interpretation, rather than the criteria, is disbarring you.

Brian McAlorum: We patients are finding another problem with that. We have only dipped our toe in the water with regard to funding; coming here is an initial step. The NHS board has to submit evidence and, at present, the north Glasgow division of NHS Greater Glasgow is proposing the cuts. Tim Davidson, the chief executive, is unwilling to discuss anything with the patients. He will not answer phone calls, letters or e-mails on the subject of uniting with the patients to get national funding. That proposal was made because there was a £58 million deficit in the NHS board's budget and I imagine that the board said, "Right, we'll save a couple of pounds here" when we came up with the idea of going for national funding, which would save the board money. Unfortunately, that has not happened.

John Scott: Have you done any costings of the money that you claim to save the NHS board? Could you put a figure on it?

Dr Reilly: No, I could not put a detailed figure on it. We have supplied one-year audits that show the reduction in GP visits, drugs and hospital visits. Our document also presents some case histories. One case saved more than £100,000 and such savings would have recurred year in, year out in the years ahead. Such cases are not untypical, but we have not had the resources to undertake detailed costings. As I pointed out, the concept that it is necessary to cost patient journeys rather than incidents is almost innovative thinking.

John Scott: Would that figure of £100,000 be an average for every case that you treat?

Dr Reilly: I do not imagine so. We picked out some example cases. I could give you only a clinician's impression and patients' feedback as solid evidence of prescribing referral services elsewhere, followed up by our in-house audits and independent external audits; the case histories would then be used as illustration. That is as far as we have been able to go with the resources that we have.

John Scott: Nonetheless, 500 times £100,000 would mean £50 million per year. You are talking about a figure of somewhere between zero and £50 million for the value for money that you provide.

Dr Reilly: I am being very conservative, but there is no doubt that we save the NHS board into the hundreds of thousands of pounds per year; it is probably an awful lot more.

Helen Eadie (Dunfermline East) (Lab): I thank Brian McAlorum and Dr Reilly for all their efforts on behalf of those of us throughout Scotland who believe in homoeopathic medicine. I was one of the signatories to the parliamentary motion on the homoeopathic hospital.

In our papers we have a letter from the Minister for Health and Community Care to Robert Brown, which states:

> "The Homeopathic Hospital previously applied for national designation in 1997 but was assessed as not meeting the criteria because the hospital provides a high volume of care, and individual interventions are relatively inexpensive because they do not require the extensive multidisciplinary teams and technology commonly required in national specialist services such as cardiothoracic transplantation. For this reason, it would be inappropriate to designate the Homoeopathic Hospital as a national service."

Would you comment on that?

Brian McAlorum: I will make one brief comment and hand over to David Reilly. It is ludicrous that something has to be expensive to require national funding. That does not make sense to me, but I am not a politician; I am a patient at a homoeopathic hospital. The hospital provides a unique lifeline for patients. It just happens that it does not cost too much, which I think is a bonus. I do not see any need for that criterion.

Dr Reilly: I agree with Brian McAlorum. It seems like a punishment for efficiency. Our difficulty, as a community, is the fact that we grew from our homoeopathic roots, synthesising them as complementary medicine expanded and leading a field that might now be called mind-body medicine. Some quite important new research is coming out about that.

We have done remarkable things with unbelievably small resources, not just with small doses of drugs. We managed to build our own building through charitable donations. Not a penny of capital money from the NHS went into it; yet, it is owned by the NHS and managed at a distance by the NHS. Whether the hospital should be praised or damned because it is cheap, its very existence is threatened. The hospital offers a service that has specialised elements as well as a national element, which is suffering from the exigencies of local expediency, in terms of its budget.

Ms White: Good morning. I want to pick up on the fact that you applied for national funding in 1997. I find it ludicrous that you are efficient but cannot get national funding. One of the criteria is apparently that you have to be very expensive. There could be some politics in the medical profession concerning homoeopathy; perhaps that is why the criteria are as they are. That aside, we are discussing moneys and the savings that NHS Greater Glasgow is talking about. Is it right that it would save £330,000 if it closed in-patient beds at the homoeopathic hospital?

On the national criteria, you talked about cardiac surgery. I met a lady who used the homoeopathic hospital after she had a heart transplant. It appears to be the only place in Scotland or in the UK where someone can get that type of treatment. As John Scott said, it is a national service that treats people not only from Scotland, but from throughout the United Kingdom. I would have thought that, if the hospital operates like a national service and looks like a national service, it would be a national service.

John Scott mentioned funding and what you save the NHS. If the hospital was a national service, the NHS, not NHS Greater Glasgow, would supply the money. At one of the public meetings that I attended, I asked a question about how much money is given to the homoeopathic hospital from the other health board areas. The officials could not tell me that; they do not seem to have a tracking system. If there was a tracking system to find out how much money the other health boards contribute, would that show not just that the hospital should be a national hospital, but that it should be held up as an example to be replicated throughout the country? Is it not the case that one of the reasons that we do not know how much money the homoeopathic hospital saves the NHS is that we do not have a system that can tell us how much money goes into it?

Dr Reilly: The savings would probably be around £200,000 to £300,000 a year, ignoring the fact that we would be unable to treat certain patients who would immediately have to move to other services elsewhere. The global saving would, therefore, be a negative one, if such a thing can exist.

On politics, it is important to remember that the rise of complementary medicine came about despite the medical community, not because of it. Complementary medicine became the second biggest growth industry in Europe, after microelectronics. Each year, 40 per cent of Scotland's population seeks some form of alternative care. The doors had to be knocked down in medicine for people to begin to shift to it. That is how cultures change. When I first offered some leadership in this area 25 years ago, I was told that my career was finished as a result. Now acupuncture is in common use in every pain-relief clinic in Scotland. The culture is shifting, but there is undoubtedly a legacy of prejudice and embarrassment around the issue.

Our centre has been used to model 25 academic centres for integrative care in America. Because of Glasgow, Scotland is seen as playing a leadership role in the development of a more integrative care model. This year, the National Institutes of Health will invest $121 million in centres for specialist development of an integrative care model, but Scotland is threatening to cut the budget of the Glasgow homoeopathic hospital. Those who can afford to opt for a more holistic or complementary model of care can do so, but where will people go who cannot afford to do that? An interesting clash in medical culture and the rest of our culture is involved.

NHS Greater Glasgow says that it cannot track where the money comes from. I spoke to someone in public health economics at Lothian NHS Board, who said, "What are they talking about? I am looking at the line that tells me how much money I send to Glasgow each year." I do not know what the source of the fudge or confusion is, but there certainly is one.

Brian McAlorum: I am a patient of NHS Lanarkshire. I contacted my health board, which pays NHS Greater Glasgow for a block booking for my treatment. That is how it is funded. NHS Greater Glasgow said that the cost was approximately £330,000, but it added a £150,000 charge if patients were not seen within 26 weeks, which has not happened. It was unfair of NHS Greater Glasgow to do that and the point should be highlighted. The cost is about half the figure that has been given.

Mike Watson: I declare an interest, as I have written to NHS Greater Glasgow on this issue and have stated publicly that I hope that the board will not pursue this policy. I know that the matter is still being considered.

A couple of the questions that I wanted to ask have been dealt with, but I want to pursue the issue of funding with Dr Reilly. As Mr McAlorum said, when someone from one health board area is treated in another, it is standard practice—whatever the treatment—that the patient's health board pays the other board for the treatment. You made a comment about the number of patients at the homoeopathic hospital who do not live in the NHS Greater Glasgow area. What was the percentage that you mentioned?

Dr Reilly: It was 50 to 60 per cent.

Mike Watson: So a considerable amount of money must go to NHS Greater Glasgow. However, you said that the board told you that it could not track the payments.

Dr Reilly: We have asked about the matter for years. Mike Watson will recall the mantra that money should follow the patient and similar initiatives. For the past 15 years, we have singularly failed to get any sense of where the money is coming from and whether it is coming to us appropriately.

Mike Watson: It will be trackable. I do not accept that it cannot be tracked.

Dr Reilly: I used to think that that was the case, which is reasonable, but in practice much of the NHS does not work too well. I have no idea how much of the difficulty is wilful.

Mike Watson: I understand the point. Nonetheless, if 50 to 60 per cent of the patients who are being treated at the hospital are from other health board areas, NHS Greater Glasgow must be receiving income that would disappear if there were no in-patient facility.

Dr Reilly: That is true. I have received inklings from one board that, if NHS Greater Glasgow cuts the service, it will cut the money that it gives to NHS Greater Glasgow. It is clear that this is a financially motivated action. NHS Greater Glasgow has stated that, so I am not saying anything out of hand. However, the proposal may backfire on the board badly, as other health boards will simply pull back their money.

Brian McAlorum: We attended a meeting of NHS Greater Glasgow in July, at which a female speaker from north division said to Sir John Arbuthnott that 60 per cent of patients come from outwith greater Glasgow. She asked whether NHS Greater Glasgow was bearing the financial burden of their treatment. He turned round and said, "Well, you tell me—that is your job." That prompted me to find out whether my health board paid for my treatment. It does; I have copies of a letter to back that up. I am fortunate enough to be able to say that NHS Lanarkshire supports and values the homoeopathic in-patient service. I greatly appreciate that.

11:00

Mike Watson: I have a follow-up on that for Dr Reilly. Are the 50 to 60 per cent of patients who do not live in the Greater Glasgow NHS Board area from all parts of Scotland?

Dr Reilly: Yes—they are from all over Scotland, including the isles. Occasionally, they come from other parts of the UK. This week, a lady from the Isle of Wight is receiving treatment.

Mike Watson: My final point relates to Andy Kerr's letter, which says:

> "The Homeopathic Hospital applied for national designation in 1997".

Were you involved at that time?

Dr Reilly: No, I was not central to that.

Mike Watson: In that case, you might not be able to answer my question. It seemed odd that the hospital itself applied for designation, because it was part of Greater Glasgow Health Board. Is not the normal procedure that a health board would have to apply for designation on behalf of a hospital?

Dr Reilly: That is correct. Our relationship with the management structure of which we find ourselves a part is that, when we cross paths, it is often traumatic. Over the years, there has been a sequence of cuts. Other countries recognise the value of the sorts of models that we are developing and are putting money into them. Scotland has a gem, which is shrinking. Whatever a better management structure is—I do not claim to understand that fully; I am grateful to the committee for considering the matter—it appears that the current structure is disrespectful of, and threatening to, the development of our work.

Mike Watson: Given what we have heard today, I think that we should write to the Minister for Health and Community Care for greater clarification of the issue. Some of the comments that he made in his letter do not stand up against today's evidence.

The Convener: Before we decide what action to take on the petition, I introduce the MSPs Stewart Stevenson and Alex Neil. Do you have anything to add?

Stewart Stevenson (Banff and Buchan) (SNP): Thank you. I am here because a number of my constituents have asked me to support the efforts that are being made on behalf of the homoeopathic hospital, because they are customers of it. I attended a meeting of Greater Glasgow NHS Board with Brian McAlorum, at which he made an excellent presentation to the board.

I represent some of the 50 to 60 per cent of patients who come from outwith the Greater Glasgow NHS Board area. As the son of a GP, I have personal experience of alternative medicine. Unusually for the 1950s and 1960s, my father used hypnotism and referred people to chiropractors if conventional medicine had not worked. I gather that, at that time, that was quite a brave thing to do. The opening of the homoeopathic hospital was the realisation of the dreams of a much wider group of people than we sometimes appreciate. In his later years—long after he had retired—my father was a keen supporter of that.

I thank the convener for the courtesy of allowing me to say a few words to the committee and I apologise for my immediate withdrawal and return to the Justice 1 Committee's meeting.

Alex Neil (Central Scotland) (SNP): I apologise for not giving advance notice of my intention to attend; I did not think that I would make it this morning. I declare an interest in that I, too, have been to a health board meeting along with Brian McAlorum and the campaign team.

As a list member for central Scotland, I cover four health board areas—those of Greater Glasgow NHS Board, Lanarkshire NHS Board, Ayrshire and Arran NHS Board and Forth Valley NHS Board. In all four areas, I have met constituents who regard the homoeopathic hospital as a life-saver. I am not exaggerating when I say that, without it, some of them would be driven to suicide; I am using their words.

I have listened to the evidence and have received all the paperwork from Brian McAlorum and others. There have been many questions about the costs. It is clear that, at best, there has been a lot of fudge on that issue. In my view, the important question is what the downside of closing part or all of the hospital would be and what additional costs that would bring to the health service, not just in Glasgow, but throughout Scotland. If a proper assessment was made of the costs, the facility would be regarded as an investment in Scotland that saves not only lives, but money.

To be frank, I find it incredible that the future existence of the facility—in part or in total—is being questioned. It is abhorrent that the situation has dragged on for months and created a period of uncertainty, particularly for patients, but also for staff. Not only do we need a commitment to save the facility and need it quickly, but we need a commitment to expand the facility. We should be talking not about closure, but about expansion.

In recent years, I have had to use alternative medicine, not at the homoeopathic hospital, but through Jan de Vries and aquapuncture. For simple symptoms such as those of sciatica, the relief that it gives is unbelievable. From personal experience, as well as constituency experience, I do not understand why the facility is being put under the microscope in the way that it is, because it would be blatantly obvious to a Martian coming to earth that it is a big plus for Scotland and should be retained and expanded.

Rosie Kane: I associate myself with what Alex Neil said. When he was speaking, it struck me that last week guidelines on the use of seratonin-based treatments, such as Seroxat and Prozac, were published. Doctors are now being asked to prescribe such drugs less frequently, and I imagine that that would be a matter that the homoeopathic hospital would be able to pick up. I therefore agree with what Alex Neil says about there being scope to expand the hospital's service.

Dr Reilly: What you say is central. Not only have most of our in-patients had antidepressants, but they arrive on seven or eight drugs on average. A woman was admitted last week on 24 drugs, which was clearly a statement of despair among the 14 specialists whom she was seeing.

Medicine needs good ideas, leadership and new models of care that are more patient centred. That is a Scottish Executive initiative. There is a paradox, because other parts of our community are recognising the value of what we do. In recognition of what the hospital is doing, the Scottish Executive asked me to be the doctor to launch the patient-centred initiative that it had introduced. The centre for innovation and change has come to us for specialist advice and we are feeding into its talking matters initiative, which is the beginning of better communication skills among health care workers. The building has the dynamic place award for Scotland for 2004 and has been recognised internationally as setting a new and inspiring model for a healing environment.

I could go on. Those are rich, cutting-edge developments of better ways of caring for people, but the curious thing is that there is an almost pointed blindness among certain elements of the community, particularly those on our political doorstep, who want to keep trying to push the hospital back into a narrow box that they would label homoeopathy, almost with disrespect. They use that as a device to refuse to see the developmental, cutting-edge aspect of what we are doing. We need ways to help people other than drugs.

Jackie Baillie (Dumbarton) (Lab): I am broadly supportive of what you are attempting to do, but I would like to clarify whether Alex Neil's call, not to the Martians, but for the extension of in-patient facilities, is what you are after. It is not, is it? My understanding of your model of care is that it involves a tight number of in-patient beds because you work best out in the communities. Will you clarify that?

Dr Reilly: I agree. Ideally, we would like to achieve a situation in which we did not need any beds, but at the moment we are dealing with the reality that, at our culture's level of development, in-patient beds seem to be a critical part of the larger picture.

Almost all our work is outward-going. Our education work is about reaching out. For example, we have trained 20 per cent of Scotland's GPs in homoeopathic medicine and when we tracked them, we found that they have a substantially reduced drugs bill. We teach in Japan, America and throughout Europe. Our vision is: how can we change medicine itself? We do not want to make other people into clones of us. How can we influence the body of the kirk of medicine? That is our deeper vision, and it is not constructive for people to label us as narrow and different. We represent a challenge to the dominant medical models.

The Convener: Therein may lie your problem. Do members have recommendations on what we should do with the petition?

John Scott: I would like the committee to write to the Greater Glasgow NHS Board to see whether we can elicit figures on the moneys that it receives from other health board areas. That would give us information on its income stream with regard to the hospital. It appears that the petitioner has been unable to get that information.

Ms White: I agree. I received an answer from the minister to say that he has that information but I have never been able to get the figures. We should write to the national services advisory group, the Scotland Patients Council and the Scottish Association of Health Councils to seek their views, and I also think that we should write to NHS Greater Glasgow because it would have to put forward the criteria for national funding.

Brian McAlorum: We will need Greater Glasgow NHS Board's support to get national funding, but would it be too bold for me to ask whether you could ask it to withdraw its proposals?

The Convener: I do not think that we can do that. We can certainly write to the board about our discussion this morning and inform it of everything that has been said, but I do not think that it would be right for the committee to request an autonomous body such as a health board to withdraw its proposals. What we heard has been reflected in members' comments and they will be reflected in the report that is sent to Greater Glasgow NHS Board, but we as a committee cannot ask it to withdraw its proposals.

Alex Neil: Would it be possible for the committee to make the point to the health board and the Minister for Health and Community Care that a timeous decision would be helpful, because the uncertainty that has been created is severely damaging to everyone concerned?

The Convener: We cannot write to the health board in that respect, but we can write to the minister. I am not sure whether we would want to, but we could.

Jackie Baillie: It is surely better to get the right decision than a quick decision.

Alex Neil: I hope that the right decision will be made timeously.

Mike Watson: We run the risk that it might not be.

Helen Eadie: Would it be possible to send the petition and a copy of this discussion, for information, to the Health Committee and to Professor David Kerr, who is examining specialist versus general services in the NHS?

The Convener: I do not think that there is any difficulty with that.

Ms White: The committee papers state that the Executive

> "does not intend to respond to any proposals from NHS Boards until the National Advisory Group on service change has reported in March 2005."

I do not know whether that is a good decision, but in relation to the petition I assume that it means that no change will take place until March 2005. Until then, we have the status quo.

Helen Eadie: The Health Committee, of which I am a member, heard that there is likely to be slippage in relation to that date. There might be a delay until after June.

Dr Reilly: Members will know the old idea that the Chinese symbol for crisis is danger and opportunity. I think that, paradoxically, we are sitting on the edge of a positive opportunity. Tim Davidson, the chief executive, told me at the beginning of the process that he deeply regretted having to make the proposal and that he was an advocate for holistic care. The professor of medicine in the trust said, "You have won the holistic care argument—this is now purely a financial argument." A positive vision could be developed by us as a community, with a national centre for integrative care. The American Government funds 25 such centres of excellence, so perhaps we could think of funding just one. Perhaps we can respond positively as part of a civic dialogue rather than adopt a merely defensive posture.

John Scott: The information-gathering process on which we are about to embark should help inform that process. With any luck, we might be able to make positive suggestions to the minister once we have all the information to hand.

11:15

The Convener: Are members happy that we write to the organisations that have been suggested? Are we agreed that we will forward our views as reflected in the *Official Report* of this morning's discussion?

Members *indicated agreement.*

The Convener: We look forward to receiving those responses. We will let people know when we receive them and we will keep an eye on the progress of the petition.

Organ Retention (PE790)

The Convener: As the second group of petitioners are now able to take their place, we will go back to our second new petition, which is PE790 from Lydia Reid on behalf of Justice for the Innocents. The petition calls on the Parliament to urge the Executive to take the following action: to conduct a public inquiry into organ retention; to consider introducing regulations to standardise the handling of children's bodies and the return of body parts after a procurator fiscal post mortem; and to consider making compensation payments to parents of children whose body parts were stored without permission.

I welcome Lydia Reid, who will make a brief statement in support of her petition, and Annmarie McDonald, who is accompanying her. You have a few minutes for your statement, after which we will discuss the issue.

Lydia Reid (Justice for the Innocents): Good morning. I apologise for the earlier hold-up. I will read a short statement.

We feel disappointed, as we are sure the committee must be, that our organisation comes before the committee today with nothing positive to say. We have only a deep feeling of despondency and disillusionment.

Let me begin by restating our reasons for asking once more for a public inquiry. As we stated at the time, the independent review group did not fulfil its remit. It did not examine past practice and give parents the truth but merely issued questionnaires, which gave trusts the opportunity to hide the truth. The website was impossible to access. The few interview scripts of which we subsequently managed to get copies were full of inconsistencies, but no member of the review group challenged those. Medical and laboratory notes were destroyed and removed from folders. Parents were told that nothing was removed from their child, but they discovered later from such documents as were retrieved that whole organs and brains had been removed without their knowledge or authorisation. The hospital helpline was a joke.

The only further inquiry that took place was carried out by a group of self-confessed accountants with no knowledge of what was in the boxes that held the parts of our children. They were given no right to look through rooms. Some pathologists who took extra care in the recording of the parts were stopped from doing so by the review group.

After that, many parents were angry and even more convinced of the need for a public inquiry. Spirits lifted a little when we read of the plans for the future, but we know better now because none of the promises has come to fruition. The forms are not used in every hospital and parents are still not given full information on a post mortem. Many parents are still bullied into signing the form by being told that the age-old permission from the procurator fiscal will be sought and given.

We believe that only a public inquiry will bring the truth to parents. Only a public inquiry will leave pathologists in no doubt as to Parliament's determination never to allow another group of parents to relive the horror that we and our families have lived through. Only this cleansing experience and subsequent spending of money on educating the public about the procedure of a post mortem—and, more important, the true need for research—will change the public perception and gain more willing signatures on these forms. That would reduce the need for subterfuge.

Chris Paterson, a parent who should have given evidence today, is proof of the fact that the procedures that are followed by the procurator fiscal have not changed at all. Tragically, his child died last December, aged three years and two months. It was a time full of pain for her parents—quite rightly, after the death of a child at home. The procurator fiscal was informed and ordered a post mortem. The child's body was taken round four hospitals so that pathologists could learn from her dead body, despite the fact that the procurator fiscal has the right to use a body only to discover the cause of death.

Within one to two days, the cause of death was known and no fault lay with the parents. They were told that a few small samples had been removed from their child to find the cause of death; however, as always, that was far from the truth. The parents held the funeral and tried to survive. Months later, just when they were beginning to surface from a fog of grief, they received a letter from the procurator fiscal, asking whether they wanted their child's brain back. I do not know whether you can understand the devastating effect that such a request can have on a parent. That was less than a year ago, after all the inquiries were over and all the promises made that this would all change.

I truly wish that those were the only parents and child to have been treated in that way; however, the same grief is felt by other parents who have discovered that their child's body has been used for research although the procurator fiscal has the right to use the body only to decide the cause of death. Even though they seek compensation as the only apology that they are ever likely to get, those parents have been told that no compensation will be paid to them. We hope that the Scottish Parliament will ensure that their grief and suffering are recognised by compensation.

Right now, for many of those parents, the future looks bleak. We hope that the Parliament will legislate to control what the procurator fiscal can do with a body and who can have access to a body, when the only reason for that should be to decide the cause of death. Please have no uncertainty: we absolutely believe that, where doubt exists about foul play, the procurator fiscal should carry out a post mortem to prove the cause of death and, if necessary, keep organs for a while to use as evidence. However, it may be that separate premises are needed to protect the bodies of our loved ones from over-enthusiastic pathologists who cannot resist the temptation of learning even without permission.

The Convener: Thank you, Mrs Reid. Before I open up the debate to questions from members, I seek some clarification. I and other committee members have been contacted by an organisation called SORO—the Scottish organisation for the retention of organs—which makes it clear that it disagrees with the petition. I do not want to go into the details of why it disagrees with the petition. Can you understand the difficulty that is faced by an MSP such as me, who has no knowledge of the situation, when one organisation takes your view and another organisation strongly disagrees with that view? Can you help the committee to understand that issue?

Lydia Reid: Yes, but I can do so only by being quite straight. I hope that I do not hurt anybody's feelings, but this is the truth. SORO was paid money by the Scottish Executive, and it supported everything that the Scottish Executive did. SORO had hundreds of parents through its gates in the beginning, but none of the parents stayed with SORO. They were not helped. Representatives of SORO would say that they were going to attend meetings but did not. Annmarie McDonald went to SORO.

Although thousands of parents in Scotland believe that a public inquiry is the right way forward, the little group of people who are SORO stand out against that and say to the media that a public inquiry is not needed. The reason for that is that they have said it and cannot go back on it.

Helen Eadie: Thank you for coming here this morning, Mrs Reid. You said in your presentation that you understand why procurators fiscal would, in some instances, want to keep organs for further investigation. Do you have in your mind—or is it in the minds of any of your supporters—an idea of how long it would be reasonable for the organs to be kept? We all know that many years—sometimes decades—down the line, it is possible for procurators fiscal to find out why a specific death has happened, even if they have kept only microscopic parts of a child's body, because forensic medicine has moved forward. What is your view of that?

Lydia Reid: I should clarify what is meant by microscopic parts. The parts are called blocks; two small blocks could be a small baby's heart or lung. Parents object to that.

The procurator fiscal must have the right to order the retention of an organ indefinitely if there is any doubt, for example, about whether a parent might have murdered their child or a hospital might have killed a child in some way. No one in Scotland should have the right to tell the procurator fiscal that organs cannot be kept in cases in which there is real doubt about the cause of death. However, a problem is that procurators fiscal are becoming involved in research. It is not the procurator fiscal's job to decide that parts of our children can be used to find the cause of cot deaths, for example.

Recently, a father asked for the parts of his child to be returned after a cot death. We cannot get to the bottom of this, but there appears to have suddenly been some obscure ruling—no one can tell us when it happened—that the organs of children should be kept in cot death cases. It has been decided that retained organs that have not yet been reclaimed by parents—quite a few such body parts have already been taken back and buried—should also be kept. Parents who waited to make sure that they had all the parts of their children are now finding that because they waited they will not be allowed to bury the parts of their babies. The situation is horrendous.

Helen Eadie: What is your organisation's response when the authorities say that the parts of the child have been incinerated or have disappeared for whatever reason and cannot be traced? How do you reconcile parents to a situation in which it is impossible to return parts to them?

Lydia Reid: Hospitals tell parents that it is impossible for a part to be returned because it has been lost or incinerated. However, we have documents that prove that the Western general hospital showed parents its pathology day book, which indicated that their child's brain had been destroyed, when in fact the book also showed that the brain was being stored in the CJD storeroom. The brain had been removed from the normal laboratory and put into the CJD room to be used for research, even though the parents were told that it had been destroyed. That is proven; it is on paper for all to see.

After we complained about that case and sent copies of the pathology day book to Parliament, Audit Scotland said that the Western general hospital was storing thousands more brains than it admitted to having. However, when I asked the hospital to match the brains that it was storing to the children of parents on a list that I provided, the hospital said that none of the brains came from children of the parents on my list. If the brains did not belong to the children of those hundreds of parents, whose brains are they?

Jackie Baillie: I have dealt with a couple of constituents who have been in that situation. I do not begin to understand the real nature of the difficulties, but it is helpful that I have had contact with such parents.

Your previous petition, PE370, was referred to the Health and Community Care Committee in the first session of the Parliament. That committee's successor committee, the Health Committee, closed the petition because it felt that the Executive was taking action and consulting on the matter. Indeed, the independent review group on retention of organs at post mortem did a two-phase job. First, it consulted on and established the nature of the problem, and secondly, it made recommendations for legislation. Please correct me if I am wrong, but I understand that the Executive will legislate on exactly the matters that you raise, for example procurator fiscal post mortems, the processes and the principles, to create a tight, robust legislative framework that will ensure that the situations that you describe do not happen again. What is wrong with that?

11:30

Lydia Reid: Hundreds of parents want to know where their children's body parts are, but hospitals will not tell them that unless there is a public inquiry—it is as simple as that. The hospitals do not want to lose the parts, which are important for research. I have a background in research and I can sympathise with that view, but it does not take away the right of a parent to bury the whole child. Pathologists do an important job, but they do not have the right to say to a parent, "I will not tell you where the part of your child is."

In the first phase of the independent review, the group's remit was supposed to cover what had happened in the past; it was supposed to find out how many brains, organs and other parts of children—and whole children—are stored in Scottish hospitals. That failed dismally; it never happened. How frightened would you be if a questionnaire came through the post? The hospitals paid no attention to the questionnaire. We spent months reading the scripts of the interviews and we found glaring irregularities. It was possible to pick out many irregularities in a single interview. Nobody picked up on that. No one in the review group said to the pathologists or the heads of the trusts, "But you said something different a minute ago. How can both statements be true?" The first phase was a nothing.

How can we legislate when rules and regulations are not being upheld? In the second phase of the review, the group recommended rules and regulations and we were promised that they would be acted on immediately, even before legislation was introduced. However, parents are still coming forward because they were bullied into agreeing to a post mortem. Parents tell us, "We were not told that when the post mortem was done the hospital would take our child's brain or other organs". Parents in that situation are here today and their cases demonstrate that the guidelines are not being followed. Why should hospitals be more likely to comply with the guidelines when legislation has been passed? There is no plan to pass a law that would send people to jail for failing to comply with the guidelines.

Jackie Baillie: Your petition calls specifically for three things: a public inquiry; the introduction of regulations—legislation; and compensation. The Executive's intention is to introduce legislation that will do exactly what you ask. Would that satisfy that element of the petition?

Lydia Reid: No, because the Executive will regulate hospital post mortems, whereas the petition is about procurator fiscal post mortems. Procurators fiscal need only copy some of the guidelines that will be set out for hospitals. As far as I can see, nobody has control over what procurators fiscal do, because they are part of an autonomous department. There should be such control. A procurator fiscal has the right to order a child's body to be taken and retained if there is any doubt about the cause of death, to find out the cause of death. Children in Scotland need that protection, just as adults in Scotland do. However, a body or parts should be retained only so that the cause of death can be discovered; procurators fiscal should not be getting involved in research. There is only one way to protect bodies: the pathology departments that carry out procurator fiscal post mortems should be moved out of hospitals and housed in separate buildings, where post mortems can be carried out only to discover the cause of death. No one else should be allowed inside. It is as simple as that. We must protect bodies.

Ms White: I have been reading the papers on your petition and about the illegal removal and storage of tissue. It is quite horrendous that people's permission is not sought for the removal of tissue, particularly in cases that involve children, and that years later parents receive letters that say that the hospital still has part of their child's body. I thought that the Executive was going to look at that when it went through the two phases of the review group's work, but from your evidence I gather that you are saying that the review group did not follow its remit. Medical notes were also missing and nobody was pulled up about that.

The Executive said that it would launch new legislation before Christmas 2004, but on 17 November it said that the organ donation and retention provisions had been removed from the relevant bill, which will focus on outlawing smoking in enclosed public places. Our briefing note states that the Executive has confirmed that there will be a bill, but that campaigners have criticised the move as they fear that reforms will be delayed. I see why I would criticise what the Executive has done, but I would have thought that you would have been a bit happier as, having initially raised the issue in 2001, you are now getting some results. Can you clarify why you are unhappy about the Executive's decision?

Lydia Reid: I did not criticise it. That criticism was made by the Scottish organisation for the retention of organs.

Ms White: Sorry.

Lydia Reid: That is okay; it is no problem. My personal opinion is that there is a lot more work to be done before legislation is drawn up. That is my personal opinion—our group has not decided on what should be put before the committee.

Ms White: Would you support the introduction of a bill?

Lydia Reid: I would support a bill if more sensible measures were taken. Pathologists are currently saying, "Let the bill go through. Who cares?" The truth is that they will not pay a bit of attention to it.

Ms White: I am trying to clarify the point. I made the mistake of thinking that you, as campaigners, had criticised the Executive's decision, but you say that it was SORO—which you say people no longer support—that criticised the way in which the Executive has handled the matter. Forgive me for mixing the two groups up. As the convener says, perhaps we did not know about all the groups.

You support the introduction of a bill, but you would still like there to be a public inquiry.

Lydia Reid: The public inquiry should come first.

Ms White: Before the bill?

Lydia Reid: Yes. My personal opinion is that nothing will change until pathologists realise that somebody somewhere within the Executive is really serious about finding out what happened to our children and to the parts of our children. Nothing will change until they realise that there will be real censure—not the whitewash that happened with the independent review group. That is proven by the cases that come to me, such as Chris Paterson's case, which was horrendous. Nothing will change until the public inquiry happens and pathologists realise that somebody somewhere will say, "You are in the wrong and you have been wrong." It cuts no ice for pathologists to sit in a hospital and say to parents, "We are sorry," because they do not mean it and nothing changes.

The rules state that the pathologist should inform the procurator fiscal, the procurator fiscal should inform the pathologist and the pathologist should inform the parents, who should have a bereavement officer. However, nothing has happened. The hospitals are not even using the forms that were sent out. Nothing has changed after all these years of campaigning. What would make people change? Surely change would occur if the Scottish Executive were to say to the NHS, "You have to change." Something must make people change, and the only thing that will do so is if the truth comes out.

Education is also important. I was astounded when I saw the pack that went into schools about organ donation for transplant. I know that the Scottish Executive had a great deal to do with the production of that pack and I cannot tell the committee how thrilled I was when I read it. It is wonderful. I would welcome the Executive doing something like that on organ retention and teaching the public that research is for their own good. I know that the situation could change in the future. People would ask more questions, but they would be more willing to give their organs so there would be no need to hide what was being done.

Rosie Kane: I thank Lydia Reid and Annmarie McDonald very much for bringing the petition to the committee.

I would like to clarify a couple of points about the background information on your petition. You state that information that revealed the truth was removed from folders and hidden and that there were blank spaces, which represented the actions of NHS pathologists. First, what is your take on why that happened? Secondly, I will ask about the very difficult issues that relate to the fact that Jessica Paterson's parents were sent a letter and were eventually able to bury their complete child when they received her brain. Did Mr Paterson ever have it explained to him why her brain was taken, what was done and why it was ultimately returned to him?

Lydia Reid: I will start at the beginning.

I can tell you about my personal experience. Having been told that nothing had been taken from my son, I went to the sick children's hospital to look at medical records and was astounded when I read them. I realised the lies that I had been told all those years ago and saw the reason why my son had died.

Everything became so different when I read the records. I sat in a little room with two witnesses, who read the records with me and, obviously, I asked several questions. The records were taken outside because I asked for a copy of them, but four pages were missing when the copy came back. Strangely, those four pages were to do with the four points that I had made. All of them were detrimental to the health board; they all proved that I had been told lies. As those four pages were gone, I stood there and said, "I am not leaving the hospital until I have the full copy of the records." Magically, the full copy appeared—I got those pages back.

That has happened to countless parents and the sad bit is that it is still happening to parents who go to look at records. If the records prove that there is a problem when a post mortem has been done and the parents pick up on that, all of a sudden pages of the records, or even whole records, disappear.

Annmarie McDonald (Justice for the Innocents): Thank you for letting Lydia Reid and me speak today. I am not very clued up on all the legal discussions; I am here as a parent because this has happened to me.

My wee boy was born in 1988 and died after two days. The doctors did not know what was wrong. My husband and I spent a short time—about 20 minutes—with him in a wee room that they had given us. We were ushered upstairs as soon as they could get us out of the room.

Over a period of two hours we were hounded by six or seven doctors to have a post mortem carried out on my baby, but I just felt that they could not help him when he was alive, and what was the point of doing something after he had died? I did not want him to be touched.

I asked several times during those two hours if I could go back with my husband and spend more time with my baby, but I was repeatedly told, "He isn't ready yet." I was not sure what they were doing, but I believed that he only had to be dressed and I thought that that would have taken five minutes. I was eventually allowed to be with him about two and a half hours after he died. He was still in the same room where I had left him, but he had on a white baby gown and was placed in a Moses basket. I bent down as I had a mum's natural instinct to pick him up, but a midwife who was there said, "No. He is at peace. Please leave him." I was a lot younger then and I thought that I had better do as I was told, so I was frightened to touch him. However, I was aware at the time—I have a picture with me—that he had heavy bandaging, like cotton wool covered in gauze, right round from his neck to the bottom of his tummy. I asked what that was for and was told that it was for leakage. I do not know where he could have leaked from, because he had never had any surgery or any tubes in his body. I thought that it could have been the umbilical cord, but that still had a clamp on it from his birth. Even if there had been a possibility of leakage from there, I do not imagine that the padding would have needed to go to his neck, but I left it. I was young and naive.

11:45

He was brought home the next day, which was the day before his funeral. I wanted to spend some time with him, but the undertaker said, "No, I'm sorry. The lid must go on. You can have a few minutes to say goodbye." I wanted more than that: I wanted a hug and a cuddle; I wanted a kiss, but I was deprived of that and the lid went on.

Since all that happened, I have had nightmares in which I see my baby cut up in bits, so when the organ retention scandal came out, I had to ask. I point out that, about six weeks after he died, I had a meeting with the paediatrician, who said that he was 99.9 per cent sure that my baby had died of a hypoplastic left heart. Only a post mortem could determine that. My baby lived for two days—he was lying there dying and fighting for his life—but the doctors could not help; they did not know what was wrong. They said that it was sheer bad luck that he was dying on Easter Sunday, because they could not get a heart specialist to look at him to see whether it was his heart. When I asked the paediatrician how he could be 99.9 per cent sure that my baby had a hypoplastic left heart, because he had not had a post mortem, I was told that they had gone over the medical records of the two days that he had lived and that is how they diagnosed his cause of death. That just does not wash with me.

When the scandal broke, I made inquiries. I was put on to a pathologist at Stirling Royal infirmary; on my father's behalf, I also made inquiries about my brother and sister, who died in 1969 and 1971. We decided that we would do it all in one go and try to get it over with rather than let it go on for a lifetime. The pathologist took a lot of details—names, events and so on—then he phoned me one day out of the blue and said, "I've got good news. I've got some information on Derek, but the information on your brother and sister is on microfiche"—I did not have a clue what that was at the time—"and it will take an expert to read it." I trusted that that was the case and I was excited, thinking that I was finally going to find out. I wanted to be told that my son had not been touched, but the unknown was torturing me, and I am sure that that was why I was having nightmares.

During that telephone conversation, I reminded the pathologist that I wanted copies of medical records, because there were still a few other things that I felt that I needed to find out about the time that my son was alive. He promised me that they would be forwarded, but I had to chase them up. It took another two weeks, and I had to phone again. I said, "My son's medical records still haven't appeared yet," and the pathologist told me, "We'll get them to you soon. We've just got a lot of work to do." I phoned him yet again and said, "If you're too busy to photocopy my son's records, could I please come up and view them?" I was told that I would have to make an appointment, so during that conversation I made an appointment for a few days later to go and view my son's records.

On the morning that I was to go and view the records, I got a phone call and was told, "I'm sorry, but your son's medical records have been destroyed." That was after I was told that I could view them. Why have they been destroyed?

The Convener: Thank you very much for that information. I am sure that it will help the members to consider the petition. Those are obviously harrowing circumstances for you, and I appreciate your taking the time to tell us about them.

Do members have any other questions?

Campbell Martin: I think that the petitioners have a very strong case and I thank both of them for making it today; they have made it very well.

My question relates to the involvement of procurators fiscal. Lydia Reid said that she accepts that they have the right to arrange for post mortems to be carried out—of course they must—but I ask her to clarify whether they sanction the retention of body parts. Are they encouraging or allowing retention or do you think that it is simply the case that hospitals are not returning body parts, in which the procurators fiscal have no role?

Lydia Reid: When somebody goes to the hospital and asks why body parts were used for research, the response is, "That's not my problem. It's the procurator fiscal's problem, because he ordered the post mortem." However, if they then go to the procurator fiscal and ask why the parts were used for research, the procurator fiscal says, "We did not do the post mortem; the pathologist did the post mortem, and it is not our problem." You can decide, but my personal opinion is that it is common knowledge that there is a free-for-all for bodies that are brought in for post mortem, whether under the order of the procurator fiscal or the hospital. That is supported by quite a lot of evidence from different parents throughout our organisation.

Campbell Martin: Is there no legal requirement on the hospitals to return the body parts after the post mortem has been carried out?

Lydia Reid: I understand that there now is such a requirement for a hospital post mortem, but the review group has given procurators fiscal the right to order that parts of children whose cause of death has not been decided—which means cot-death babies, because the medical profession is desperate do to research on such babies—be kept regardless of whether the parents agree. The procurator fiscal is meant to order that those parts be kept in case further research shows a method of finding the cause of death—that is the way the PF puts it—but I cannot see how the issue will be progressed without research being done on the parts that are stored under the procurator fiscal's order, because no cot-death baby ever has a hospital post mortem. Only the procurator fiscal would order a post mortem on a cot-death baby, so from where else will the parts to use in the research come, except the babies that are stored under the procurator fiscal's orders? It must be that those parts are used for research, but we are being told that they are not. Tell me where else the researchers will get them from.

The Convener: I ask members what actions we should take on the petition.

Helen Eadie: As someone whose daughter is a procurator fiscal, I have been interested to hear the discussion this morning. Perhaps we could write to the Crown Office and Procurator Fiscal Service and ask for its views on the petition, as the petitioner calls for an examination of the role and power of procurators fiscal to order post mortems. We could also write to the Scottish Executive to seek its views on the petition and to ask it what timescale it is planning for the proposed legislation to which members have referred.

Rosie Kane: I suggest that we ask the Executive whether it is minded to consider compensation payments to the parents. Perhaps we should approach the Cot Death Society—I do not know whether that is the right body—to ask for its view on how the matter could be better handled.

Lydia Reid: The independent review group and the Executive have used the Cot Death Society constantly, but it is merely a group that exists to raise finance for research, so it is not a great deal of help to any parent. It does not hold meetings to support parents or take their opinion on how things should progress. It does not, as we do, send out questionnaires to ask how parents feel about what has happened to them; the society simply raises money for research into cot death.

Rosie Kane: We could still get a response from the society, based on its knowledge.

John Scott: I have the greatest sympathy for Annmarie McDonald and parents who find themselves in this situation. Allegations are being made that there is a conspiracy involving pathologists, fiscals, the research community and hospital staff to thwart parents' wishes. We should ask the Executive why it thinks that those people might want to conspire in that way.

Lydia Reid: The opinion of our organisation is that those professionals are desperate for body parts for research. It is as simple as that. People are perhaps unaware of the good that has been achieved in the world through research, and I bet that there is no one in this room who has not benefited from research in some way or another—through pills, for example. However, the public does not have knowledge of that and they are therefore very reticent—especially since the organ retention scandal has happened—about giving permission for a hospital post mortem.

It is unthinkable that a doctor should walk up to someone and say, "Okay, your relative has died and the organs are not suitable for transplant, but could we please use them for research?" If a doctor said that to somebody in a hospital there would be a riot and the papers would get hold of it. Why has the public not been educated about the use of organs for research? Why has that discussion not happened? Why are we sending out packs to schools about the donation of organs for transplant but not including information about research? We have to take away the secrecy from the pathologists and hospitals. We have to teach people that there should be no secrecy and that using organs for research is just as useful as using them for transplant.

The Convener: We will write to the Executive, including the *Official Report* of our discussion. We will ask the Executive to comment on the specific concerns raised by Mrs Reid about the relationship between the PFs and individual hospitals. It would be useful to get the Executive's view on that. We will let the petitioners know about the responses that we receive from the different organisations and we will keep an eye on the petition for them. I thank them for bringing the issue to us this morning and for the information that they have given us.

Autistic Children (Gastro-enterological Investigation and Treatment) (PE792)

Autism Treatment (Scientific Think-tank) (PE793)

Autism (Public Inquiry) (PE794)

The Convener: Our next three petitions, PE792, PE793 and PE794 are connected. They are in the name of Bill Welsh on behalf of Action Against Autism. Do members agree to consider all three petitions together?

Members *indicated agreement*.

The Convener: PE792 calls on the Parliament to inform the parents of children in school and pre-school in Scotland of the research findings of various paediatric scientists who have identified inflammatory bowel disease and other bowel disorders in many autistic children, and to ensure that their children are entitled to free gastro-enterological investigation and treatment.

PE793 calls on the Parliament to urgently set up an independent scientific think-tank to assess and advise on scientific, medical and other breakthroughs now emergent worldwide in the treatment of autistic spectrum disorder, bringing into the forum independent scientists and experts with knowledge of all innovative developments in the way this previously enigmatic condition is being addressed.

PE794 calls on the Parliament to set up an urgent independent public inquiry into why an epidemic of the previously very rare childhood condition autism has been overlooked by public health officials, an oversight which may have unnecessarily condemned thousands of innocent children to years of pain, distress and confusion.

Before being formally lodged, the three petitions were hosted on the e-petitioner site from 1 November 2004 to 26 November 2004. PE792 gathered 237 signatures, 240 signatures were collected on PE793 and PE794 gathered a total of 264 signatures.

In recent years, a range of work has been conducted on autistic spectrum disorder and the Parliament has considered a number of petitions on the topic. In June 2001, the Executive responded to a report by the Health and Community Care Committee on PE145 by establishing an expert group on measles, mumps and rubella and subsequently developed a joint-funded research programme on ASDs with the Medical Research Council. Four related petitions are still under consideration by the Health Committee: PE452 on the diagnosis and treatment of adults with ASD on psychiatric wards; PE474 on heavy metal poisoning; PE538, which calls for the establishment of an advisory committee on treatment of autism; and PE577, which requests the development of an autism-specific medical facility.

In March 2004, the Executive announced a funding package of almost £2 million to provide opportunities for training, awareness raising and better service provision through multi-agency working to support people with ASD throughout Scotland. Do members have any comments to make on the three petitions?

12:00

Helen Eadie: Work in this area is on-going in the Health Committee. Perhaps the Public Petitions Committee should close the petitions today, but send an information note about them to the Health Committee. In the context of that committee's consideration, the comments in the three petitions could be taken on board.

At the most recent Health Committee meeting when the petition was considered, I raised issues from the briefing note that was prepared by the Scottish Parliament information centre, as did David Davidson. David had been asking questions at EU level about heavy metal poisoning and I raised questions about the effect of mercury on pregnant women, as well as about the fact that mercury is still used in plumbing throughout Scotland, when it ought not to be used in new-build housing schemes. So, I propose that we send the petitions to the Health Committee.

The Convener: Do members agree with that, since the Health Committee is doing ongoing work on those original petitions? It might be useful to add our three to that consideration.

Mike Watson: I do not object. However, two of the petitions ask the Parliament to set up an independent think-tank and an independent public inquiry. The Parliament cannot do those things. It is surprising that the petitions are worded in that way given that—I notice from the note paper—the parliamentary advisers to the group are Murdo Fraser MSP and Carolyn Leckie MSP, who I thought would have known that. I do not disagree with sending the petitions to the Health Committee, but PE792 and PE793 seem to ask for something that cannot be done.

The Convener: A lot of petitions ask for public inquiries—we debated one in Parliament that asked for a public inquiry.

Mike Watson: But it is not for the Parliament to set up such an inquiry.

The Convener: You are absolutely correct that the Parliament cannot do that, but the Executive can. It is for the Parliament to ask the Executive to set one up. I am not sure whether we are getting into semantics about what we can and cannot do. I take your point and I do not disagree with you, but the essence of the petition is not that it asks the Parliament to do something that it cannot; it asks the Parliament to ask the Executive to hold a public inquiry. Perhaps one should look at the wording of petitions more closely, but this is not out of line with what has gone before.

Helen Eadie suggested that the petitions would fit in with what the Health Committee is already looking into. If members agree, we could close the three petitions at the moment and send them on to the Health Committee for consideration with the other petitions.

Rosie Kane: I have not been on this committee long, so perhaps Helen Eadie or others can help me out with clarification. My understanding is that well over 3,000 children suffer from autism and that the figures are escalating. Has the chief medical officer been contacted about such petitions in the past? Have we had any replies?

The Convener: The present clerks were not the clerks when PE452 and PE474 were lodged. They were discussed prior to Jim Johnston becoming the clerk to the Public Petitions Committee. I am not sure whether the chief medical officer was contacted. However, if we contacted the Executive, the response would come from the Health Department. Even if we did not write to the chief medical officer directly, there must have been some input from that source. I do not know whether that helps.

Rosie Kane: I would like to know whether that was the case. I will look into the matter.

The Convener: If we refer these petitions to the Health Committee, it can take them into consideration along with the other autism petitions. Do we agree to close the petitions?

Members *indicated agreement*.

Current Petitions

Nuisance Hedges (PE497)

12:05

The Convener: The first current petition is PE497, from James and Pamela McDougall, which calls on the Parliament to urge the Executive, following its consultation exercise of 2000, to introduce legislation at the earliest opportunity to alleviate the nuisance caused by hedges.

At its meeting on 25 February 2003, the committee agreed to keep the petition open and to monitor progress of the legislative proposals in the new session. Following recent amendments to standing orders on the procedures for members' bills, Scott Barrie's proposal for a high hedges bill has fallen, along with every other proposal. The clerk to the non-Executive bills unit has advised that Scott Barrie will be required to produce a consultation paper under the new procedures if he wishes to introduce a member's bill.

I have been contacted by Scott Barrie, who has told me that he intends to introduce a bill on which he has been working. Do members want to wait to see Scott's proposals?

John Scott: We have been waiting some time for the bill. It is a long time since Scott Barrie said he intended to introduce it. I hope that he will do so quickly. If he does not, perhaps the Executive should consider addressing the matter in the new planning bill that it intends to introduce. Has a similar bill been passed in England and Wales? Is there room for a Sewel motion here? I, too, have constituents with this problem—it is quite an issue.

Rosie Kane: I think that there has been such legislation.

The Convener: I am not sure. I understand that Scott Barrie intends to introduce his bill in the new year. The Executive may be waiting for him to do so before it incorporates the measure into its proposals. That is a matter between Scott Barrie and the Executive.

Jim Johnston (Clerk): I understand that the UK Anti-social Behaviour Act 2003 contains provisions on the issue for England and Wales.

John Scott: Presumably it is not possible to transpose part of the act to Scotland.

Jim Johnston: That is correct.

The Convener: Shall we ask Scott Barrie to comment formally on the matter? If he does not, we could ask the Executive whether it intends to do something in this area. Do we agree to contact Scott officially to find out what his plans are and to continue to investigate the issue?

Members *indicated agreement*.

Abandoned Properties (PE602)

The Convener: The next petition is PE602, from David Cleghorn on behalf of Dedridge community council. The petition calls on the Parliament to take the necessary steps to decentralise to local authorities the previously centralised authority held by the Scotland Office under the planning regulations to recover abandoned private sector properties.

At its meeting on 15 September 2004, the committee considered responses from Shelter, the Scottish Executive, the Empty Homes Agency and 20 local authorities. The committee agreed to invite the Minister for Communities to revisit the issues raised in the petition in the light of the proposed private sector housing bill.

In his response, the minister states:

> "The Executive has made clear in its previous correspondence that local authorities have powers of compulsory purchase for a range of purposes, including for the provision of housing accommodation."

Regarding the proposed legislation, he states:

> "We hope that the package of measures proposed would make it easier for local authorities to take effective action where a house is in disrepair or below the Tolerable Standard."

Would members like to comment?

Ms White: This is a very important issue. We should refer the petition to the committee that considers the housing bill at stage 1.

The Convener: The bill has not yet been introduced, but we can refer the petition to the lead committee on the bill once that happens. We could leave the petition in its care until such time as it can use the information as part of its consideration of the bill.

John Scott: It is far from clear what recommendation, if any, we should make, given the evidence that we have. The jury is definitely out on this matter. There seem to be conflicting views on whether the proposal is necessary. However, it would be helpful if the lead committee on the housing bill were able to consider the petition carefully.

The Convener: Do we agree to close the petition and to refer it to the relevant committee?

Members *indicated agreement*.

Yorkhill Hospital (Centre of Excellence) (PE655)

The Convener: PE655, from Mr and Mrs Gill, calls on the Parliament to investigate the resource and other difficulties currently being faced by Yorkhill hospital as a result of its status as the centre of excellence in cardiac for Scotland and to consider whether it is appropriate for the hospital to continue in that role.

At its meeting on 21 January 2004, the committee considered responses from the Scottish Executive and NHS Greater Glasgow, and agreed to seek further information on staffing from Yorkhill NHS Trust and NHS Lothian. The committee also agreed to seek the views of the petitioner on the responses received.

The committee has received details of staffing levels from both Yorkhill NHS Trust and NHS Lothian, as requested. The petitioners invite the Executive to explain the reasons for the 400 per cent increase in mortality rate from a procedure increase of 7 per cent over the three-year period 2000 to 2003; why last year was a bad year and this year seems to be better; and the corrective actions that were taken in response to the 13 deaths in 2003 that were attributed mainly to developments in interventional cardiology.

This is a petition that we must continue to consider. The petitioner has posed some clear questions and it would be useful for the Executive to give answers to those before we do anything else with the petition. Do we agree to refer the three questions posed by the petitioner to the Executive for comment?

Members *indicated agreement*.

Forestry Commission (Consultation Guidance) (PE691)

The Convener: The fourth current petition is PE691, from Boyd Calder on behalf of Burnawn Residents Group. The petition calls on the Parliament to investigate the Forestry Commission's implementation of its guidance on consultation with residents of areas that have widespread logging, drainage and planting activity nearby.

At its meeting on 5 October 2004, the committee agreed to invite the Forestry Commission Scotland to comment on a response from the petitioner. In its response, the commission states:

> "With the introduction of the new Scottish Forestry Grants Scheme (SFGS) in 2003, an opportunity was taken to strengthen the emphasis on making local communities aware of forestry proposals."

In response to the petitioner's comments regarding the public register, the commission states:

> "The Public Register is displayed both on the Forestry Commission's website and, in paper format, at local libraries."

Would members like to comment?

John Farquhar Munro: I agree with the recommendation.

The Convener: The recommendation is that, given the response from the commission, we agree to take no action on the petition.

John Scott: We have received a full response from the commission, which is welcome.

Mike Watson: Has the response been sent to the petitioner?

The Convener: We will inform the petitioner of the response that we have received. Do members agree to close the petition?

Members *indicated agreement*.

Gulf War Syndrome (PE709)

The Convener: The next petition is PE709, from Alexander Izett, and calls on the Parliament to initiate an inquiry into the health aspects of and other devolved issues related to Gulf war syndrome.

At its meeting on 15 September 2004, the committee considered a response from the Minister for Health and Community Care, together with an appended report entitled "The UK Government's Policy on Gulf Veterans' Illnesses: Response by Ministry of Defence". The committee noted that the UK Government's response stated:

> "There is scientific evidence that some Gulf veterans report a large number of multisystem, multi-organ, non-specific, medically unexplained symptoms as well as recognised medical conditions. However, the overwhelming consensus of the scientific and medical community is that Gulf veterans' ill-health cannot be characterised as a discrete 'Gulf War Syndrome' because the multiplicity of symptoms they report are not the same in every case and such symptoms/illnesses are common in military personnel who did not serve in the Gulf."

The committee noted that the response does not examine whether the symptoms were caused by the cocktail of drugs that was used and requested that the Parliamentary Under-Secretary of State for Defence, the minister for veterans, comment on the matter.

The committee requested the petitioner's views on the minister's response:

> "I have made clear that Gulf veterans' illnesses is an issue that I and the UK Government take very seriously and, as one which has always been a Ministry of Defence responsibility, I can see … no merit in the committee pursuing this matter any further."

In response to the Minister for Health and Community Care's letter, the petitioner states:

> "I am delighted that the Minister has responded in such a positive way and I sincerely hope that he will indeed look into any shortcomings regarding the NHS treatment offered to veterans in Scotland."

He also states:

> "I fear that we will never receive a detailed explanation from the MoD as to what exactly was contained within these somewhat controversial inoculations."

Do members have views on the matter?

12:15

Rosie Kane: For the record, I find the response from Ivor Caplin MP a little bit cheeky and irritating. He needs a wee Public Petitions Committee smack on the wrist. He says that he expressed to Jack McConnell

> "serious reservations about the Public Petitions Committee's ability to address a 'non-devolved' Defence related issue."

The issue was brought here in good faith by an individual and I do not like the cheeky tone of Ivor Caplin's letter. He says that Alexander Izett contacted him but I know that Alexander has had little or no response or explanation from the minister. I want to put it on the record that he is not being appropriate, either in his letter or to Alexander Izett.

Ms White: I share Rosie Kane's views regarding the minister. He describes the issue as a

> "'non-devolved' Defence related issue"

but it is a health issue and, obviously, health is devolved to the Scottish Parliament. I can see merit in the committee pursuing the matter, even if he cannot. That is just a comment on the letters that we received from a minister at Westminster, which show how much he thinks of the Scottish Parliament. I hope we can prove him wrong.

Mr Izett mentions in his letter of 30 November that he wanted to submit to the committee

> "further evidence of no fewer than a few hundred pages"

but he was told that he could not do that and that he should summarise it. He says that that information would help us in our deliberations. I would like to see that information, because this is an important issue. Although the petition is signed by one man, the issue affects others and many MSPs have had letters from and contact with other sufferers. We should examine this serious issue, so I would like the petition to continue until we have seen the additional information.

Jackie Baillie: I was not going to rise to the bait, but I will. I have a problem when we start to get slightly stroppy about Westminster ministers who say, "Actually, this matter is reserved to Westminster" when the issue is indeed reserved. I would have a problem if Westminster ministers, or for that matter MPs, started to consider and comment on devolved issues. We need to understand what we are responsible for and take action on it. The petition is about the health service and treatment within it, which is something that we are responsible for and should therefore comment on. I do not associate myself in any way with the remarks that were made by my two colleagues about the minister for veterans' response.

I am pleased with the Minister for Health and Community Care's response because, as the petitioner acknowledges, it is positive. He makes a commitment to address any of the shortcomings that have been identified. I do not see how much further we can go, so I recommend that we close the petition.

Helen Eadie: I have nothing to add to what Jackie Baillie said. I agree with her and I support her suggestion that we close the petition.

John Scott: I too recommend that we close the petition, but nonetheless I believe that the issue is not being adequately addressed. I was interested to hear Jackie Baillie's point that English MPs at Westminster should not comment on Scottish matters. I trust that she will take that up with her colleagues Robin Cook and George Foulkes.

I do not think that there is much more that we can do as this is a Westminster issue. I concur with Jackie Baillie in that regard.

Helen Eadie: I do not wish to be adversarial, but I will be. The fact is that a huge amount of work has been done on the issue. A constituent came to me about it early in my time as a parliamentarian and I found that a huge amount of work has been done in the House of Lords, the House of Commons, in America and throughout the world on the global issue of Gulf war syndrome. Massive efforts are being made by scientists, doctors and politicians to address it. Perhaps John Scott's point is that such work is not being done by the Scottish Parliament but, as Jackie Baillie said, there are reasons for that. A huge amount of work is being done—I have an enormous file on the issue in my office. It is unfair to say that people throughout the UK have not been interested. We are committed to supporting our troops.

John Scott: In the interest of letting the committee get on, I will let you have the last word.

The Convener: It will not be the last word, because Campbell Martin wants to come in.

Campbell Martin: There is an easy way to sort out any problems between Scotland and Westminster and it is called independence. If we had independence, we would have a normal Parliament with real powers. I would prefer us not to close the petition yet because the petitioner's response raises a pertinent question on health, over which this very limited Parliament does have powers. He says:

> "I fear that we will never receive a detailed explanation from the MoD as to what exactly was contained within these somewhat controversial inoculations."

If our health service is to deal adequately with the health issues, surely we must know what was in those inoculations. Perhaps the slightly arrogant and unhelpful minister for veterans could provide a detailed explanation. He is the relevant minister in the MOD, so perhaps he could provide a detailed explanation of what went into the inoculations.

The Convener: I do not think that there is a real issue in the committee. We recognised at the outset which matters are reserved and what the point of the petition is, and we took up only the health issue, which is a devolved matter. The views of the minister for veterans are his and he is entitled to them. If we believe that information can be gathered from Westminster that will help us in our deliberations, we will pursue it. I am not perplexed about the minister's views on our ability to write to Westminster on reserved matters. We will continue to do that as and when we see fit. That is not the point of the petition.

As Campbell Martin and others said, the petition is about what the Scottish health service is doing to address the health of Gulf war veterans. On that, the petitioner said that he welcomes the positive response from the Minister for Health and Community Care. If we focus on that, I do not think that there is any disagreement. We can ignore or take seriously the letter from the minister for veterans as we see fit, but it has no bearing whatsoever on our deliberations on the petition. If we can agree that the petitioner is satisfied with the positive response from our Minister for Health and Community Care on the health issues, we can close the petition.

Jackie Baillie: Absolutely.

Rosie Kane: What about Campbell Martin's point? How can the health service deal with an unknown—

The Convener: It will still have to get that information from the Ministry of Defence, but that matter will continue regardless of whether we take a view on it. The information will come from the MOD at the behest of the health service. The Minister for Health and Community Care outlined what he is doing in respect of the health service and the petitioner said that he thought that that was a positive response. The MOD situation will take its course. As the minister said, Gulf war syndrome is a serious matter that the MOD is looking into. We have no influence over that. If we agree that Westminster will take care of its business and we will take care of ours, we can close the petition.

Ms White: I concur with everything that was said about health, but I would like to see the further evidence that the petitioner mentions in his letter of 30 November. He was told that it was far too big for the Public Petitions Committee to look at.

The Convener: If you want to read the report, you can write to the petitioner and ask for a copy. I do not think that receipt of a 100-page document on medical evidence will help the committee to deliberate on the petition. If Sandra White is interested in the technical details, that is fine; she is entitled to write to Mr Izett and ask for the information. I do not think that the committee would benefit from having the report.

Ms White: I raised the point because I thought that it would benefit the committee to receive the report.

The Convener: I do not see how it could benefit the committee. We are not investigating Gulf war syndrome; we are considering how the Scottish health service deals with Gulf war veterans. That is what Mr Izett asked us about and that aspect of the petition has been addressed. If you want to know more about Gulf war syndrome, you should take the matter up with the petitioner.

Ms White: I still put forward my original suggestion, that we should continue consideration of the petition until we have seen the report.

The Convener: You can push the matter to a vote, but you are dividing the committee and there is no reason to do so. If you want to see the document, you can write to Mr Izett and ask for a copy. I would rather that you did not divide the committee on the matter.

Campbell Martin: There remains a question about what went into the inoculations. The convener says that Westminster will deal with the matter, but we cannot conclude consideration of the petition while that question is still out there. Surely the committee could ask the Minister for Health and Community Care to ask his Westminster colleagues—if that is the appropriate procedure—about what went into the inoculations, so that the Scottish health service can deal with the situation.

The Convener: Your suggestion would be a good one if we had not already done what you suggest. We already put that question to the minister and received a response—

Campbell Martin: Do we know what went into the inoculations?

The Convener: We know that the Minister for Health and Community Care's response was described by Mr Izett as "positive".

Campbell Martin: But what went into the inoculations?

The Convener: That is not a matter for the committee.

Campbell Martin: It is a matter for the Scottish health service.

The Convener: I do not want to get bogged down in the issue. The petition did not ask the Parliament to consider that matter. We wrote to Westminster to try to get as much information as possible from the Ministry of Defence. The MOD responded in its way, but the Scottish Executive Minister for Health and Community Care said that he has looked into the issue, which he takes very seriously. Given what the petition asked us to do and that the response from the Minister for Health and Community Care satisfied the petitioner, I see no purpose in keeping the petition open so that we can have a dialogue with the MOD.

Campbell Martin: The purpose would be to get answers.

The Convener: That is not what the petition sought. You can take the issue to a vote, but I would rather that there was consensus round the table about the fact that the petition did not ask the Parliament to investigate Gulf war syndrome, because it does not have that authority. It asked that the health service in Scotland tell Gulf war veterans what it is doing to address their concerns. If we accept that fact, we can close the petition. If members want to take the petition down a different route, we will have to divide the committee on the matter.

Ms White: My position has nothing to do with the letter from the minister for veterans. He is entitled to say what he has to say; I am entitled to say what I have to say. Mr Izett said that the report contains

> "ALL available evidence relating to the ill-health of Gulf War veterans".

Health is devolved to the Scottish Parliament. The petitioner says that the MM National Gulf Veterans and Families Benevolent Association thinks that the report should be provided to the committee in support of the petition. I am sorry to push the matter to a vote, but we should continue consideration of the petition until we have seen the report.

The Convener: Sandra White proposes that we continue the petition while we ask that specific question. Do other members want to close the petition?

Jackie Baillie: I move that we should close the petition, but I think that a straight vote on Sandra White's proposal will suffice.

The petitioner's response falls into two parts. First, in relation to the response from the Minister for Health and Community Care, the petitioner says:

> "I am delighted that the Minister has responded in such a positive way".

That deals with the health service aspect of the matter. Secondly, the petitioner says:

> "I fear that we will never receive a detailed explanation from the MoD".

That is the point that divides the committee. We have addressed the health matters and the petitioner is happy with that. On that basis, we should take no further action on the petition.

The Convener: We will vote either to close the petition or to keep it open and ask the MOD about Gulf war syndrome. Does the committee agree about what we are voting on?

Ms White: No. My proposal was that we should keep the petition open until we see the report, which Mr Izett said would be helpful in support of the petition. The petition called for

> "an inquiry into the health aspects"

of Gulf war syndrome.

The Convener: I know what you are saying, but it amounts to the same thing. We are voting either to close the petition or to keep it open.

Ms White: Yes, but not for the reasons that you mentioned.

The Convener: Okay. Campbell Martin made a separate suggestion. If we keep the petition open, we must do so on the basis that two reasons for doing so have been given, one by Sandra White and one by Campbell Martin. If we vote to keep the petition open, we will proceed with it on the basis that members have asked for two things to happen.

Ms White: I am happy with that.

12:30

The Convener: The proposal is, that we close the petition. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Baillie, Jackie (Dumbarton) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
Scott, John (Ayr) (Con)
Watson, Mike (Glasgow Cathcart) (Lab)

AGAINST

Kane, Rosie (Glasgow) (SSP)
Martin, Campbell (West of Scotland) (Ind)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
White, Ms Sandra (Glasgow) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0. The petition is closed.

Affordable Housing (PE732)

The Convener: The next petition is PE732, from Norman Lawrie, on behalf of the royal burgh of Haddington and district community council, on guidelines to promote the development of affordable housing. The petition calls on the Parliament to urge the Scottish Executive to review the current guidelines on new housing developments to ensure that a larger proportion is allocated to affordable housing.

At its meeting on 26 May 2004, the committee agreed to seek comments from the Executive. In particular, it asked for an update on the Executive's review of affordable housing, together with details of its plans in that area. The committee also agreed to seek comments from East Lothian Council and the Scottish Federation of Housing Associations.

In its response, the Executive states that although the analysis of its affordable housing review, published in July this year

> "concluded that there was not a chronic problem in Scotland with overall housing supply, it highlighted affordability and supply problems in particular localities, and problems of low demand and surplus housing stock in other areas."

The Executive also states that

> "£1.2 billion will be spent on affordable homes over the next 3 years"

and that it expects later this year

> "to publish new advice on Planning and Affordable Housing."

The SFHA response states that, although it has been "encouraged" by the Executive's review of affordable housing,

> "the Executive's commitment to this issue will best be judged by the outcome of the current spending review around September this year. Certainly we believe current rates of provision of affordable rented housing are less than half the annual amount required."

East Lothian Council provides a copy of its policy on affordable housing which had not been adopted at the time of the proposals at Briery Bank to which the petitioner refers.

Would members like to comment?

Mike Watson: It is helpful to have the document from East Lothian Council, which explains the percentage for Haddington. Given the responses that we have received, I am not sure that there is anything more that we can do with the petition. I do not know the SFHA's view on the spending review, but generally the issues that it has identified for Haddington are covered by the percentage figures that we have received.

John Scott: I agree with Mike Watson. However, the SFHA's view that the issue is essentially one of land release and zoning is interesting and worthy of note. The real need is for more land to be made available, rather than for more affordable housing to be included in projects.

The Convener: Do we agree to close the petition?

Members *indicated agreement*.

Adults with Learning Difficulties (Provision of Services) (PE743)

The Convener: The next petition is PE743, from Madge Clark on behalf of the Murray Owen Carers Group. The petition calls on the Parliament to urge the Executive to review the implementation of "The same as you? A review of services for people with learning disabilities" to ensure that the needs of adults with learning difficulties who are still living at home and are cared for by elderly parents are given the same level of support and community care opportunities as is given to hospital-discharged patients.

At its meeting on 9 June 2004, the committee agreed to seek comments from the Executive, Enable, the Scottish Association for Mental Health, the Scottish Consortium for Learning Disability and the Convention of Scottish Local Authorities.

In his response, the former Deputy Minister for Health and Community Care stated:

> "The Executive has made it clear that local area co-ordinators should be available in all areas. Further information will be collected later this year, providing a clearer picture about progress with implementation of *The same as you*? … I chair the national Implementation Group, which has produced 2 reports to assist implementation of key recommendations … "*The same as you?* set out a 10 year programme of change and we remain firmly committed to achieving that."

In its response, Enable stated:

> "The subsequent difficulty has been fully implementing these far reaching proposals. Whilst recognising that many were medium to long term plans, the Scottish Executive has never produced a clear action plan with targets and timetables which we were led to believe would emanate from 'The Same as You?' … The implementation group has not looked at the issue of family carers for adults and this petition might provide the impetus for a further report from the group."

SAMH stated:

> "the petition refers to issues concerning services for learning disabilities, and as a mental health organisation we do not consider it would be appropriate for us to comment".

South Lanarkshire Council stated that it

> "and its partners have taken significant steps to improve services, many of which would have happened without the national review given the Council's commitment to practice in this area and which our investment clearly demonstrates."

The Scottish Consortium for Learning Disability stated:

> "All areas should appoint a sufficient number of local area coordinators to ensure that they are available to all families."

Do members have any comments?

Jackie Baillie: I suggest that we invite the Executive to comment on the responses from Enable and the Scottish Consortium for Learning Disability. However, I will draw out three points.

First, I welcome the minister's commitment on the 10-year programme of implementation, but Enable has a point. We need a fix on what the targets and performance indicators are and on whether Enable feels that the Executive is ahead of target, behind target or where it would expect to be. It would be enormously helpful to have that detailed knowledge.

The second point is that South Lanarkshire Council's response acknowledges that there are problems with housing and accommodation, particularly for those individuals with learning disabilities who are getting older and currently living with family as carers. That is the crux of the presentation that the petitioners made to us, and given that we have now identified it as a problem, we should ask the Executive whether there is anything that it can do to resolve matters.

Thirdly, as 2004-07 partnership in practice agreements will land on Executive desks soon—if they are not there already—it might be useful to pick up the Scottish Consortium for Learning Disability's point that we should ask about who is awaiting housing and support packages, who has unmet needs in that regard and who has a single shared assessment but is still living with their family. If we can ask the Executive to ask local authorities those questions, we will start to shine a light on the issue that the petitioners brought to us.

I recommend that we pick those issues out in a letter back to the Executive.

John Scott: I agree entirely with what Jackie Baillie says. In addition, I suggest that we write to COSLA for its views, because it will have to carry out much of the implementation. There is also an issue with the long-term funding arrangements. I would like assurances from the Executive on those because, as people with learning disabilities go back into the community, the costs of placing them there are becoming ever greater. There is also an issue with where carers will come from. There is a Scotland-wide shortage of carers and we need some indication from the Executive as to how it will address that problem in addition to those that Jackie Baillie has raised. I also concur with her about family carers. That issue is a ticking time bomb, and we need to get it sorted.

The Convener: Linda Fabiani is with us. She has followed the issue and will obviously want to comment on the situation.

Linda Fabiani (Central Scotland) (SNP): I would be happy to listen to the committee's views, because I have a lot of confidence that the responses and views of members of the Public Petitions Committee will be similar to mine. I would appreciate the chance to come in at the end, if there is anything that I feel should be picked up.

The Convener: Jackie Baillie has succinctly summed up the points that we have to make, so if you want to add anything that you want us to consider, now is the time.

Linda Fabiani: I am delighted at the points that Jackie Baillie raised. The committee has very much grasped the issue.

On the petitioners' behalf, I had a meeting with Scottish Executive officials. One thing that came out of that was my feeling that we are back to the old situation in which performance can look good, depending on what criteria are used to measure it, but only when we look behind it do we get the real, human stories of what is happening on the ground. The detailed information for which we are now asking will flush out some of those stories.

I acknowledge that members have some sympathy for South Lanarkshire Council, which has openly admitted that it is not doing enough and that people are not happy. However, the council could have told me that a year ago when I requested a meeting on behalf of people in the community that I represent and the council refused to meet me. That was not helpful and I am glad that the committee has taken the matter on.

I would like the petitioners to be given the opportunity to respond to the responses that the committee received, which would be valuable.

The Convener: That opportunity is given as a matter of course, but I take your point. We will wait for the Executive's response to the responses of the different organisations and we will consider the petitioners' response to whatever information we can gather. Are members happy to do that?

Members *indicated agreement*.

Home Safety Officers (PE758)

The Convener: The final petition for consideration this morning is PE758, which was lodged by Jim Black on behalf of the Scottish Accident Prevention Council. The petition calls on the Parliament to urge the Executive to place a statutory requirement on all local authorities to employ home safety officers and to provide the necessary funding to achieve that.

At its meeting on 15 September, the committee agreed to seek the views of the Scottish Executive and COSLA. The Minister for Health and Community Care, who responded on behalf of the Executive, said:

> "Imposing a statutory responsibility on local authorities is inconsistent with that shared responsibility, and could alter the perception and participation of these partners, and perhaps undermine the progress that has been made in recent years."

COSLA responded:

> "Whilst COSLA values SAPC's work, its firm view is that it is a matter for democratically accountable local authorities to determine their own staffing policies and to determine how to address all aspects of community well-being, including home safety, within the context of their own local circumstances and priorities."

Helen Eadie: I am disappointed by that response. Representatives from SAPC are here today. In the past two months, in one street in a council estate in the community that I represent, three deaths that could have been avoided have occurred. In the past year there have been a number of fire and other deaths in my constituency—it is dreadful to attend the funerals of the people who died. Only six or seven weeks ago, a councillor's son was killed in a chip-pan fire. Such fires are preventable and not enough is being done about the matter. Whether or not a requirement should be imposed on local authorities to employ home safety officers, the issue should be addressed.

I spoke to SAPC office-bearers today, who told me that the organisation independently approached local authorities throughout Scotland to seek the views of every authority. In response, 78 per cent of councils said that they supported the proposal that is being put forward. That puts a question mark over how COSLA reached its view. I am not content with COSLA's response and the matter should be pursued. We should write to all local authorities in Scotland to seek an independent answer.

Local authorities might reply that their officers do not have time for that kind of work. However, a few years ago two environmental health officers sat in the office of one of my constituents for two hours while talking about health and safety. Two officers can be freed up to do that, but we are talking about a much more important measure, because the cost to the health service of dealing with the consequences of accidents is millions of pounds, not to mention the cost in misery and suffering of the people who have falls or are burned to death. There is grief throughout Scotland when such accidents happen, as we know from experience in our constituencies. There is a much more important job to be done and the matter should be legally enforceable. There should be legislation to support the SAPC's proposal and we should write to all local authorities in Scotland for their views.

The Convener: I support that.

Rosie Kane: I strongly agree with Helen Eadie. I well remember the good sense that the petitioners made when they addressed the committee—I think that was the first time I attended the Public Petitions Committee. Their proposal is practical and sensible and it sticks clearly in my mind. Helen Eadie has outlined the situation perfectly. I, too, am disappointed by the responses.

Ms White: I also concur with Helen Eadie and I am grateful to her for putting her views so forcefully. I was surprised by COSLA's comments. I think that a number of years ago, 90 per cent of councils supported the idea of having home safety officers. I whole-heartedly back Helen Eadie's proposal.

John Scott: I am also disappointed at the apparently conflicting evidence. COSLA appears to take a different view from that of the individual local authorities and we must investigate that. Given that the Justice 2 Committee is considering the Fire (Scotland) Bill, we should perhaps copy the petition to that committee—without losing control of the petition—so that our on-going dialogue can inform that committee's debates on the bill at stage 2.

The Convener: I see no difficulty in that. Are members happy to write to individual authorities and await their responses, before considering the matter further?

Members *indicated agreement.*

The Convener: That concludes this morning's business.

Meeting closed at 12:46.

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