PUBLIC PETITIONS COMMITTEE

Tuesday 1 December 2009

Session 3

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CONTENTS

Tuesday 1 December 2009

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PUBLIC PETITIONS COMMITTEE
17th Meeting 2009, Session 3

CONVENER

*Mr Frank McAveety (Glasgow Shettleston) (Lab)

DEPUTY CONVENER

John Farquhar Munro (Ross, Skye and Inverness West) (LD)

COMMITTEE MEMBERS

*Rhona Brankin (Midlothian) (Lab)
Bill Butler (Glasgow Anniesland) (Lab)
*Nigel Don (North East Scotland) (SNP)
*Robin Harper (Lothians) (Green)
*Anne McLaughlin (Glasgow) (SNP)
*Nanette Milne (North East Scotland) (Con)
*John Wilson (Central Scotland) (SNP)

COMMITTEE SUBSTITUTES

Claire Baker (Mid Scotland and Fife) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Nicol Stephen (Aberdeen South) (LD)
Bill Wilson (West of Scotland) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Celia Danks (LDN Now)
Margaret Anne Gachagan (LDN Now)
Christine Grahame (South of Scotland) (SNP)
Christopher Harvie (Mid Scotland and Fife) (SNP)
Dr Godfrey Joseph (Multi Ethnic Aberdeen Ltd)
Malcolm McCarthy (Multi Ethnic Aberdeen Ltd)
Daniela Rotariu (Multi Ethnic Aberdeen Ltd)
Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)
Bob Thomson (LDN Now)

CLERK TO THE COMMITTEE

Fergus Cochrane

ASSISTANT CLERKS

Franck David
Alison Wilson

LOCATION

Committee Room 1

Scottish Parliament

Public Petitions Committee

Tuesday 1 December 2009

[THE CONVENER *opened the meeting at 14:02*]

New Petitions

NHS Translation and Interpretation Services (PE1288)

The Convener (Mr Frank McAveety): Good afternoon. Welcome to the 17th meeting this year of the Public Petitions Committee. All electronic devices should be switched off. We have received apologies from Bill Butler and John Farquhar Munro, the deputy convener. I welcome to our committee business this afternoon, as an observer, Johannes Fritz, who is carrying out research into petitions work on behalf of the German Bundestag. I hope that our deliberations will provide him with something that he can take back home to assist the petitions process in the Bundestag.

The first petition that we will consider this afternoon is PE1288, from Dr Godfrey Joseph, on behalf of Multi Ethnic Aberdeen Ltd—MEAL for short—which calls on the Scottish Parliament to urge the Scottish Government to ensure that every national health service board has the structure, funding and capability to provide speedy, accurate and appropriate translation and interpretation services for patients and their families and that such services are consistent across NHS boards.

MEAL has been involved in the Parliament’s community partnership project, which aims to encourage greater participation in the Parliament’s work, especially through the petitions process. I welcome one of the productive results of that today—depending on how our dialogue goes over the next half hour, mind you. I hope that it will be of mutual benefit to MEAL and to the committee.

I welcome to today’s meeting, along with Dr Joseph, Malcolm McCarthy and Daniela Rotariu. I invite Dr Joseph to make some opening comments.

Dr Godfrey Joseph (Multi Ethnic Aberdeen Ltd): This petition is about improving interpretation services in the NHS by using modern technology, such as videolink and internet link, and updating services to provide a visual language interpretation service that will be fast, accurate and less expensive. The added visual dimension and impact of videolink and internet link make them a superior tool to talking through a telephone line.

Having the ability to explain on the internet or by video would contribute to a better understanding between doctor, interpreter and patient, leading to a more accurate diagnosis. In an emergency situation, where a face-to-face interpreter may not be available, we see it as best for the patient to be able to see the interpreter on screen. One of the hospital consultants said that he would get better service from a visual, internet-based interpretation than from Language Line, as it would give patients a sense of speaking to a real person and enable them to point to different parts of the body to explain their symptoms to the interpreter. He also said that it would be cost effective. Hospital consultants have signed the petition.

Language Line is quite expensive. There is evidence that doctors are reluctant to use it, sometimes even in emergencies. It also does not cover all languages. If the patient does not speak any of the common languages of which we are aware, they could be linked visually, by video or the internet, to interpreters in the countries from which they originate. We could have links with reputable hospitals abroad; consulates could recommend interpreters. Preliminary inquiries show that in some countries, such as Romania, some interpreters in hospitals are volunteers, so no cost is involved. In India, we could get 24-hour interpretation for £5 to £6 an hour; in Poland, it would cost £6 to £10 an hour. The low cost of visual interpretation would encourage doctors to use it more liberally. At present, there seems to be a reluctance to use Language Line, because it is so expensive.

Developing links with competent visual interpreters in other countries could help British people when they are ill abroad, and a reciprocal arrangement could be set up.

A fast, more accurate diagnosis due to visual interpretation could mean speedier recovery periods, with the patient spending less time in hospital, reducing hospital costs and fatalities. There could be other spin-offs. Visual interpretation could help deaf people in medical emergencies. The knowledge that Scotland had such modern and up-to-date services geared up for medical emergencies would provide business and trade visitors and tourists who are non-English speakers with peace of mind. The Scottish Parliament could lead the way by being at the forefront of putting modern technology to good use. That would be ground breaking in Scotland and would attract worldwide acclaim.

The visual interpretation service could be much cheaper than the service that is currently used, as both internet links and videolinks are fairly inexpensive. Visual interpreters are sourced worldwide and charge a fraction of the current cost. That would reduce considerably the cost of the service, saving the NHS a substantial amount of money.

The Convener: Thank you. Malcolm McCarthy and Daniela Rotariu are welcome to respond to committee members' questions. I invite opening questions from members.

Nigel Don (North East Scotland) (SNP): Good afternoon, friends. NHS Grampian has already responded to my original request, some weeks back, for a response on some of the issues that were originally raised. I put on record my appreciation for Nigel Firth's contribution in that regard. NHS Grampian's response takes the whole debate forward. It means that we are now talking about what could be added by visual links, which we have heard you discuss, rather than just face-to-face or audio interpretation. What costs would be involved? Are there hospitals around the world in which the service is already available?

Dr Joseph: Links during surgery can take place between different hospitals in the United Kingdom and, sometimes, abroad. I am talking mainly about visual translation and interpretation services, which have not been developed.

Nigel Don: I do not disagree with you about the value of visual interpretation; everything that you have suggested sounds perfectly sensible. My immediate concern is to know how practicable—in the sense of being cost effective and available—the service might be. Are there areas around the world in which we can already point to the technology being used successfully for that kind of thing?

Dr Joseph: I think that I have already mentioned some of the costs. From Poland, it is about £6 to £10 an hour, and it is £5 to £6 an hour from other places. That is much lower than what it would cost to use Language Line or a face-to-face interpreter. Last year, Glasgow spent about £1.6 million on interpretation and translation. If those costs are lower because we go to the countries directly for the services, the money could be used more effectively for patient care.

Nigel Don: I understand, but the point that I might not have yet made very effectively is that equipment is a substantial cost. I am just reflecting that if there were a camera and television screen for feedback beside every bed in every ward in Aberdeen royal infirmary, and plugs to plug them into, that would be a substantial infrastructure cost.

Dr Joseph: It would not be necessary to have it for every single bed. Rooms could be allocated where it could be done, and they could be provided with an internet link or videolink for the person who needs translation or interpretation.

Nigel Don: Okay, thank you. Am I right in thinking that we do not yet know very much about what happens in the rest of Scotland? You are reflecting on the situation that you are aware of in Aberdeen, which I fully understand, and you are asking the committee to inquire about what might be happening around Scotland.

Dr Joseph: We have identified that there is an unmet need, and that doctors are reluctant to use face-to-face interpreters or Language Line because of the cost, so if we find a cheaper alternative that also has a visual dimension, doctors might be less reluctant to use it. They might use it more liberally; they might use it when they need to use it. We have a few cases where people have been reluctant to use it.

Daniela Rotariu (Multi Ethnic Aberdeen Ltd): We are aware of some cases in which people who belong to ethnic minorities have had to rely on friends or family members to interpret, which means a breach of doctor-patient confidentiality. There was a case of a Polish woman who repeatedly requested a Polish interpreter but was refused. Finally, she brought a friend to her antenatal appointments, and it was a very embarrassing situation for both of them. If the interpretation could have been done via a web link and a female interpreter could have been provided, it would have reduced the stress for the patient and for the interpreter.

Nigel Don: Finally, do you have documentary evidence of doctors not wanting to use the interpretation service because of the cost? If that is the case, it is quite worrying.

Daniela Rotariu: We have patients' experiences.

Dr Joseph: We have also talked to consultants who say that it is too expensive.

Nigel Don: Have you taken that up with NHS Grampian in any other forum?

Dr Joseph: NHS Grampian has sent me the figures for how much it spends every year on interpretation and translation.

Nigel Don: But it has not specifically addressed the issue of doctors or consultants saying that they do not want to use the interpretation service because of the cost.

Dr Joseph: Consultants have told me that directly.

Nigel Don: Thank you.

Rhona Brankin (Midlothian) (Lab): Thank you for coming to the committee. The information in front of me states:

> "NHS Health Scotland is working with procurement specialists ... to develop proposals for national contracts …

A draft contract is expected to be available for consultation in autumn 2009".

I presume that you would agree that a national service is required and that, wherever people are in Scotland, they should have access to the same sort of services. What concerns do you have about the planned national contract? Do you know about it?

14:15

Malcolm McCarthy (Multi Ethnic Aberdeen Ltd): We have not been party to a consultation process on that. The committee needs to be aware that coming here today is the first step of the journey for us. If the committee is supportive of the petition, we are happy to progress the matter, but you should be aware that there will be gaps in our knowledge and experience. We are currently finding out whether there is support for the principle.

Rhona Brankin: Absolutely—I accept that. If the committee decides to take the petition forward, the next stage will be to find out from the Government what, if anything, it has in train.

Malcolm McCarthy: We have a body of anecdotal evidence of people's experiences—mainly those of our volunteer group—which, along with the partnership that we have with the Parliament, has driven the issue. We examined the information underpinning the issue that was available to us, which came from direct contact with people who in some instances do not wish their names to be put into the public domain, for a number of reasons, and from desk web research. It is important that people appreciate that that is the stage we are at.

Rhona Brankin: So we would be able to elicit that information. Thank you very much for that.

Robin Harper (Lothians) (Green): Somewhere at the back of my mind, I remember that, a few years back, there was talk of setting up a videoconferencing service for consultants so that they could watch one another operating and swap experiences. Do you know whether that ever got anywhere? I am trying to ascertain whether there are already videoconferencing facilities in our hospitals that could be used—in other words, that there is a starting point for the idea that we are discussing.

Dr Joseph: As far as surgery is concerned, I think that some videoconferencing is going on already, but we are talking about an internet link, which would be probably less expensive than video.

Anne McLaughlin (Glasgow) (SNP): You are right to raise the issue. I am a Glasgow MSP, and I know that it is a big issue in the city, where around 140 different languages are spoken as a first language. I am a member of the cross-party group on racial equality, at whose last meeting we discussed the fact that, for example, even if there are only two people in Orkney who speak something other than English as their first language, it should not matter. They should still be entitled to access the same health and education services.

Would it be worth having some type of pilot? Has there been a pilot scheme anywhere in Scotland? In the long run, I think you are right that we would save money, as Nigel Don said, but an initial investment would be needed, and right now there does not appear to be much money around. It might be worth carrying out a pilot scheme somewhere and considering the international examples to find out what the effect would be on improving people's access to health care.

I agree that the visual part of communication is important. People can communicate without the visuals, but the visuals make it so much easier to understand. It would be good to find out how much evidence there is that such a scheme would improve people's access to health care, what initial investment would be needed and what savings we could make in the long run. It would be good if, before money becomes available to make that initial investment, we could have a pilot scheme and could get more evidence from international examples. Would that be worth considering?

Dr Joseph: As we said, with Language Line the visual cues are missed out. What I propose is a happy medium between what Language Line offers and face-to-face interpretation, which would involve talking to a real person and being able to see an image of them. It would be worth while having a small-scale pilot to see how that would run.

Anne McLaughlin: I know that we will come on to talk about how to progress the petition, but it would be worth while getting more information on other countries that have adopted such a system and the benefits that they have accrued from doing so.

John Wilson (Central Scotland) (SNP): Good afternoon. I want to follow up on Anne McLaughlin's questions. How did you get the figures for how much it would cost to provide such a service from other countries? It is interesting that you say that an interpreter could be obtained at a cost of £5 an hour if we did it over the internet from Poland. How did you get your figures?

Are the interpreters from other countries that you refer to medical practitioners? I think that you indicated that they might just be volunteers. That raises an issue of patient confidentiality, which has already been mentioned. I know that not every NHS board relies on the telephone interpretation service. Some health boards rely on people who come in and interpret on behalf of foreign language speakers—I have seen that happen in my own general practitioner's surgery. Would the people from other countries who would interpret on behalf of GPs or consultants be medical practitioners? What about confidentiality? How will the problems of confidentiality that we face at the moment be resolved by getting someone who might be 5,000 miles away to interpret on behalf of a patient who is seeing a consultant or a GP?

Dr Joseph: The figures that I quoted were provided by people who do interpretation and translation work in Aberdeen. They contacted people in their home countries to find out what the rates are there.

John Wilson: Are those people who provide interpretation services in Aberdeen identifying that there is a problem with the number of interpreters or with interpretation services as a whole in Scotland? Does the fact that someone who does interpretation in Aberdeen has to contact someone in Poland to find out whether interpretation can be provided more cheaply through an internet service indicate that are there issues to do with what is being delivered in Scotland, or is it simply that interpretation can be delivered more cheaply if we go on the internet and pay for the service to be provided by someone in another country?

Dr Joseph: The figures that I quoted are the rates in the countries of the people concerned. That is what translation or interpretation would cost in their countries.

John Wilson: If those are the rates in their countries, we need to ascertain what the chargeable rate would be for a GP or a consultant in Scotland who wanted to buy into such a service. There would be a cost involved in doing that, which goes back to my question about whether the services in question would be provided by medical practitioners in the country of origin or by volunteers, which was not answered. You say that it costs £5 an hour to provide an interpretation service in Poland. I am trying to work out what the chargeable rate would be for a GP or a consultant who wanted to buy into that service. Would it be £5 an hour?

Dr Joseph: Those are all things that need to be investigated. Linked to that is the computer element, but I have checked that out and it is inexpensive. I understand that people in those countries are willing to provide translation at that rate. When we use face-to-face interpreters, there are also travelling costs. Sometimes, we have to get people to come all the way from Derby to Aberdeen to provide translation and interpretation services. The proposal will cut out those costs.

John Wilson: Among my other questions, I asked whether the interpretation services in the examples that were given are provided by medical staff in those countries or by ordinary volunteers.

Dr Joseph: Well, the interpretation and translation services that are offered in the UK are not necessarily provided by medical people.

The Convener: One of the concerns is about the volume. In Glasgow, for example, there has been a substantial number of new residents from the Slovak Roma community, which is something that Anne McLaughlin and I deal with on a day-to-day basis as representatives in the area. We face problems in getting the right languages to engage with that community, which is substantial in—and unique to—our part of Glasgow. There are also problems with getting enough capacity in the right languages in other parts of Scotland where there have been economic shifts and changes in the nature of the workforce, particularly around Inverness-shire and other parts of the Highlands.

Are health boards up to responding to that scale of both movement and numbers? Can they deliver health care and support to the people who present themselves? Our experience is that GPs are under incredible pressure and face problems with getting information and understanding people, never mind analysis of their medical conditions. Do the health boards understand the scale of the problem throughout the country?

Malcolm McCarthy: I do not think that they do. That is part of the issue that we are looking at today. I would be the first person to put my hands up and say that we do not have detailed costings. The question about that is an extremely reasonable one, but it is one for the next phase. We are saying as a nation that we want to live longer and healthier lives and we want that to be one of our national outcomes, but the bottom line is that we will not do that unless we have an effective service that is fair and equal for everybody in the country.

If we have five volunteers in a small charity such as MEAL who are saying to us, "Excuse me, your health service is very good, but it has gaps for people who cannot speak English," that is an issue that needs to be addressed. To consider how it should be addressed is the next step forward.

The Convener: Our briefing paper on the petition states that a draft contract was expected to be available for consultation in autumn 2009, following work by procurement specialists in the NHS to develop proposals for contracts for interpretation. Have you seen that draft contract?

Malcolm McCarthy: No.

The Convener: Has it been delayed, or did it never appear?

Malcolm McCarthy: To be honest, we do not know. We are not party to that discussion.

The Convener: Okay.

Daniela, given your experience with different communities, do you believe that there is a major gap in understanding because the nature of the languages and dialects might not be initially obvious?

14:30

Daniela Rotariu: Yes. Not all languages are represented, so there can be difficulties with understanding people who speak more obscure languages. Let us say that there is an emergency case involving a British citizen. They speak English, but they are unconscious and their next of kin is somewhere in Malaysia. It will be difficult to get their next of kin to give consent for them to have an operation unless we have the links in place.

I had to fill in registration forms with a GP five years ago for my family and me. I was just given the forms, and nobody asked whether I needed any help. I did not know that interpreting and translation services were available at the surgery. I had to record very important information on the forms on, for example, allergies and previous health problems. I stood there for two hours, but nobody asked whether I was all right. I would therefore say that even some general practices are reluctant to let people know that there is an interpreting and translation service. The situation may be better now, but I am not aware of that.

The Convener: The other problem that I think all members have encountered in different areas is that the time taken to deal with what you described means that less consultation time is available for everybody in the community, including newcomers. Might your proposal reduce that kind of delay and address that time management issue?

Daniela Rotariu: It will, because the waiting time for an interpreter for a planned appointment is 24 hours, but it could be more if the language concerned is more obscure, and sometimes no interpreter is available. There is no 24-hour provision of interpreter services.

I have an example that involves a woman who was in Aberdeen maternity hospital giving birth to her first daughter. She does not want her name disclosed, because she had other issues as well as the language barrier. The doctors offered her access to the Language Line service from time to time, but they mainly relied on her husband to be there and do the interpreting. That was not right, because her husband is not a doctor and has no knowledge of medical terms. In addition, she was placed in the position of having to eat whatever was given to her because the menu was in English only. If the doctors wanted to say something to her, they just waited until her husband came. They were sometimes not happy to use Language Line.

Therefore, there is a system of interpreting and translation, but it is not efficient and it is not used thoroughly.

The Convener: Do members have any final questions before we go to comments?

Anne McLaughlin: Dr Joseph argued that some doctors do not use Language Line because of cost, but it does not sound in Daniela's example that the problem was cost. It seems that it was just a hassle for the doctors to use Language Line, so they just waited until the husband got there. What the petition proposes sounds like a brilliant idea, but are you convinced that doctors, particularly those who do not use Language Line, would use such a service for their patients? Would more work have to be done to convince medical staff that they need to take into account the patient's right to access an interpretation service, rather than wait until somebody who can speak the patient's language happens to pass by?

Daniela Rotariu: If the doctors know that the service exists and that it is much cheaper than what they currently use, I think that they will use it.

Dr Joseph: They will use it more liberally.

Daniela Rotariu: It would be more beneficial for the doctors and for the patients, and would reduce waiting times.

Anne McLaughlin: You think that it is just cost that stops them using Language Line.

Dr Joseph: Yes, from what I understand from the consultants.

Malcolm McCarthy: If what the petition proposes were to be introduced, we would need to consult extensively on it. History tells us that many good ideas have been delivered to people without asking them in the first place whether they think that it is a good idea. As far as I am concerned, a consultation is critical. We could ask five consultants whether it is a good idea, but there are more than five consultants in the country. If it is decided that the issue should be addressed in the way that we have suggested, consultation and further research will be essential before things can move to another level.

The Convener: I am aware that we have other items on the agenda, so I ask committee members to make suggestions on progressing the petition.

Nigel Don: I think that, with the audiovisual element that we discussed, we have already taken a step forward from the original position that was set out in the petition. That is good, but the measure needs to be researched on two, perhaps three levels. First, we need to find out what the world knows about it and whether we can pick up on any examples elsewhere. Secondly, we have to work out the cost of an existing—or potential—audiovisual system. Thirdly, we should also ask the medical fraternity how it feels about this opportunity. Anecdotal evidence suggests that people feel that the current services are not what they would altogether want, and we need to think about carrying out research or getting some research carried out on whether this idea is as good as has been suggested—or, indeed, as good as we think it is. Mr McCarthy is absolutely right. We need to ask the right people the right questions and undertake some research. However, how we do that is not entirely obvious to me. I guess that the first port of call is to ask the Government what it is up to, but other people might be able to help.

Nanette Milne (North East Scotland) (Con): Perhaps we should get in touch with the Scotland Patients Association to find out whether it has received representations from patients on this issue, how it feels about it and whether it has done any work on the difficulties that people in Scotland who do not speak any English face in accessing NHS facilities.

Rhona Brankin: That would be useful, but we should also contact the communities that we have been talking about through community leaders or organisations. It is also important to get an update from NHS and local health boards.

John Wilson: If we are doing that, we should contact a selection of them. I was particularly struck by the comment that an estimated 140 languages are spoken in Glasgow alone. It would be useful to ask NHS Grampian, NHS Borders and NHS Greater Glasgow and Clyde about the number of languages they cater for and how GPs, consultants or whoever else identify and deal with any new language that might come up.

We should also ask the Equality and Human Rights Commission to tell us the number of identified languages in Scotland. Four or five years ago, before I came to Parliament, I asked about the translation of documents into Polish, only to be told that the Scottish Executive did not have a budget for that. We have moved on since then, but it would be useful to find out the current position.

Of course the issue is not just about interpreting spoken language. We should also consider the translation of written language, which I realise is a more expensive undertaking, and ask the EHRC what it is doing not only about interpretation of the spoken language but about translation of the written material that is produced by health boards and other public bodies in Scotland.

Anne McLaughlin: It might be interesting to get a few international examples and to find out what approach is being taken down south in areas of Wales and particularly England with a high concentration of people who have another language as their first language.

The Convener: Okay, so we want to keep the petition open. We will explore and gather information as Malcolm McCarthy suggested. We will bring it back to the committee, and you will be kept fully up to date on its progress. Between then and now, you are free to submit any further information on the petition. Hopefully it will benefit you and, in the long term, it might be of benefit to those individuals who need to access NHS services in Scotland.

Low-dose Naltrexone (PE1296)

The Convener: The next petition is PE1296. I welcome Robert Thomson on behalf of LDN Now, which calls on the Scottish Parliament to urge the Government to make low-dose naltrexone readily available on the national health service to auto-immune disease sufferers, as well as to those who suffer from other conditions that are not classified as auto-immune, such as HIV/AIDS, cancer and infertility; to ensure that each NHS board area thereby reduces the danger of sufferers having to access riskier alternatives and incur higher costs by purchasing the drug through private medical providers; and to provide guidance to all general practitioners on LDN protocol and require them to collect the clinical data on LDN.

Along with Bob Thomson, I welcome Celia Danks and Margaret Anne Gachagan. I invite Bob to make his opening comments.

Bob Thomson (LDN Now): We will not be surprised if this is the first time that you have heard of low-dose naltrexone. Your first objective should be to ensure that NHS staff and their patients know the facts about LDN as a treatment for auto-immune diseases, cancers, HIV/AIDS, autism and infertility. We are not here to tell you that it is impossible for NHS patients to get LDN, because it is not. However, the decision to prescribe is left entirely with the doctor, who is often ill informed. To us, that is a serious failure to serve NHS patients and dealing with that should be your second objective.

At the root of those issues is a lack of clinical trial evidence. Naltrexone has been out of patent for 25 years, so we cannot reasonably expect private industry to do the research as there is no profit motive for it. The Parliament or NHS in Scotland should fund or co-fund LDN trials, because they would be a sound investment for huge long-term savings.

Naltrexone is a 32-year-old drug that has been licensed at more than 10 times the LDN dose for more than 24 years. It has been prescribed to pregnant women, and has also been used in infertility treatment. The only test dose that induced any reversible changes in liver enzymes was in excess of 300mg a day, which is 6,666 per cent of the LDN dose. Worldwide, 100,000-plus patients are taking LDN and there is growing evidence that it works. There are 80 published papers and 20 clinical trials. In 2007, a Penn State University study on Crohn's disease showed that 89 per cent responded and 67 per cent went into remission, and healing was seen. That has been repeated on a larger scale.

In a 2008 six-month trial in Italy, Gironi studied 40 primary progressive multiple sclerosis patients, of whom only one progressed to the illness and the rest stayed as they were. Furthermore, in a survey of more than 600 MS patients, 94 per cent reported an improvement after taking LDN. That is more than three times better than the response to beta interferon, which costs 30 times as much as LDN.

14:45

That last point about cost is vital. Consider some drugs that are in use just now. Tysabri, which is used for MS and Crohn's, costs £14,730 per patient per year. Mesalazine, for Crohn's and ulcerative colitis, costs £9,600 per patient per year. Azathioprine, for various auto-immune diseases, costs £4,435 per patient per year. All those drugs have serious side-effects.

We personally have saved the NHS in Scotland tens, if not hundreds, of thousands of pounds by taking LDN instead of those drugs. When Celia Danks was diagnosed with lung cancer in 2006, she was given six to 12 months to live. She asked her GP for LDN and he gave her it, probably because he thought that she had nothing to lose. Three years later, Celia is still here and her oncologist can see no evidence of the disease.

With £68 million in chemotherapy costs and 151,000 cancer deaths in the UK each year, should not LDN be the first option for cancer treatment? Privately, LDN costs £300 per patient per year. That is 6 per cent of the cost of the cheapest drug that I mentioned. A conservative estimate is that the UK NHS could save at least £800 million per year in MS treatment alone. Can we afford to dismiss those huge potential cost savings merely because the private sector has no interest in trials?

How would you feel if you learned tomorrow that you, your partner or your child had a chronic auto-immune condition or an incurable cancer? Knowing what you know now, would you not fight for the option of LDN treatment, or would you prefer to take your chances with the hugely expensive, serious-side-effect-laden drugs that are currently offered? Today, you can start the journey to ensuring that 5 million Scots know about LDN and do not have to go private to obtain it. You have the opportunity to make Scotland the global centre of excellence in LDN research and treatment.

The Convener: Thank you very much, Bob. As Margaret Anne Gachagan and Celia Danks will have seen from our consideration of the previous petition, all the petitioners should feel free to respond during the questions session.

Rhona Brankin: Clearly, the major problem is that LDN is not licensed at the moment, although the drug is used in some cases. To the petitioners' knowledge, has the Government previously said anything about LDN? The drug has not been on my radar and I have not read about it in the papers.

Bob Thomson: There has been a bit of a campaign, involving a loose affiliation of people, called LDN Now. Today at 4 pm, a 13,000-signature petition will be submitted to the UK's petitions system, when Dr Chris Steele from the television programme "This Morning" hands in the petition to 10 Downing Street.

Basically, the problem is that LDN is not very well known. I have dealt with about 12 different doctors and consultants in the NHS, but only two of them have heard of LDN. One of them was my GP, who refused to prescribe the drug. The other was a nurse, who had a relation who was taking LDN for Crohn's disease. So, yes, there is a problem of perception and knowledge.

However, the basic and fundamental problem is that there is not enough trial evidence. The whole system is currently predicated on the idea that pharmaceutical companies will spend money doing trials. Unfortunately, with the drug being out of patent, pharmaceutical companies would get no benefit from doing that. I do not blame them for that—they are in business to make money—but they have no incentive to trial a drug that costs £300 a year instead of a drug that costs £14,000 a year. The problem is that someone somewhere needs to do the trials, which are just not happening quickly enough for patients.

In effect, patients such as Celia Danks and myself are experimenting on ourselves with an unlicensed drug because we cannot obtain it through the proper channels. The doctors will not prescribe LDN because it is not licensed. The drug is already licensed at much higher doses. As is obvious from what we have said, safety has not been a question at those high doses. We are talking about a dose of 4.5mg, whereas the drug has been tested at up to 300mg. Even at those levels, there was little evidence of danger.

A doctor in Ireland called Dr Phil Boyle has prescribed the drug with great success to women who are trying to become pregnant. That is another issue. The drug has so many applications that people tend to think that it is some kind of wonder drug, as it is often portrayed in press articles. However, to be honest, we would then need to consider steroids as a wonder drug, given that they deal with lots of different conditions.

We simply need to get the trials done and get the evidence out there. At the moment, if a person goes to a GP—I am sure that this can be clarified—the GP can prescribe an unlicensed drug, but there will be a liability question. The GP and the pharmacist who dispenses it will be 50 per cent liable. Therefore, many doctors rightly shy away from prescribing unlicensed drugs, but that does not help the patient.

Celia Danks (LDN Now): That is not the only issue; there is also the science of low-dose naltrexone. The doctors know about high-dose naltrexone being given to opioid users—drug addicts and so on—but they are not aware of its chemistry. That does not help them to make decisions. They are not familiar with it, and many doctors like familiarity.

I read about LDN and asked my oncologist for it. I had gone through many things and seen many things on the internet. When I came across LDN, I looked at the science behind it and liked what I saw. I asked my oncologist whether he would give it to me, but he could not do so because of protocol. I then went to my GP, who said no because she did not know anything about it. The second GP whom I went to said that he would give it to me because I had nothing to lose. It was expected that I would be dead in a year at the most. I started to take LDN and have surprised them all because I am still here, and I am damn well determined to stay here. I think that that is down to LDN. It would be a public scandal if it were not investigated. In the meantime, people who are on it should stay on it, and doctors should be educated about it now.

Rhona Brankin: Is it licensed in other places in the world? Do people get it from enlightened GPs or order it on the internet?

Celia Danks: Some people order it from India and Canada on the internet and some get it from their GP or go to a private GP to get it. Holistic doctors in America, for example, are more prone to giving it. Over here, only Dr Tom Gilhooly in Glasgow, Dr Bob Lawrence in Wales and a spattering of GPs prescribe it. Approximately 6,000 people in Great Britain take it because they know about it, but let us remember those who do not know about it. Worldwide, we know of 100,000 people who take it.

Bob Thomson: Rhona Brankin asked whether LDN is licensed. It is important to say that many drugs that are not licensed, such as chemotherapy drugs, are routinely prescribed to people. It is strange that LDN does not seem to be treated in the same way. There are many perception problems and many education problems, as Celia Danks said. When naltrexone is mentioned to people, they immediately say, “Oh, naltrexone is for drug addicts.” One of our colleagues has talked to the health editor of *The Guardian*, who responded in that way. They said that the paper had already covered naltrexone and that it was for drug addicts. We are talking about a completely different application of the same drug. In low doses, the effect is the same, but it affects the immune system, and that is the effect that we are looking for.

Nanette Milne: I can see the problems. There is a catch-22 situation. If the evidence base does not exist, it is difficult for doctors to prescribe. I had not come across the drug either, but I am way out of touch clinically, so that is not surprising. High-dose naltrexone is licensed, but is it approved by the National Institute for Health and Clinical Excellence and the Scottish Medicines Consortium?

Bob Thomson: Yes. It is routinely administered. I think that it has been used for 25 years in America, but I am not sure exactly how long it has been used in the UK.

Nanette Milne: I wondered about that, because many drugs are not prescribed here until they are approved by the National Institute for Health and Clinical Excellence and the Scottish Medicines Consortium.

Bob Thomson: Naltrexone is very old: it goes back to 1967. It was initially developed for the war on drugs in the United States. The drug company was not too interested in it, which is probably why the patent expired before it was looked into in great depth; its development was more a matter of pressure from the US Government. It has been prescribed in doses that are very high compared with those that have been prescribed to Celia Danks and me. I take only 2.5mg, which works for me. The dose depends on the person. Naltrexone is not new; it is an old drug that has been neglected. We are doing our best to stop that.

Nanette Milne: I can see that we will have to ask questions, but I am not sure whether I see the way forward if there is no evidence base to take it forward.

Celia Danks: There is plenty of patient evidence. We are talking about more than 100,000 people that we know of worldwide and at least

6,000 in Great Britain. They are evidence, as am I. I am alive although I should not be. How can you possibly say that there is no evidence?

Nanette Milne: It is just that, in the modern world, trials are set scientifically.

Bob Thomson: I have lost 30 per cent of my kidney function to mesalazine, a drug that has been trialled, authorised and licensed. That does not mean that it is safe or that bad things cannot happen to those who take it. No bad side effects have ever been recorded as happening to anyone who takes LDN. The most commonly reported side effect is lucid dreams—sleep disturbance, that is all.

Celia Danks: That is worth suffering for a while.

Bob Thomson: In fact, one of our doctors has said that LDN is statistically safer than paracetamol.

Margaret Anne Gachagan (LDN Now): We agree that we need evidence—that is why we are here; we want people to take that point on board—and need public money for it. Private money will not do it because the drugs companies will lose money and profit not only on LDN but on all the other drugs. Bob Thomson and Celia Danks would not have chosen to use some of those drugs before they came across LDN.

I am here because I have a friend who has multiple sclerosis who came across LDN through their own research. They are using it and the positive impact that it has made on their quality of life is phenomenal.

Yesterday, I spoke to Dr Tom Gilhooly, who said that LDN is a phenomenal drug. The sooner the evidence is available, doctors hear about it and patients hear that doctors are confident in it, the better. I am frustrated; I tell lots of people how LDN can improve their quality of life and, as in Celia Danks's case—and others, I hope—can extend life. However, they are not confident because the doctors are not confident. They do not have the energy or confidence to go and argue for a drug.

That is why we are here and we hope that you will take that on board.

Celia Danks: An old lady who lived in Falkirk was diagnosed with lung cancer and her daughter in America asked me to keep an eye on her, so I did. She was not offered any chemotherapy or radiotherapy because she had some underlying problems, which I did too at the beginning. She died last week but if she could have been offered LDN as a matter of routine, it could perhaps have given her more time with her family and given her hope. As it was, she had none. That is dreadful.

Bob Thomson: We often come back to the point that part of the general practitioner's Hippocratic oath is "First, do no harm." LDN does no harm; there are no serious side effects. The worst that can happen is that somebody takes it and it does not improve their life much. People who find that it works find that they get benefits pretty quickly. It would take only a few weeks to say whether the drug worked for somebody. People can wait months for chemotherapy drugs, so why can they not be on LDN in the meantime? What is the worst that can happen to them?

Celia Danks: Nothing.

Bob Thomson: It is incomprehensible that we are having the discussion. Why are we even talking about it?

The Convener: I am conscious of the time. A number of members are keen on the issues that your petition has thrown up, so let us try to identify what they are.

Anne McLaughlin: I am glad that Celia Danks is still alive and that LDN has helped her so much. Bob Thomson made a good point when he asked us to think about what it would be like if a member of our families was diagnosed tomorrow. I have looked at the list of conditions that the petitioners say LDN can help and I am thinking about all the people I know who suffer from those conditions and wondering whether I should tell them about the drug. I have also lost family members to some of those conditions. That makes me think that, if anybody was convinced that the drug would work, they would fight tooth and nail to get it for their family members.

The important point is about a clinical trial. You said that the drug does no harm, but the point of a clinical trial is to show that that is the case. I understand your point that one reason why clinical trials are needed is so that GPs and patients feel more confident in using LDN.

I used to work for the organisation that is now called Cancer Research UK. Has that organisation or other similar ones said anything on whether they would run clinical trials?

15:00

Celia Danks: I have just written to Cancer Research UK. The first time that I wrote, it was interested, so I was scandalised when I found that it was not willing to consider a trial. We must remember that Cancer Research UK is probably sponsored by the very drug companies that do not want LDN. Cancer Research was not really interested—it thinks that LDN is one of those fads like the Budwig diet. I have written to Cancer Research again and I am waiting for a reply. I asked how much expenditure goes on the more vicious cancers, such as lung and pancreatic cancers. Those get the least funding, whereas breast and bowel cancer get far more funding from Cancer Research UK. I am waiting for a response to that letter.

Anne McLaughlin: From my experience of working with Cancer Research UK, I know that it raises funds from a variety of sources, but that it is absolutely principled in that it does what it believes to be right, regardless of the source. Once this discussion is finished, the committee will consider who we will contact to make progress on the issue. You have written to Cancer Research UK, but it would be worth while for us to write to it, too. I do not know a great deal about the issue, but we should write to whichever organisations perform clinical trials, other than drugs companies.

Celia Danks: It would probably be done by a university, funded by the Government. As you said, the big pharmaceutical companies will not touch the drug, as it is out of patent and worthless. That is the same as the situation with aspirin 30 years ago.

Bob Thomson: A trial is the important thing. We look to you, as public servants, to ask about all the avenues. Basically, private industry has failed us. That system does not work, because we cannot get a trial of the drug. To be honest, the GP system has failed us, too. One good point that has been raised is about what happens if somebody’s GP prescribes LDN on the NHS, but the GP retires and the other GPs in the practice refuse to prescribe it. If the patient is not exactly flush with cash and cannot afford to go private, what would they do then? Some people have asked whether that is a human rights issue, because people are being refused treatment. Those are the issues that people have to deal with. They have to find out which GP they can go to to get the drug. How do they know? Do they have to keep phoning GPs until they find one in their area who will prescribe it? That is not a satisfactory state of affairs.

Celia Danks: It is not as if people can swap GPs at will just because they want something from one that they cannot get from another. That is just not allowed.

Bob Thomson: I work freelance, so I am not being paid for being here today and I am losing money. I am not doing this for me, because I can afford to go private, but many people cannot and many people do not even know about the drug. That is why we are here.

Robin Harper: From what we have heard so far, it is clear that naltrexone has the potential to be shown to be extremely efficacious in the treatment of a fair number of conditions but, as you have presented to us, a clinical trial is needed. There is a basis for a clinical trial, because 6,000 people are currently taking low-dose naltrexone.

Bob Thomson: There have been trials already, but they are on a smaller scale because they are coming out of universities.

Robin Harper: My point is that we have those 6,000 people already, so surely, notwithstanding concerns about medical confidentiality, through their doctors it would be possible to get enough of them to volunteer to continue on the drug and to subject themselves to whatever tests a clinical trial would require. There is huge potential, so we need to ensure that a trial happens.

Nigel Don: The issue is hugely interesting and obviously very important. We have all got the gist of what you are trying to do. What follows is not meant to be cynical; I am just trying to pick up on the wonderful list that you have given us of conditions that low-dose naltrexone treats. A clinical trial of a drug is designed to deal with a particular condition. Patients who have that condition are found and are given either the drug or a placebo. However, your list includes Alzheimer’s, multiple sclerosis, rheumatoid arthritis and a range of cancers. I am not a doctor, but those seem to be very different conditions. What would a clinical trial look for if there were four completely different conditions to assess?

Celia Danks: Those conditions have a common denominator, in that it is the immune system that is affected. I do not know whether you know the action of low-dose naltrexone. When a drug user takes it, it blocks the receptors on the cells and stops the feeling of pleasure associated with the drug. The dosage is minute—only 4.5mg—but that is enough briefly to blockade the receptors on the cells. The body is fooled into thinking, “Gosh! I haven’t got enough endorphins,” and the level of endorphins in the body is raised. In turn, that stimulates homeostasis. Is that clear?

Nigel Don: It would be absolutely clear if I understood it, but I do not. However, that is my problem, not yours. Do not worry about it.

The Convener: That is why you are not a doctor, Nigel.

Nigel Don: Exactly.

You say that there is a common denominator in the immune system, which is absolutely fine. That is where I will have to stop. It would be for the doctors to sort out how on earth a clinical trial could be conducted on the immune system, which is very complex. That would be for the clinicians to worry about—it is not my problem.

Bob Thomson: A number of different trials would be required for different conditions. The main ones that we have focused on include MS, which affects 105,000 people in Scotland and is a big problem here. That would be a great one to start with. Cancer is also a huge problem and requires huge expenditure. I bet that you get people coming here every day, telling you that they want money for stuff. We are telling you how you can save a lot of money.

Nigel Don: Okay. For the record, what you have demonstrated is the commonality—which I suspected, despite the fact that I am not and never will be a doctor—and the fact that proof of the efficacy of low-dose naltrexone in treating a huge number of conditions would require a large number of separate clinical trials. However, we will let the clinicians and statisticians worry about that—that is not your problem, nor is it mine.

Bob Thomson: The science of how LDN works on the different conditions has been pretty well covered. There has been 24 years of that in the US, but not at the trial level—guys in labs have been conducting minute experiments to see how it works. They understand that quite well.

The Convener: You will detect a keen interest in the issues that you have raised. We want to make progress. We have heard about Bob Thomson's and Margaret Gachagan's experiences, and we have had Celia Danks's personal testimony. Given the critical nature of what you were facing, Celia, it is tremendous to see you here today.

Celia Danks: It is horrendous for people not to have any hope or choice. Let us give them a choice.

The Convener: Okay. We will try to identify ways in which we might move the petition forward. I invite committee members to suggest people with whom we might explore the points that the petitioners have raised.

Anne McLaughlin: I know that we will contact NHS boards and the Government. I suggest that, given the conditions that Bob Thomson has cited, we also contact the MS Society Scotland, Alzheimer Scotland, Cancer Research UK and other cancer research organisations.

Bob Thomson: You might also contact the National Association for Colitis and Crohn's Disease.

Anne McLaughlin: We could contact the main organisations for the main conditions that the petitioners suggest that LDN could treat, asking them what their clinicians and researchers think about its effectiveness and their possible involvement in the conducting of clinical trials.

Celia Danks: I think that the clinical trials bit will be good, but their knowledge of it will be of its use by drug users. A lot of them will dismiss its use in such a low dose and will say, "Oh, you're on about LDN again."

Bob Thomson: To be fair, I think that they are reluctant, being the huge organisations that they are, to give people false hope. That is part of the problem; they do not want to advocate anything unless they are absolutely certain that it works. Obviously, that comes back to the trial issue.

Celia Danks: I could tell you about a trial that was done on pancreatic cancer by Dr Burt Berkson in America. Pancreatic cancer is a big killer—the person is dead within a year. I believe that he used low-dose naltrexone with low-dose chemotherapy and a substance called alpha-lipoic acid. Seven years later, that patient is walking about. If it does not work for everybody, that is fine; aspirin does not work for everybody.

The Convener: We need to gather all that information and see whether we can chap on a few doors. Ultimately, you want some of these doors to be opened to something more extensive, but we must chap on the doors first. Let us identify whom we wish to contact.

Nanette Milne: We should get in touch with the Scottish Medicines Consortium and probably also NHS Quality Improvement Scotland to ask what they think about LDN, whether they are aware of any indications or contra-indications, and what their reasoning is.

Bob Thomson: You mention the Scottish Medicines Consortium. I have not found it easy to determine what its metric is before it would licence LDN and what evidence it needs—that is not very clear.

The Convener: We want to pull together all the key organisations or institutions that deal with such issues, such as the Scottish Medicines Consortium, NICE and a number of others. We should raise the issue with the appropriate representative bodies of the pharmaceutical industry or the pharmacists' professional bodies. I am conscious of what Bob Thomson has said about the economics of the situation and the incentives for the private sector in respect of drugs provision. It is not necessarily in their interest to put the information together, so we must establish whether other specialists can give us advice on the issue.

John Wilson: It would be useful to write to some health boards to find out how extensively LDN is being used. The petitioners have mentioned 6,000 people throughout the UK using it and have said that certain GPs are readily giving out LDN to patients who require it, but perhaps it would be useful to write to Greater Glasgow and Clyde NHS Board—

Margaret Anne Gachagan: There is only one chemist that dispenses it—Dicksons in Rutherglen—so that information could come from there.

John Wilson: We should get the information from the health boards, convener. For example, it would be useful to contact Lanarkshire NHS Board and possibly one other NHS board to find out whether they are aware of GPs prescribing the drug. As the petitioners said, MS is highly prevalent in Scotland; it may be that other GPs are prescribing the drug but that that is not being picked up. I know that there are GPs who prescribe certain drugs to patients although they do not necessarily want to be identified as prescribing those drugs. We should get the information from health boards, in case LDN is much more widely used than we understand it to be.

To follow up on Anne McLaughlin’s point, it may be useful to write to the charitable organisations. I understand what the petitioners are saying about some of the charitable organisations undertaking research, but the convener also made the point about the pharmaceutical companies perhaps being reluctant to see LDN in mainstream use, because it could undermine some of the drugs that they are marketing to health boards, GPs and others at a much greater cost than LDN. There is a market force element to the issue. We must ensure that the charitable organisations that Anne McLaughlin mentioned are looking at all the options for their members in respect of research into the diseases for which they collect funds; between them, those organisations have a very large pot of money for research and they give a lot of money to various academic institutions to carry out such research. If we could get some of that money tied into undertaking research on the impact of LDN, that would be useful.

Rhona Brankin: You said that research is going on in the US; it would be useful to get some information about the state of the current research.

Bob Thomson: I will give the clerk a CD-ROM that I have brought with me; it contains some information and links to various websites. The main epicentre of the research is Penn State University in America. Dr Ian Zagon and Dr Jill Smith are doing most of the research; they are currently doing research into Crohn’s disease. Even in Mali, an HIV trial is being undertaken by Dr Jacqueline McCandless, but that is charity funded. Work is always being done on LDN, but it is not yet being done on the scale that is required.

15:15

Celia Danks: I have with me some information on the trials. Would you like me to leave it?

The Convener: The clerks can pull together any information that you have for us. That will help the committee as we explore the issues, so thanks for that.

Thanks for coming to speak about the petition. When Bob Thomson contacted me and said that he was going on to the number 10 petitions website, I said, “Oh no, the Scottish Parliament Public Petitions Committee is much more effective.” I hope that your experience has been positive—I believe that we have a genuine opportunity through the structures in place in the Scottish Parliament to interrogate an issue. We cannot guarantee that people will always be ecstatic at the end of the process, but we can move on many of the issues that people are concerned about. I am delighted that you have had the chance, along with Margaret Anne Gachagan and Celia Danks, to come along and I hope that it has been a positive development for you.

Bob Thomson: It has been an opportunity to let you all know about LDN, and that in itself is positive.

The Convener: Thank you for your time. We will have a five-minute comfort break.

15:16

Meeting suspended.

15:22

On resuming—

Education (Scotland) Act 1980 (Parental Choice) (PE1284)

The Convener: PE1284, by Graham Simpson, calls on the Scottish Parliament to urge the Government to note the successful outcome of a number of legal cases brought by parents against local authorities involving placing requests for children and on councils to desist from applying any policy on class sizes that conflicts with the numbers stipulated in law and the statutory right of parents under the Education (Scotland) Act 1980 to choose the school that they wish their children to attend.

Elizabeth Smith MSP had been hoping to speak on this petition, but we spent a lot of time on the previous petitions and she has had to leave for an urgent meeting at 3.30 pm. Do members have any comments?

Robin Harper: As the petition makes clear, there is a problem: the law says one thing but something else happens in practice. The Government must either take effective steps to enforce the law or change it.

John Wilson: Under the current legislation, local authorities have to consider certain criteria in meeting a placing request. Correct me if I am wrong, but my understanding is that if a placing request puts undue pressure on a school's classroom or teaching provision it can be refused. In the cases that have been successful in challenging such decisions, the sheriff has felt that the school in question could meet the request. The issue raises a number of difficulties. If we went too far down the road by acceding to all placing requests, some educational establishments—some primary schools—could close if all parents decided that one school was better than another and made placing requests for it. That would undermine the process of delivering education locally for children.

Rhona Brankin: The petition was lodged on 5 October, but developments have occurred since then. The then Cabinet Secretary for Education and Lifelong Learning, Fiona Hyslop, announced that the legal position on class sizes would be reviewed, so we need an update on that.

The Convener: We will see whether the new incumbent's healing and conciliatory words make a difference.

Nanette Milne: It would be interesting to find out how a selection of local councils apply the policies on class sizes and whether that is within the statutory rules.

John Wilson: Given what Nanette Milne said, it might be useful—although it is a bit mischievous of me to suggest this—to contact East Renfrewshire Council, because a debate is taking place between it and a neighbouring local authority on placing requests.

The Convener: We want to make progress on the issues that the petition raises. As Robin Harper said, broader policies are part of the public debate that we as MSPs have in the chamber. This morning's announcement might mean that opportunities to amplify opinions are available in the next few weeks. I take on board all the comments.

Nanette Milne: I suggest that we find out what the Association of Directors of Education in Scotland thinks of the petition and what parents think through the Scottish Parent Teacher Council.

Rhona Brankin: The issue is complex. As has been said, two policies are competing and both are popular with parents. If we ask for evidence from East Renfrewshire Council, we need evidence from Glasgow City Council, too, because specific circumstances apply there, which do not necessarily reflect what is happening in other areas.

John Wilson: I said that I was being mischievous.

The Convener: Never, John.

I thank members for their comments. We will take the suggestions on board.

Safe Guardian Law (PE1294)

The Convener: PE1294, by Allan Petrie, calls on the Scottish Parliament to urge the Government to implement a safe guardian law to allow family members to care for children who might be at risk. Do members have comments?

Robin Harper: The question is more about regulation than law. Nothing prevents a kinship carer from being identified to care for a child who is at risk. The petitioner would just like that to happen immediately, which I presume is to ensure that kinship carers have the opportunity to offer their services first. That is my understanding—I do not know whether it is correct.

Nanette Milne: I have concerns about kinship care matters. I am involved in cases locally that involve the question of where kinship carers stand and whether they should be regarded more as foster or even adoptive parents. We should proceed with the petition and try to find out information.

15:30

Nigel Don: It is worth putting it on the record that I have known Mr Petrie for some time and I have talked to him about the petition.

My understanding is that the petitioner is simply asking that members of the same family be higher up the list of those to whom the authorities naturally turn. He would like them to have some rights to be heard. I have no idea how on earth we get the balance right; I think that we just have to talk to the Government and ask it to show us a way through.

Rhona Brankin: I echo that. We all realise that many children could be supported through kinship care in many circumstances. We know that there are a lot of issues around kinship carers and how they are supported, but I would certainly be keen for the committee to look at how the option of kinship care can be considered as early as possible in the process.

Robin Harper: I add that, from my experience on the children's panel, there should not be an automatic assumption that kinship establishes a right or that a member of the extended family is necessarily the best person to care for the child. Sometimes, it is the entire extended family that is the child's problem.

Rhona Brankin: It is having the option that is important.

Robin Harper: Yes. I understand and sympathise with that.

The Convener: Okay, so we want to explore those issues with the Government department that is responsible, the minister, the British Association for Adoption and Fostering and so on.

John Wilson: I suggest that we also write to the Association of Directors of Social Work, because one of the issues is clearly how social work departments interact with the family situation. I would therefore like to get a view from the ADSW.

Rhona Brankin: We should also contact the Scottish kinship care network.

Nigel Don: It is perhaps worth noting that there is not going to be a tidy answer—this is not going to be an easy one. It is always a question of striking the right balance. As Robin Harper said, sometimes the extended family are precisely the right people and sometimes they are precisely the wrong people. There is no prescription, and there is never going to be one.

The Convener: Thank you for your comments on that. We will progress the petition.

Planning
(Protection of National Scenic Areas)
(PE1295)

The Convener: The final new petition today is PE1295, by Flora Dickson. It calls on the Scottish Parliament to urge the Scottish Government to clarify how sites that have been identified as areas of national scenic value can then be considered as suitable locations for the building of crematoria and other developments; whether allowing applications under the planning system to build crematoria and other developments runs contrary to the reasons for sites being designated as such; and whether the promotion and protection of our natural heritage should merit the conducting of a full and robust environmental impact assessment for every planning application.

I welcome Christine Grahame, who is a frequent visitor to our committee.

Christine Grahame (South of Scotland) (SNP): Unfortunately for you, convener.

The Convener: It is always a pleasure, Christine—you know that. I invite you to make some opening comments on the petition.

Christine Grahame: Thank you, convener. I appreciate that the committee rightly does not involve itself in specific planning applications, but let me explain briefly, by way of background, that the petition came about because of an application to build a crematorium in the Borders. That is much needed—I did a survey of 1,200 households and 97 per cent agreed that they want one—but people were split down the middle about whether it should be where the council wants to put it, which is in a designated national scenic area in the Eildon hills, or elsewhere.

Scottish Natural Heritage referred the matter to the Government, which has not called it in. The committee will see from the Scottish Parliament information centre briefing paper—which is very helpful, certainly for me—that SNH may send such applications to the Government, which then decides whether to call them in. If it decides not to, that is the end of the matter. In a way, the current issue is now back with Scottish Borders Council, where it belongs.

Two general issues arise from the petition. One is about the status of national scenic areas and whether any worth is put on calling them that, given that the protection that they are afforded appears to be limited. The second issue is about environmental impact assessments. I note from the SPICe briefing paper that waste management regimes for crematoria are set out in the Environmental Protection Act 1990 and related legislation but that it is not mandatory for consents to be in place before planning applications are granted.

Mortonhall crematorium, for example, covers a large area; it contains a large building and requires access roads, traffic management and parking. There are a lot of buildings on such sites, not just one. Even Warriston—I am afraid that I know only the Edinburgh crematoria—has a couple of areas to which families can go, waiting areas, parking, landscaped areas and traffic issues. On that basis, it seems rather weak that no environmental impact assessment should be required. Before putting any building into an area of national scenic beauty, we should want to know what impact that will have on all aspects of the area. That is true regardless of whether the building is a crematorium or a commercial operation of any kind; of course, a crematorium is a commercial operation.

We need to consider what protection is offered to areas of national scenic beauty and what environmental impact assessments are required. I accept that the requirements for crematoria were subject to a review in 2008 and that there is no prospect of changing them. However, the fact that it is not mandatory for an environmental impact assessment to be carried out before planning permission is granted is something of a lacuna. I find that quite strange.

Robin Harper: It may be strange. I am trying to think my way through the issue. We have been furnished with the relevant provisions of Scottish planning policy 14, which states:

> "Development which would affect a designated area of national importance should only be permitted where … the objectives of designation and the overall integrity of the area will not be compromised".

That is a kind of environmental assessment.

SPP 14 also refers to whether

“any significant adverse effects”—

that is very specific—

“on the qualities for which the area has been designated are clearly outweighed by social or economic benefits of national importance”.

It is for councils to make that judgment, with reference to the wishes of local people.

Given the population density of the Borders, I would not have thought that the area would need a crematorium anything like the size of Mortonhall or even Warriston, so I am not sure that the comparison is useful. However, Christine Grahame makes a sound point about the lack of a requirement for an environmental impact assessment. I should have thought that such an assessment would be required. Unfortunately, if that is not in the legislation, it is not in the legislation, but councils could require an assessment to be carried out as part of the evidence.

If a development is over a certain size—I cannot tell you exactly what size—an environmental impact assessment must, in law, be carried out. Developments can escape such assessments only if they are relatively small and minor.

Rhona Brankin: This policy area remains far too vague. It would be useful for us to get clarification from the Government of its position.

The Convener: Would Anne McLaughlin like to comment?

Anne McLaughlin: I was not indicating that I wanted to speak, but I will.

The Convener: Does anyone else want to speak? [*Laughter.*]

Anne McLaughlin: I was just playing with my pen.

I am probably not of much use to you. I have read somewhere that crematoria are not good for tourism, but the first thing that I do when I go on holiday is visit the local cemetery, as cemeteries are fascinating places. However, I agree that we need to get clarity on the issue.

Rhona Brankin: Is it really the first thing that you do?

Anne McLaughlin: Well, perhaps not the first thing.

The fact that I love cemeteries and graveyards does not mean that everyone else does. I take seriously the point that the petitioner is trying to make.

The Convener: Anne McLaughlin will be the cheerleader for next year’s Crypt-Kickers tour.

Rhona Brankin: When I said that we need more clarity about Government policy, I was referring to national scenic areas as a whole. Much more clarity is required.

The Convener: We want to make progress on the petition. We will ask a series of questions to the Government and Scottish Natural Heritage about criteria, assessment and how applications emerge.

There will no doubt be continuing pressure for a crematorium from people in areas such as the Borders, but the issue is where appropriate locations should be and how the matter can be managed at a local authority level but within the broader parameters for sites of natural interest and so on.

Christine Grahame: The wording in the briefing from the Scottish Parliament information centre is:

“Development which would affect a designated area of national importance should only be permitted”.

Is “should” the same as “must”?

The Convener: I am not a lawyer; you are, Christine.

Christine Grahame: I am. “Must” is very different from “should”. I think that there has been some discretion there.

The Convener: Are there different prices for “must” and “should” among lawyers?

Christine Grahame: Yes. “Must” is easier. I suggest that we should investigate why the word “must” is not used—the wording is:

“Development … should only be permitted where … the objectives of designation and the overall integrity of the area will not be compromised; or … any significant adverse effects on the qualities for which the area has been designated are clearly outweighed by social or economic benefits”.

Some balancing has been done there. The committee might wish to raise that with the minister.

The Convener: I am getting old, and I would call that the Petrocelli option: to explore the legal meaning—

Christine Grahame: Only you and I can have seen “Petrocelli”.

The Convener: No—there is a wee golden satellite channel where you can catch up.

John Wilson: I suggest that we also write to the Scottish Environment Protection Agency to get its view on siting crematoria. It is important that SEPA is called on to comment on such issues.

The Convener: Is this your final final point, Christine?

Christine Grahame: It is my very final final point—I am not pushing my luck. Would it be possible to ask Scottish Borders Council whether it has done an environmental impact assessment regarding traffic, parking and size? I refer again to the wording in SPP 14, which begins:

> "Development which would affect a designated area of national importance should only be permitted".

It would be interesting to know whether the council has complied with the policy, even though it might not be mandatory.

John Wilson: Is the application to build a crematorium by Scottish Borders Council?

Christine Grahame: No, I think that the council has got a private developer to do it. You have caught me a bit, but I think that is the case. [*Interruption.*] I am being told by Chris Harvie, who lives in Melrose, that it is indeed a private developer. The council is the planning authority, obviously.

John Wilson: I suggest that we write to Scottish Borders Council to find out whether it has carried out an environmental impact assessment and whether it has asked the contractor that will develop the site whether it has carried out such an assessment.

Christine Grahame: If the council had been both the developer and the planning authority, there would have had to be a referral to ministers—that would have been mandatory. Therefore, the council is obviously not the owner and developer.

The Convener: I think that we have now discussed the issues that we need to explore. If there are further issues of another, theological nature, we will deal with them when the petition comes back to us. Thank you for your time, Christine.

Current Petitions

High-voltage Transmission Lines (Potential Health Hazards) (PE812)

15:44

The Convener: Item 2 is consideration of current petitions, the first of which is PE812, by Caroline Paterson, on behalf of Stirling Before Pylons. It calls for the Scottish Parliament to urge the Scottish Executive to acknowledge the potential health hazards associated with long-term exposure to electromagnetic fields from high-voltage transmission lines, and to introduce as a matter of urgency effective planning regulations to protect public health.

A couple of elected members have shown a keen interest in the matter in the past. I welcome Chris Harvie MSP and Dr Richard Simpson MSP.

Christopher Harvie (Mid Scotland and Fife) (SNP): The petition focuses on potential health hazards associated with long-term exposure to electromagnetic fields from high-voltage transmission lines. The matter is of particular concern to me, as the proposed 400kV high-voltage Beauly to Denny line will run through built-up areas of my Mid Scotland and Fife constituency, from Bannockburn to Dunblane.

I have heard numerous concerns expressed about the detrimental effects of the proposed overhead line on landscape, scenery and tourism. The health aspect is by far the most worrying of those effects.

When I submitted my previous statement in May, I listed in some detail the studies that provide evidence for tangible health risks. I am not satisfied with the responses that have now been received from the Health Protection Agency and the Scottish Government. Both claim to uphold the 1999 European recommendation guidelines on public exposure to electromagnetic fields—EMFs. Those guidelines are outdated: they basically permit high-voltage power lines to run directly above homes, schools and nurseries, and they give a benchmark guideline of 100 microtesla. Subsequent studies have shown that even 0.4 microtesla can pose considerable health risks.

In its response of 25 September, the Health Protection Agency admits that its current advice is based on

> "a comprehensive review of the science published in 2004".

That is a year before the agency was set up in its current form. It claims that recent research is being monitored but that it has not sufficiently changed the balance of evidence.

In response, I point to the appended list in my notes of 12 peer-reviewed publications since 2002, all of which evidence considerable health risks—particularly to children and infants—resulting from proximity to power line EMFs. However, the HPA has not engaged with or advised the Westminster and Holyrood Governments on any of them. Instead, the joint Government response of 16 October states:

> "The HPA advises that the EMF association with childhood leukaemia is weak and unproven".

There is no mention of any other associated conditions such as Alzheimer's, adult cancers, motor neurone disease, miscarriage, or other cancers and brain tumours in children.

The HPA's dismissal of those studies contradicts the Scottish Government's confidence in that body's diligence, expertise and ability to review and advise

> "on the totality of the available scientific evidence".

Furthermore, the precautionary principle to which the UK signed up in the Maastricht treaty means that decisions need not be based on such established evidence. The principle comes into play when health risks begin to emerge that might, in time, be substantiated by research.

Denis Henshaw, who is a professor of physics at the University of Bristol and the author of one of the papers, points out:

> "We have long passed the stage where application of the Precautionary Principle and of appropriate legislation against undue exposure is warranted, including a substantial lowering of permitted MF exposure limits, currently 100 microtesla. In the case of high voltage overhead powerlines, these should not be built close to houses".

Other European countries with advanced electricity-dependent economies, such as Germany, Sweden and Switzerland, have already taken precautionary steps, even though the UK remains intransigent. The Scottish Government needs to engage critically with such evidence, and consider an enlightened precautionary approach. That would mean either routing the proposed Beauly to Denny line away from residential areas, or—better still—undergrounding it in crucial areas, thus avoiding all health risks and other disadvantages.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Chris Harvie has outlined the case in some detail. We have already presented to the committee the fact that the evidence for childhood leukaemia is certainly at the point beyond the precautionary principle and is well established. We now have a new paper from Japan, by Tomohiro Saito and colleagues, on "Power-Frequency Magnetic Fields and Childhood Brain Tumors: A Case-Control Study in Japan". There is some indication of growing evidence that brain tumours could also be a factor here.

We await a further study that will cover six countries and include those Japanese data. One problem is that the numbers are very small, and studies therefore have wide confidence intervals, which makes things difficult. If even just a few cases switch from one direction to another, one can get a negative rather than a positive outcome.

The proposed new pooling of data from Sweden, Norway, Finland, Denmark, Germany, the UK, the USA and Japan is under way, and we look forward to the analysis. We would expect it to confirm health risk associated with high-frequency lines, particularly those of 400kV-plus.

The other arguments that have been put forward by the proposers of the line are that putting the cables underground would be inordinately expensive. Circumstances have changed since the process began. The old oil-filled underground lines are now being replaced with what is called XLPE—cross-linked polyethylene—cable, which rapidly reduces the cost. The latest German line to be implemented, as a result of new legislation and as one of four pilots, cost only seven times the amount. As oil and gas pipelines are already laid around Stirling, I suspect that costs there would be even lower because there is no evidence of massive rock formations on the route that is proposed by SNH, which came in purely on landscaping.

In North Yorkshire a line has been put underground because of one particular 18th century church. Stirling has the Wallace monument, the Sheriffmuir battlefield and the view from the castle. There are small power lines there at the moment and they are not particularly intrusive, but the proposed new one will be substantially higher and will affect the landscape. It is also proposed to put lines underground at Elstree, Beddington and the Olympic park—some of them will be tunnelled, but some will be XLPE lines—so England is going ahead with the undergrounding of lines for a variety of reasons.

Since I last presented evidence to the committee, other countries have also made similar moves. Copenhagen is undergrounding two lines of 12km and 22km respectively, and in Germany, following new legislation that came in this summer, four pilots are being done on lines of 16km and 30km. A considerable number of other countries are already undergrounding. We therefore suggest that the 23km on the route around Stirling should be undergrounded for health and landscaping reasons.

The Government has indicated that it will give its response before Christmas to the reporter's report that was tabled in March, but it might be that the committee will wish to make further comment at this stage before a final decision is reached.

Nanette Milne: We should certainly keep the petition open. We had a detailed submission from the petitioner before the meeting, so we could forward that to the Scottish Government, along with Richard Simpson's up-to-date information about undergrounding. I do not know whether the Government already has that information, but it would do no harm for us to forward it. I do not think that we can do much more at this point when the issue is with the Government, and I do not think that we can discuss it again until we have heard more from the Government.

The Convener: We recognise the contributions that Dr Simpson and Professor Harvie have made today. If we pull them together as part of our response, we can pass it on to the Government and wait for its response on the report.

I thank you for your patience, gentlemen. It has been a long afternoon.

Stewart Committee Report (PE1106)

The Convener: PE1106, by Jamie Webster, calls on Parliament to urge the Government to review the aspects of the Stewart committee report, "Keeping Offenders Out of Court: Further Alternatives to Prosecution", that relate to the rights of victims of crime to obtain information on handling of their cases.

The petition has been before us on a few occasions. I suggest that we suspend it for the moment because we are still waiting for information from the Crown Office and Procurator Fiscal Service about its policy on public disclosure of warnings. It was expected in spring 2008, but it has been delayed. Can we suspend the petition until we receive it?

John Wilson: I suggest that we write to the Lord Advocate to find out why there has been a delay and when we can expect the report that was due in 2008.

The Convener: Thank you for that. I accept those two suggestions.

Knife Crime (Mandatory Sentencing) (PE1171)

The Convener: The next petition is PE1171, by John Muir, calling on the Scottish Parliament to urge the Government to introduce mandatory sentencing for persons who are found carrying knives or other dangerous weapons in public. Members will be aware that we have given the petition substantial consideration, which culminated in a major debate in Parliament on knife crime in Scotland. What do members want to do with the petition?

Nanette Milne: For a start, there are a couple of projects that we do not know the results of yet. One is campus cops and the other is medics against violence. It would be interesting to know the outcome of those two projects.

Nigel Don: If you will forgive me, I will take a slightly pedantic line on this. I am bothered that we are having debates in the chamber and in public in which people are using the word "mandatory" incorrectly. John Muir himself understands that the word—which he included in the petition—may not have been the one that he really meant to use. I understand that you used the word in introducing the petition, convener, because it is in the petition. However, John Muir's latest letter—which, incidentally, contains a vast amount of good sense—states:

> "The importance of 'Damian's Law' was never specifically the absolute introduction of mandatory sentencing".

The word "mandatory" does not need to be qualified by the word "absolute", because it means absolute. It comes from the Latin word for "to command", and commands do not come with ifs, buts or maybes. Therefore, if folk want to talk about mandatory sentencing, they should be made aware of the fact that they are saying that there are no ifs, buts or maybes.

If members think that the carpet fitter who puts the Stanley knife in his pocket and, at lunch time, goes around the corner looking for a pie for lunch should be sent to jail for having that Stanley knife in his pocket, they may wish to advocate mandatory sentencing. However, like me, they may think that it would be better for there to be a presumption that there will be prison sentences for those who are caught carrying knives. That would be a much better way of putting it, although there may be other wording for it. Can we please register that "mandatory" means something and that we will not help the discussion or improve the English language if we use it to mean something else?

Only a couple of pages previously in the committee's notes, on page 4 of his letter of 20 October, the cabinet secretary correctly uses the word "mandatory" to describe

> "conditions fixed by the Scottish Government".

The word has a place in the discussion, but can we please use it properly? More specifically, can we please not use it improperly?

Rhona Brankin: In my view, it is absolutely clear to the vast majority of the public what "mandatory" means. I would be concerned if the term were softened, because I know that there is a huge amount of public support for mandatory sentences for people who are found carrying knives and other dangerous weapons.

The Convener: Nanette Milne has made a specific suggestion, and both Nigel Don and Rhona Brankin have made comments on meaning and interpretation, which are now on the record.

Fergus Cochrane (Clerk): I will meet John Muir tomorrow afternoon. I can have a chat with him about the word “mandatory” and see whether he wants to amend the terms of the petition.

The Convener: We are, ultimately, the custodians of what petitioners put forward. As long as it is deemed to be acceptable under our standing orders, what the petitioner wants is what we must deliberate on. In the knife crime summit and the public debate that we have had in the chamber and in the wider world, there has been discussion about how we could, through legislation, implement a policy to tackle the use of knives and so on.

I think that the intention is to reach a situation in which people feel that a stronger message is sent out to those who carry knives with intent—I am not talking about tradespeople. Ultimately, the issue is about the fact that too many people in our communities—tragically, it is mainly young men—carry knives with intent on evenings out or at the weekend, when activity is guaranteed. We can explore those issues, but I acknowledge the positions that members have taken.

16:00

Rhona Brankin: I would not want Mr Muir to think that the views that have been expressed about the word “mandatory” necessarily reflect the view of the Public Petitions Committee.

The Convener: We will ensure that that is made clear.

Rhona Brankin: I disagree with those views.

The Convener: I understand that.

Nigel Don: My point was about the use of a word. That word has a meaning, which I think Mr Muir understands. I, personally, am surprised at the length of the sentences that are handed down. I would have thought that anyone who carries a knife with intent should expect to go to prison, so I am probably of the same view as most people, including Mr Muir. That is not my point. As the convener has just said, it is a question of intent.

In addition, there is the slight problem of the fact that, in this country, we expect our judges to use discretion. We take away judicial discretion at our peril, which is why we must ensure that we know precisely what we are saying. The proposal to have a Scottish sentencing council is one way of dealing with the issue and getting people to sort out what the policy should be.

John Wilson: The convener quite rightly identified that the issue is about carrying weapons with intent. Nigel Don gave a good example of the difficulty with a mandatory policy. If someone who was working near a certain shop that sells pies went out at lunch time with his tool-belt on or with a Stanley knife or chisel in his pocket, he could be stopped in the street and arrested, because that would be mandatory for anyone who was caught carrying a dangerous weapon in public.

We need to be clear about what we are saying about how we treat people. The convener made it clear that intent is the determining factor when it comes to mandatory sentencing of people who carry dangerous weapons in public. We all need to be extremely careful about how we proceed. Are we saying that a person should be convicted and sentenced just because they happened to be, when they were stopped by the police, carrying in their back pocket a Stanley knife that they use at work for opening parcels or whatever? Should such a person be arrested and put in prison just because they had forgotten to take out of their back pocket the Stanley knife that sits there eight or 10 hours a day while they are at work?

Rhona Brankin: It is clear that when Mr Muir lodged his petition, he was not thinking about people who happen to carry Stanley knives around with them. That is pretty self-evident, to be frank. I would not want Mr Muir to get the impression that the committee was being in any way critical of his petition. The issue will be considered by Parliament when it deals with the forthcoming legislation. It will be up to Parliament to make the decision.

Robin Harper: One of the most important things to come out of the work on knife crime was the Government’s encouragement of campus cops and medics against violence, but what concerns me about those initiatives is that they seem to be more like extremely small pilot projects. If we want to do something in schools, we must adopt a whole-school approach instead of just focusing on second year. All that we have are pupil numbers.

We need to ask the Government whether it will step up the initiatives on the back of the two pilots and go for a whole-school approach that has a chance of being effective. It will not be particularly effective to carry on piecemeal. Taking just the second year in perhaps no more than three schools would give the Government an idea of whether the initiatives might work with second years, but it would not have any impact on overall knife crime in the school or area.

The Convener: We will have a major opportunity to get to the heart of the issue in the chamber debate. Members will determine the best course of action on the sentencing council and the role that judges need to play as part of the wider concern that we all have about the impact in our parliamentary areas on individuals, not only the victims, but young men who, at a particular age, have chosen to behave in a certain way for which they need to be punished, which also has future consequences for them and their families. I am conscious that members feel strongly, but we want to interrogate the additional points a bit more thoroughly. I thank Robin Harper for his contribution on that petition.

A90/A937 (Safety Improvements) (PE1236)

The Convener: Our next petition is PE1236. It was lodged by Jill Campbell and calls on Parliament to urge the Government to improve safety measures on the A90 by constructing a grade-separated junction where the A937 crosses the A90 at Laurencekirk.

Mike Rumbles has spoken to the petition in the past. I welcome him to the committee and ask him to make a brief opening speech on the petition.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I was struck by Transport Scotland's answer to the committee's question about why the strategic transport projects review concluded that there should be no grade-separated junction at Laurencekirk. The agency said that it was not necessary because the accident level at the southern junction had improved, but it failed to examine the accident statistics at all three junctions around Laurencekirk. If it had done so, it would have seen that the figures in its own report show that, in the three years since the improvements were made in 2005, there had been 13 accidents compared with only six accidents in the three years before that. Transport Scotland's own figures show that the accident situation is getting worse, not better.

Since writing to the committee, the petitioner—Jill Campbell, who is in the public gallery—has obtained from Grampian Police the information that the full cost of dealing with fatal accidents, such as the latest one in September, comes to the incredible figure of £1.9 million. Add to that the costs of all the accidents that Transport Scotland includes in the report that the committee has, and the total cost of dealing with all those accidents—remember, we are talking about the past four years only—is £4.3 million.

In the same report, Transport Scotland says that the cost of a grade-separated junction at Laurencekirk would be in the region of £4 million. The cost to the taxpayer of not building such a junction there is enormous, not to mention the human cost to devastated families.

The scandalous point about the situation is that those costs do not come out of the transport budget, but they all come out of the budget that is available to the Scottish ministers. If ever there was a case for employing common sense in the spending of taxpayers' money, this is it. It is particularly galling that the last sentence of Transport Scotland's response to the committee says that the junction's "adverse effect" on Aberdeenshire Council's housing expansion plans—it has huge expansion plans for Laurencekirk—should be covered by a private developer. In other words, the Minister for Transport, Infrastructure and Climate Change will not authorise a grade-separated junction but will leave it to a housing developer to do it.

Where do we take the petition? It would be appreciated if members would call the transport minister to the committee and ask him specifically whether he considers it to be a good use of public money to spend more on clearing up the aftermath of accidents around Laurencekirk than on improving the junction. I know that the petitioner would like you to do that. The minister could save public money by constructing a £4 million grade-separated junction.

I have focused my comments on the money, but I am far more focused on the loss of human life and the families that are devastated by it. It is mounting; it is getting worse, not better. Please help.

The Convener: Thank you very much, Mike. Do committee members have any immediate comments or observations?

Nanette Milne: Mike Rumbles made some very valid points. I appreciate that we are talking about different budgets across ministerial portfolios. I was going to suggest getting back to the Scottish Government, but I would be happy to invite the minister to give oral evidence to the committee, if members agree.

The Convener: We will pursue that suggestion. Robin, are you just moving your pen?

Robin Harper: I was just nodding my head.

The Convener: I am sorry, but I am being incredibly attentive to matters this afternoon.

We will take forward Nanette Milne's suggestion. The petitioner's letter raises specific points that we should forward to the minister. We had a good experience in respect of the petition on cancer drugs of identifying a number of issues early on to which the minister could respond. That certainly helped when we had Nicola Sturgeon in front us. We will therefore send the petitioner's points to the minister's office and see from our diary where we can fit in an appearance by the minister.

Same-sex Marriage and Mixed-sex Civil Partnership (PE1239 and PE1269)

The Convener: Petitions PE1239 and PE1269 are grouped together. PE1239 is by the LGBT Network, calling on the Parliament to urge the Government to amend the Marriage (Scotland) Act 1977 to allow two persons of the same sex to register a civil marriage and a religious marriage, if the relevant religious body consents. Petition PE1269 is by Tom French on behalf of the Equal Marriage Campaign, calling on Parliament to urge the Government to amend legislation to allow same-sex marriage and mixed-sex civil partnership.

We have had PE1239 before us on a number of occasions. We have explored some of the issues that it raises with those who would determine the legislation. The position has been made clear to us, but I invite members to comment on how we should handle the petition.

Robin Harper: I am reluctant to close the petition, because the issue still exists. Way back in 2000 or 2001, on a similar kind of human rights issue, the then Scottish Executive set up a committee to look into the issues around hate crime, which eventually ended up in a bill in Parliament. I am minded to ask whether the committee would approve the idea of writing to the Government to ask whether it would set up a similar committee and invite appropriate people to take part in it to carry on the discussions.

Anne McLaughlin: What are the Public Petitions Committee's options? It just seems to me that the Scottish Government says that what the petition seeks is not a priority at the moment and the UK Government says that it is has no plans to change the law. Nobody says that they are against what the petitioners ask for; they just say that it is not a priority at the moment. However, I have had a number of e-mails on the issue, as I am sure my colleagues have, and the point is very well made that it is about equality for people who want same-sex marriages.

I am not sure whether we can do anything, because I am—well, I cannot call myself the new member of the committee any more, because Rhona Brankin is now the newest member of the committee. However, as a relatively new committee member, I am just looking for advice on what we can do with the issue and whether what Robin Harper suggests is a possibility.

John Wilson: I support Robin Harper in asking that the petition be continued, because I think that issues have arisen from the responses from the Minister for Community Safety and—as Robin pointed out—the UK Government on the petition. I am also conscious of a current court case in which a couple have taken the Austrian Government to the European Court of Human Rights on the issue of same-sex marriage. I suggest that the minister be asked to arrange a meeting that is not dissimilar to what Robin suggested, but which in the first instance is a meeting with the petitioners to discuss fully the issues and concerns.

I am quite concerned at the suggestion in Fergus Ewing's letter to the committee that people in same-sex marriages would, under the petition, have greater legislative rights than people in other marriages. Such issues have to be addressed.

I suggest that we ask the minister to meet the petitioners and that we keep the petition open until the European Court of Human Rights has made its judgment on the case that is before it.

16:15

Rhona Brankin: I am not sure what Robin Harper was suggesting.

Robin Harper: I was suggesting that an ad hoc committee be set up with representatives of Government, the Cabinet Secretary for Justice and representatives of interested parties in order to take the conversation forward. That would be a way of keeping the issue alive, keeping the Government onside and doing some ground work to prepare the way for legislation in the next parliamentary session, if not in the next two years. It would be good if the process did not have to start from scratch at that point and if there were a group of people who had already investigated the issue thoroughly.

Rhona Brankin: Do you think that we should call on the Government to establish a committee?

Robin Harper: Yes. The Cabinet Secretary for Justice would be the person who could establish such an advisory committee.

The Convener: We face a dilemma with regard to the powers that we have to either do that or get the UK or Scottish Government ministers to—

Robin Harper: It was a suggestion.

The Convener: I know, Robin.

Over the past few months, we have all received e-mails on this issue from people with differing perspectives. I think that we should interrogate some of the issues that John Wilson raised about the minister's letter. That will enable us to determine whether we can do anything to help the petition on its way. If we cannot do anything further as a committee, individual members and other campaigners have opportunities to take matters forward, although it might not easily be done through the structure that Robin Harper has suggested.

I am feeling frustrated by the fact that we have been unable to help a number of petitions to make progress because action must be taken by people in other areas of the decision-making process. We can alert people to issues and tell them that we would like things to be done but, ultimately, other people have to sanction any action.

Robin Harper: What I am saying is that there is a previous example in which an advisory committee was set up on an equalities issue by the minister who then had responsibility for justice. In a sense, we are simply pointing out to the justice secretary that he might do something similar and that it would be a good idea if he did.

The Convener: In the correspondence that we receive on this matter, the issue of equality is always raised. We have a committee in the Parliament that deals with equality, but I do not know whether its work programme includes consideration of matters with which the petition is concerned.

We should explore the issues that John Wilson has identified. That will enable us to identify the best course of action. Do members agree?

Members *indicated agreement.*

Faith-based Schools (PE1262)

The Convener: PE1262 continues our wee run of interesting petitions. It was submitted by Luca Scarabello and calls on the Parliament to urge the Government to ban all faith-based schools from teaching only their particular faith and to make all schools teach non-denominationally. Are there any comments from members?

Anne McLaughlin: I think that everything that needs to be said about the petition has been said. The curriculum for excellence makes it clear that schools must teach about other faiths, and I do not think that there is any evidence that that does not happen. My personal experience is that that does happen. What can you do?

The Convener: We might consider closing the petition, given that we have explored a number of points and it seems that, within the frameworks that we have legislated for, people have the right to have their faith or lack of faith respected. For example, parents can request that their child does not receive such instruction.

Robin Harper: Would it be appropriate to ask the Government whether it could give specific guidance to local authorities?

The Convener: I think that such guidance already exists. The issue of faith and religion in Scottish schools has been a fairly contested issue for at least my whole life. There are views about whether we should have denominational schooling, but the petition is concerned with the procedures around the teaching of religion. We have explored those issues and have received assurances about the legal framework that exists around a child in school.

Anne McLaughlin: It was good that the petitioner raised the issue, because we wrote to many organisations and faith groups, which served to remind them that they ought to be doing what the petition asks for. It was worth submitting the petition, but I do not think that we can take it much further.

The Convener: Do we agree to close the petition on the grounds that have been discussed?

Members *indicated agreement.*

National Suggestion Box Network (PE1264)

The Convener: PE1264, by Alan Hind, calls on the Parliament to urge the Government to set up a network of national suggestion boxes to allow members of the public to submit their comments, ideas and suggestions directly to it. I think that it is quite an attractive option, as I have a few things that I would like to say—as long as the system is confidential, I should be okay.

I do not know whether we can take the matter much further than we have, as the Government has told us that there are already a number of ways in which it consults the public. Consultation is always a central feature of any legislative proposals that come before the Parliament and people have had lots of opportunities to make suggestions on many interesting topics in the past couple of years.

Rhona Brankin: I am a new member of the committee and I was not here when this matter was discussed initially. Was there a suggestion that the committee should change its name to the petitions and suggestion box committee?

The Convener: I have enough trouble as it is, without that. Do we agree to close the petition?

Members *indicated agreement.*

Robin Harper: We already have the sort of suggestion boxes that the petition calls for. They are painted red and are called postboxes.

The Convener: Exactly.

School Closures (Children with Additional Support Needs) (PE1266)

The Convener: PE1266, from William Stevenson, calls on the Scottish Parliament to establish how the procedures and guidelines that are used by local authorities to close a school properly reflect and recognise the needs of children with additional support needs.

Nanette Milne: I think that the Schools (Consultation) (Scotland) Bill has dealt with the issues that are raised in the petition. I do not think that there is anything further that we can do.

Anne McLaughlin: I take issue with a couple of points in the submission from Glasgow City Council. It says that the council provided interpreters to explain the consultation documentation. It is true that interpreters were available, but if you did not know that your school was closing and you did not know that interpreters were available—because you could not read the initial letter, which came in English only—there was no point in those interpreters being there. The council also says that, out of the 4,156 reasons raised against the closure proposals, only one related to a concern about a child with additional support needs.

That is the issue that the petition deals with, and I find it extremely difficult to believe that only one consultation response raised that concern. Billy Stevenson, the petitioner—who was present today but has had to leave—raised that issue, and I am sure that several other parents also raised it. It was one of the biggest issues in the campaign.

The Convener: Do you have any suggestions about what we should do with the petition? It has been suggested that we close it.

Anne McLaughlin: I do not know what else we can do. The petitioners were right to raise the issue, however.

The Convener: And you have put on the record your concerns about the response from one of the organisations that we consulted.

School and Nursery Closures (Public Inquiry) (PE1267)

The Convener: PE1267, by Richie Venton on behalf of the Glasgow save our schools campaign, calls on the Parliament to urge the Government to conduct a public investigation into the impact on a range of issues of the proposed closures of schools and nurseries by local authorities. Do members have views on how to deal with the petition?

Anne McLaughlin: The petitioner's response raises many issues. Schools are central to many communities, and one of the main things that the petition calls for is consideration of the impact of school closures on a wide range of things apart from education, such as social inclusion and jobs. There does not necessarily have to be a public investigation. PE1295 proposes environmental impact assessments and I think that the petitioner who lodged PE1267 was looking for that kind of thing—retrospective social impact assessments or investigations. Obviously, that will not happen, but we might want to say to the petitioner that he could lodge another petition calling for such social impact assessments to be made in future. That might be worth it.

The Convener: Okay. The petition raises broad issues. I suggest that we close it in light of our discussions on it and because school closure programmes do not require the Scottish ministers' consent. It is therefore difficult for the committee to take a view on the matter.

School Buildings (Asbestos Management Plan) (PE1268)

The Convener: PE1268, by Catherine Mitchell on behalf of St Gilbert's primary school and all schools in the west of Scotland, calls on the Scottish Parliament to urge the Scottish Government to take action against local authorities that have failed to implement a robust asbestos management plan and procedures for school buildings that contain asbestos, and to ensure that parents and teachers who require data that are held by local authorities about asbestos in school buildings have full access to them. We have discussed the petition before. Do members have any comments?

Anne McLaughlin: The petitioner, Catherine Mitchell, is one of the few people left in the public seats.

The final thing that the petition calls for is to

> "ensure that parents and teachers who require data about asbestos in school buildings held by local authorities have full access to this."

I do not see how that call has been answered, although it might have been; I might have missed something. I understand that most of what is in the petition needs to be taken up with Glasgow City Council or the Health and Safety Executive specifically. We have guidance for when parents and teachers know that there is asbestos, but I am not sure that the point about access to data on asbestos in school buildings has been addressed.

The Convener: Irrespective of where people have stood on the difficult council decisions that have been faced—there are different perspectives—we should be conscious of the issue of asbestos in schools, particularly in those that were constructed in the 1960s, when there was a massive expansion of the school estate and materials that are perhaps no longer appropriate were used. I am not convinced that enough answers have been provided to what is in the petition or about the relationship that the Government would want with local authorities and others. I am sure that many buildings, not only school buildings, are involved. On that basis, we cannot easily dismiss the petition.

Rhona Brankin: Again, I come to the matter as a relatively new member, but I have read the papers. The Health and Safety Executive has taken some action, but we need to know that there is on-going monitoring and that local authorities are carrying out their asbestos monitoring and management duties as set out in asbestos management plans. The key issue is how the Government ensures that that is happening.

Nigel Don: I would like to go beyond the convener's comments about other buildings. Education authorities should now be aware of the situation. Because of what we and the petitioner have done, every education authority in the country should now be clicked into the possibility of asbestos being an issue in our schools. The Health and Safety Executive also has a website that tells people about asbestos. However, the problem remains that there will be asbestos in buildings that nobody knows is there; more important, nobody is looking for it.

16:30

If you are demolishing a building, you will take precautions; indeed, that is what demolishers do. They know about these things. However, someone who is simply knocking a building about does not really know anything.

I have no idea how we disseminate the information that should be available, but I am sure that, by bumping into asbestos that they do not know is there, plenty of people will put themselves at a slight risk. We should stress the slightness of the risk in this respect; it is a great deal better to bump into the stuff than to be padding around in it, as those who were manufacturing it had to do 40 or 50 years ago.

I do not have a way forward to suggest, but we should recognise that there is a blind spot. There are people who, until they find the asbestos, will simply not know that there is an issue or that the material is present.

The Convener: I am inclined to keep the petition open, but if we do so we need to think about what action to take. Do members have any comments?

Robin Harper: Surely local authorities keep the original plans and procurement details. You are shaking your head, convener.

The Convener: Half the problem is that they have not always done so. Local communities know that certain buildings contain various forms of asbestos, which is why there has been a reluctance to demolish buildings automatically. A proper assessment needs to be carried out, and the economics of that are quite challenging.

Nigel Don: It is a principle of engineering practice that, when you build something, you tend to assume that everyone knows—and will always know—the custom and practice of the time, so you do not bother to write anything down. When the next generation, which has learned something different, tries to find out what the previous generation did, they are unable to do so. It was assumed that everyone knew these things; now no one knows them. That, I suppose, is the nature of change.

Rhona Brankin: I have not had recent experience of this issue, but my understanding is that the management plan involves identifying the presence of asbestos and then putting in place a plan for managing it. The key issue, therefore, is enforcement and the extent to which local authorities are complying with asbestos management legislation and have a plan in place. I certainly think that all of them should have done so.

The Convener: I suggest that we keep the petition open as we seek responses on two points. First, we should write to Glasgow City Council, seeking its views on members' comments about the petitioner's concerns. Secondly, I am not sure whether the responsibility for this issue is the same at both Scottish and UK levels, but we should write to whoever in Government has such responsibility about the possibility of formulating an action plan that is centred on the various statutes and the actions identified by the HSE and asking whether there have been any recent breaches of those statutes by local authorities.

John Wilson: Given that the HSE has raised certain questions in its letter to education authorities, we should ask the organisation whether it has come across any adverse reporting by local authorities. Although its presumption is that action plans should be in place, its letter of 8 October seems to be asking authorities whether they have action plans in place and, if not, what they intend to do about it. It might be worth while finding out what responses the HSE has had from local authorities and whether every authority has put in place plans to deal with the issue. After all, people usually find that they have asbestos only when they drill a hole in a wall to hang up a picture.

Of course, that brings us back to Robin Harper's comment that the plans for these buildings should surely have been kept. The fact is that the plans for many schools that were built 40 or 50 years ago were destroyed by successor administrations, which means that nowadays no one knows what the buildings are made of. That poses real difficulties because, as you said, convener, we are talking not just about school buildings. As the wonder material of the 1950s and 1960s, asbestos was used extensively in houses and office blocks. There are wider issues to take on board, but we certainly need to concentrate on the problem of asbestos in schools that the petition has highlighted.

The Convener: I look to the clerk to assimilate our contributions constructively. We will keep the petition open while we explore the process issues that members have raised. The petition will come back to the committee in due course.

Changing Places Toilets (PE1270)

The Convener: Our final petition is PE1270, by Linda Burke, on behalf of the Profound and Multiple Impairment Service and the Learning Disability Alliance Scotland. Essentially, the petition urges the Government to request that local authorities use British standard 8300:2009 to ensure that at least one public toilet built to the changing places standard is provided in the centre of every town with a population greater than 15,000 and in every new larger and publicly accessible building and complex. Again, we had an opportunity to discuss the petition in detail at a previous meeting. I invite comments from members on how we might pursue the petition.

Rhona Brankin: I would like to continue the petition, which is on an issue that is important not only for those with disabilities but for people with a range of needs. I suggest that we contact a range of organisations about the issue. I understand from reading the accompanying papers—as I said, I am new to the committee—that the petition has been lodged following a survey that showed that toilets built to the changing places standard are relatively rare. I suppose that we need to get information about current provision, what attitude local authorities take to the petition's proposal and what the implications would be of making such toilets more widely available.

Nigel Don: My reading of the petition—which feels like a long time ago now—was to the effect that everyone was saying, "This is not necessarily my problem." Legally, that might well be true, but I cannot help feeling that if the Scottish Government wanted an appropriate standard of toilet in every main place—however that might be defined—it could have a quiet word in the ear of the appropriate local authorities to say, "Hey guys, please could you find a way of doing this that takes your local circumstances and planning opportunities into account?" The cost to a local authority of ensuring that there is one such toilet in the middle of every large town and city would not be huge. Surely no one needs the authority to say that. The Government could just have a quiet word.

Robin Harper: The information before us repeats the point that only three of the 32 local authorities even bothered replying to the petitioners to confirm that an equality impact assessment had been carried out to see whether changing places toilets were needed. That level of response is, I suggest, almost inexcusable. The local authorities should be held to account for that by the Government. If the Government will not hold them to account, the Convention of Scottish Local Authorities should do so. My feeling is that we should write to both the Government and COSLA to tell them that that is not good enough. The issue must be pursued.

Nanette Milne: I was going to suggest that we take up the issue with COSLA, as Robin Harper has mentioned.

The Convener: We will keep the petition open as it raises a number of issues. I think that our response should be quite strong about the need for an equality impact assessment. I believe in subsidiarity and in devolving decision making, but local authorities also have a responsibility, I believe, to deliver what is set out in the concordat.

John Wilson: Convener, I suggest that we also write to the British Council of Shopping Centres to find out how that organisation advises its members on the operation of existing malls and shopping centres. Although we can also write to local authorities about town centres, I am aware that a number of Scotland's town centres and major shopping centres are owned not by local authorities but by other bodies. Therefore, it would be useful to get the views of the British Council of Shopping Centres.

Nigel Don: I do not wish to disagree with my colleagues, but surely we do not need an impact assessment. For example, the legislation to say that we would have wheelchair access to public buildings was not dependent on how many wheelchairs there would be; it was introduced simply because there should be a facility. One person would be enough; indeed, the possibility of one person would be enough. If we are not providing facilities to allow some people to get into our cities and town centres to enjoy the services there, it does not matter whether there is one or 20 people—the presence of the facility is the issue. Even if it was argued that nobody who lives in a town needs such a facility, by not putting it there we prevent somebody who needs the facility from visiting the place. I am therefore not sure that I follow the logic of the need for an assessment. The point is that the facilities are needed.

Rhona Brankin: It is an equalities issue, so it might be worth contacting the Equal Opportunities Committee.

The Convener: Rather than send the petition to that committee now, it would be useful for us to keep it until we exhaust some of the points that members have made and see whether we can get a better response and awareness. As Nigel Don said, we need a more proactive attitude to provision, rather than a reactive one. Do members agree to keep the petition open and pursue those matters?

Members *indicated agreement.*

New Petitions (Notification)

16:41

The Convener: Agenda item 3 is just to indicate that notification of new petitions has been given to members. We note those petitions and we will bring forward the appropriate ones at our next meeting.

I thank members for the work that they have undertaken this year. We have one more meeting before the recess, which is on Tuesday 15 December at 2 pm.

Meeting closed at 16:42.

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