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Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 15 December 2010

Session 3

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HEALTH AND SPORT COMMITTEE
38th Meeting 2010, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
*Mr Frank McAveety (Glasgow Shettleston) (Lab)
Nanette Milne (North East Scotland) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Salah Beltagui (Muslim Council of Scotland)
Leah Granat (Scottish Council of Jewish Communities)
Dr Mini Mishra (Scottish Government Primary and Community Care Directorate)
Mike Palmer (Scottish Government Chief Medical Officer and Public Health Directorate)
Shona Robison (Minister for Public Health and Sport)
Frauke Sinclair (Scottish Government Chief Medical Officer and Public Health Directorate)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 15 December 2010

[The Convener *opened the meeting at 10:01*]

The Convener (Christine Grahame): I welcome everyone to the 38th meeting of the Health and Sport Committee and remind you all to switch off mobile phones and other electronic equipment. Apologies have been received from Rhoda Grant.

Given that one of our witnesses for item 1 on the agenda is, through absolutely no fault of her own, stuck on a motorway—it is the same story for many people—I intend to move to item 5, which is consideration of our draft budget report, which we agreed previously to hold in private. Do members agree?

Members *indicated agreement.*

10:02

Meeting continued in private.

11:09

Meeting continued in public.

Certification of Death (Scotland) Bill: Stage 1

The Convener: I return to the first item on the agenda, which is stage 1 consideration of the Certification of Death (Scotland) Bill. We will take evidence from two panels of witnesses, first from representatives of faith groups and secondly from the Scottish Government. The committee has also received supplementary evidence from the Government and from Dr Colin Fischbacher of the information services division of NHS National Services Scotland, a letter from the Finance Committee and a report from the Subordinate Legislation Committee.

I welcome Leah Granat, who is deputy director of the Scottish Council of Jewish Communities, and Dr Salah Beltagui, who is convener of the Muslim Council of Scotland. I thank you both for your tolerance in allowing us to deal with other business and keep to our timetable while Ms Granat navigated the traffic to get to the Parliament.

Leah Granat (Scottish Council of Jewish Communities): I thank the committee for accommodating me.

The Convener: Not at all. I think that we should switch to horses—it might be faster. I thank the witnesses for their written evidence and seek questions from members.

You seem to be gathering yourselves. Please do not feel inhibited, Mary—do you want to kick off?

Mary Scanlon (Highlands and Islands) (Con): I have not prepared any questions, but I will ask something just to get the chat flowing.

The Convener: Ian McKee is ready to jump in.

Ian McKee (Lothians) (SNP): In its submission, the Scottish Council of Jewish Communities states:

"We support the principle of effective scrutiny"

but suggests that accuracy

"should not be an overriding consideration if no significant issues depend upon it such as legal proceedings."

One would hope that there would be no hint of such proceedings in most death certification procedures and that it would simply be a matter of administering the system well and ensuring that death certificates contain the most effective information to allow us to plan our health services accordingly. Do I take from your evidence that you are concerned about burials being delayed just to ensure a more accurate diagnosis for statistical purposes?

Leah Granat: We have to strike a balance between the need for accuracy and information to plan, as you say, appropriate medical provision and the need for communities and—the overriding factor—the need for the bereaved to be able to move to a point at which grieving can begin. In the Jewish community, the seven-day shivah period—in other words, the formal grieving process—begins only after burial. There has been a lot of research in this area and, according to psychologists, when grieving is delayed it becomes a much longer and much more difficult process for the bereaved.

As I say, there has to be a balance. Although we need accurate information, that information might not need to be as detailed as is sometimes sought. For example, it might be enough to know that someone died of a heart attack; knowing the exact mechanism of a particular attack might not be of any particular value to anyone.

Ian McKee: As I understand it, in technical terms the vast majority of deaths will be very expeditiously dealt with under the bill: a death certificate will be issued and that will be that. However, 1 to 2 per cent of deaths will be subject to quite an elaborate review procedure. Leaving aside situations in which relatives express concern—we all know about the legal position in

that respect—I wonder whether the proposal to subject 1 per cent of deaths to more rigorous scrutiny involving a medical reviewer travelling various distances, looking at notes, interviewing the doctor and relatives for the sake of accuracy and so on will cause problems for your religious communities.

Leah Granat: It will, indeed. In the Jewish community, there is a very strong imperative for speedy burial. At the moment, the vast majority of Jewish burials in Scotland take place either on the same day or early the following day and if a review had to be carried out before burial could go ahead it would cause delays and a great deal of distress to a lot of people.

11:15

However, the committee has received evidence that it is unlikely that review would involve post-mortem examination of the body. Professor Fleming suggested:

"it is not clear to us why that cannot be done as a post-registration event. It is not there to pick up flaws that would block registration".—[*Official Report*, *Health and Sport Committee*, 1 December 2010; c 3760-1.]

In that case, why should not registration and subsequent disposal of the body simply go ahead? The review could take place in parallel and continue afterwards. Where the disposal is by means of burial, it will still be available in the extremely rare circumstances in which the body needs to be examined.

Ian McKee: Are all Jewish deaths followed by burial rather than cremation?

Leah Granat: Yes. Very occasionally, the Liberal Jewish community permits cremation, but in Scotland the figure is well below one disposal by cremation every couple of years.

The Convener: I invite Dr Beltagui to comment on the cultural differences that exist.

Dr Salah Beltagui (Muslim Council of Scotland): The experience of burial is important in Islam, too. Burial is supposed to take place on the day of death or the next day, unless there is some necessary delay. The delay that will be caused by the review, which is a paper exercise, could continue after the burial. Muslims do not practise cremation. As Leah Granat indicated, because the body still exists, there is a chance of getting it back, if necessary.

I want to raise the issue not of the review but of the post mortem, which often takes a long time. If the bereaved see no reason for it, it becomes a cause of anxiety for them. It is important to make the point that the burial provides a kind of closure for the bereaved; the recovery process starts after that. If the burial is delayed, it is like starting again after a week. That is the main reason for having the burial take place on the same day. We need to look at the delay that takes place when there is a post mortem, because that happens a lot and sometimes lasts for a week or so. Resources may need to be made available, in some cases.

Ian McKee: Can you give me a rough estimate of the proportion of Scots who are members of your religious communities?

Leah Granat: In the previous census, which is now quite out of date, around 6,000 people identified as being Jewish.

Dr Beltagui: The only source to which I can go is the previous census, which indicated that there were about 60,000 Muslims all over Scotland. Members of ethnic minorities make up about 2 per cent of the total population, and about half of them are Muslims.

The Convener: That is helpful.

Leah Granat: The issue does not affect only the Jewish and Muslim communities or even only ethnic minority communities. Delay to burial is distressing generally. If we establish that there is no reason why registration and disposal—certainly by means of burial—cannot go ahead in parallel with review, that will be of benefit widely across the community.

The Convener: I think that we would accept that, generally.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have two questions, one of which follows on from the last comments. Dr Beltagui suggested, in evidence on section 5, alternatives to post mortem, such as scanning. Is that being used at all at the moment?

Dr Beltagui: I think that Leah Granat knows more about that than I do.

Leah Granat: In Scotland there has to date been no post mortem by means of scanning. However, in England it is now recognised in the recent Coroners and Justice Act 2009 that magnetic resonance imaging scanning is an alternative form of post mortem. It has been used as a pilot study for a couple of years in the Manchester area and has been extremely successful. It is very popular there with the coroners as well as the communities who do not want invasive post mortems. One of the reasons why it is very popular is that it can occasionally provide information that cannot be achieved by a surgical post mortem. For example, pneumothorax is very visible on an MRI scan, but as soon as a knife is inserted for a surgical post mortem the air escapes and the evidence no longer exists.

We would also urge the more general use in Scotland of view and grant, which is a particularly

Scottish form of post mortem. Its use is very variable; for example, the figure for view and grant in Glasgow is around 1 per cent and in Dundee it is about 35 per cent. In our submission on the bill we raised that issue of variability, which is due to the individual preference of senior staff in the relevant departments, who either like or dislike the use of view and grant. In the bill, registration could go ahead in parallel with review, but it would be left entirely at the discretion of the reviewer, which could result in the same situation as with view and grant. For example, a reviewer in one area could be happy to go ahead with parallel registration, but in another area the individual reviewer might not be so happy. However, that could change. For example, until a couple of years ago there were no recent cases of view and grant being used in Edinburgh, but somebody new came into post and view and grant began to be used more widely. Therefore, as we suggested—

The Convener: I am sorry. I am listening, but what is view and grant? We have two former general practitioners on the committee who perhaps know what it is, but some of us do not.

Leah Granat: I apologise. View and grant is a form of non-invasive post mortem examination whereby the pathologist will gather together all the available medical records of the deceased person and look initially to see whether they provide evidence of the likely cause of death. There is then a visual but non-invasive inspection of the body, which may sometimes also include, for example, taking small samples for toxicology investigations. However, it is a non-invasive form of post mortem that is highly preferable for the Jewish and Muslim communities.

Dr Simpson: That is very helpful, because we will obviously need to return to such issues. There are two mechanisms in the bill for ensuring that nothing happens that should not happen in relation to a death. One is the random review, and the committee has discussed and taken evidence on whether that is satisfactory. There clearly is a particular problem with delays, to which the witnesses have alluded. I presume that that will include problems at weekends, which are already a difficulty for your faiths.

The other mechanism is that a person with an interest can apply for a review of a certificate. Do you have any comments on that? A person with an interest can be someone who has an interest in the deceased or it could be the person who will be deceased themselves. They can make a statement, and if they have concerns about how they may die or about their care during the last phase of their illness they may desire a review. Do you have any comments on either of those aspects?

The Convener: That is a strange one—people suspecting that there may be suspicious circumstances.

Dr Simpson: It does happen.

The Convener: I never said that it does not happen; it is just strange.

Dr Beltagui: If there is any objection from the deceased, the family or the people interested, it should be followed up. In such a case, they would be asking for the delay, so there would not be an issue with that.

The main thing about the alternative methods and everything else is that we need some more research and training. As Leah Granat explained, the system has been tested in England for a couple of years, and the evidence is conclusive in some cases and inconclusive in others. We need more work in the medical area to find alternative ways to speed up the process and to deal with the other issue, which is respect for the human body—dead or alive. We can reduce anxiety by acting without intrusive methods.

Leah Granat: As Salah Beltagui said, if the request for a review comes from the family, there will clearly not be so much concern about delay to the grieving process. However, there would be a difficulty if there was disagreement between close family members in which one child wanted a review and others did not, or if a partner, husband or wife wanted a review but the children did not. I do not have a solution to that. It is obviously a difficult situation, and it would have to be dealt with case by case.

Dr Simpson: Should the bill refer to a vexatious declaration of interest to deal with someone applying for a review for malicious purposes? I ask in this session because delays are regarded by your faiths as being very important. I hope that it would never happen, but if someone wanted to cause difficulties in the family they could do that by calling for a review.

Dr Beltagui: I think that there is something in the bill already about who deals with the body if there is a conflict in the family. That could be extended to this issue. Different steps can be taken if there is a difference of opinion in the family.

The Convener: There has been no indication that there are further questions, so I ask the witnesses whether there is anything that they have not been asked but which they feel we ought to have asked.

Leah Granat: I want to raise an issue that we raised in evidence. It has been discussed in earlier evidence sessions and we would very much like reassurance about it.

The bill discusses parallel registration and review. It does not talk about parallel disposal and review. In earlier evidence, Frauke Sinclair said fairly explicitly that the Scottish Government view is that in this case "disposal" and "registration" mean exactly the same thing. We would certainly appreciate reassurance that that is the case. Perhaps—thinking about the drafting of the bill—if it means parallel disposal and review, the bill should refer to that rather than simply to registration, which might imply that registration can go ahead but the burial cannot until the review is concluded.

11:30

The Convener: The minister is coming next, so that will be a good point to put to her.

Leah Granat: Section 24 of the bill is about prohibition of disposal without authorisation and—this is looking ahead to secondary legislation—the documents that would be required for disposal to go ahead. The bill's explanatory note states that the registration certificate would probably be one of the required documents.

The Convener: The certificate ties in.

Leah Granat: Yes. The certificate ties in because if one of the other required documents is a confirmation that any review has ended, that would put a stay on burial. It would be problematic if registration had gone ahead but disposal could not.

The Convener: That is helpful. Dr Beltagui, is there something that you wish we had asked but did not?

Dr Beltagui: I will make one point, although I do not know whether you will agree with it. The review group started about 2005, and the first point in its report summary of recommendations was that

"The procedure for certifying deaths should be sensitive to the many different faiths and beliefs in Scotland and ensure as short a delay as possible between death and disposal."

I would like the word "faith" and consideration of faith to be included in the bill not just for our purpose but for the future. The older bill, from 1850-something, was exclusive of anything except a certain faith. We do not want that to continue.

The Convener: Those are very helpful points.

Leah Granat: I want to follow up on what Salah said about sensitivity to different communities. In the equality impact assessment, there is discussion about the bill being fair because there will be a uniform process for everybody. I just want to emphasise that fairness is not the same as uniformity.

The Convener: Exactly: you make that point in your written submission.

Those are two very good points, so I thank you very much. I hope that it was worth your while to struggle through to see us. That concludes the evidence session.

11:32

Meeting suspended.

11:36

On resuming—

The Convener: I welcome our second panel: Shona Robison MSP, Minister for Public Health and Sport; Mike Palmer, deputy director for public health; Dr Mini Mishra, senior medical officer; and Frauke Sinclair, bill team leader. They are all from the Scottish Government.

Before we move to questions, I invite the minister to make a brief opening statement.

The Minister for Public Health and Sport (Shona Robison): Thank you, convener.

There is no doubt that the current arrangements for death certification require reform. Currently, as you know, up to three medical practitioners sign off cremations without that being linked to a systematic quality improvement programme. Families that opt for cremation pay at least £147 to doctors for that service, which I do not believe is fair.

Instead of checking the actions of every doctor, we propose to introduce a systematic quality improvement system through targeted reviews that are linked to existing clinical governance arrangements, and to complement that with a proportionate level of deterrence.

Fundamentally, I believe that an intelligence-led independent medical reviewer system is more effective than a system that is based on a second signature by another certifying doctor, or a non-targeted system such as the one that is being introduced in England, which is likely to cost bereaved families in the region of £170.

I appreciate, from the evidence sessions so far, that the committee has concerns that our proposals may not act as a sufficient deterrent to wrongdoing nor involve sufficient scrutiny. Our proposals deliberately build flexibility into the number of medical reviewers, the sample size for random reviews and the number of additional targeted reviews. Using that flexibility, I propose some significant enhancements that I believe will help to address the committee's concerns.

First, I propose to double the number of cases in the random sample, which is designed to provide

a benchmark for measuring annual quality improvement, from 500 to 1,000 a year. When that is added to the proposed number of targeted and interested person reviews, it will amount to around 2,000 comprehensive—or level 2—reviews a year.

Secondly, I propose to add to that a larger programme of independent level 1 reviews that are to be applied randomly to around 25 per cent of all deaths. That will capture around 13,500 deaths a year. Level 1 reviews will be conducted by medical reviewers, who will check the medical certificate of the cause of death and discuss it with the certifying doctors before sign-off. If a medical reviewer found cause for concern, a level 2 review could follow.

Furthermore, the legislation has been designed to require an annual report to Parliament on the activities and performance of the reviewers. I would be happy to agree that a report should come back to the committee on the workings of the new system after a suitable period, to review how the system is working before further roll-out. That would take account of stakeholder input, which will feed into the monitoring and evaluation plans that will be developed in due course.

I believe that the package provides robust enough deterrence and reassurance to the public through widespread independent scrutiny of MCCDs, while harnessing the benefits of a targeted quality improvement approach that is proportionate and keeps the financial burden on bereaved families and the Government at a reasonable level. I am happy to take questions.

The Convener: Thank you for that additional information. Ross Finnie will begin.

Ross Finnie (West of Scotland) (LD): Thank you, minister. That was helpful because you have sensed that I and, I think, other committee members have been wrestling with the question of balance. We were a little surprised in our initial session with the bill team. Although we accepted that, if a Harold Shipman sets out to criminally avoid detection, that is what he will do, and no system in the world is likely to pick that up—perhaps we did not express our acceptance of that clearly enough to the bill team—we found it instructive that the burial and cremation review group report of 2007 suggested that, even though the system cannot ultimately pick up a Shipman, it ought to have elements that will act as a deterrent to anyone seeking to defraud or criminally avoid detection. We were surprised because the bill team gave the impression that fraud or criminal activity has no part in the new system. Indeed, the bill team leader answered in such terms. I am therefore pleased that you have proposed an enhanced level of scrutiny that seeks to address that.

We are getting into what Professor Fleming and Dr Fischbacher talked about in their evidence about relying on statistical probabilities to give us confidence. Has the decision to double the number of cases to be scrutinised from 500 to 1,000 and to increase the proportion of level 1 reviews to 25 per cent been made on any statistical basis, or have you simply had to apply a reasonableness test in arriving at that figure?

Shona Robison: A reasonableness test has been applied, with the recognition that, when the test sites have been in operation for a year, that should begin to give us some ability to judge whether there are any concerns about the new system. That is why the test sites are so important. As the figure of 25 per cent will be under ministerial direction to the registrar, it can be changed upwards or downwards in light of the evidence that we gather from the practice of the new system.

What is proposed is a reasonable compromise, and it is proportionate cost-wise. The proposed system is affordable and it will increase the Government's contribution by around £600,000. I feel strongly that I do not want to increase the level of fee to be paid by members of the public; I want to hold that at the £30 that we have proposed. We therefore propose that Government expenditure will cover the additional cost of having level 1 reviews in 25 per cent of cases.

That is the rationale, and it can be tested during the test site period.

11:45

Ross Finnie: In earlier evidence, the Government seemed to take the position that the previous system of checking was "perfunctory", although that claim was very much challenged by Professor Fleming, who said:

> "A 15 per cent improvement in accuracy and picking up on dozens of unnatural deaths does not seem to me to be perfunctory."—[*Official Report*, *Health and Sport Committee*, 1 December 2010; c 3754.]

I do not want to play with words, but I want to get some sense that what we are about to embark on has some foundation. You might well direct my attention to the pilots or test sites and suggest that, as a result of those, a more rigorous statistical analysis could well be applied to provide the degree of comfort that the committee has been searching for over the past few weeks of evidence taking.

Shona Robison: Doubling from 500 to 1,000 the number of comprehensive reviews is itself a significant step. After all, those level 2 reviews will be fairly in-depth and will involve checking not only the paperwork associated with the death but the appropriate medical records and the results of any

medical investigations; discussions with the certifying doctor, other relevant staff and the deceased's family or informal carers; and consideration of any other evidence including, if necessary, arranging to view the body.

The test sites will allow us to reflect on whether the system is working not just with regard to level 1 and level 2 reviews but in a number of areas. For example, communication with families will be important and we will be able to find out whether we need to do more in any area in response to feedback from stakeholders on the test sites. I regard that as very important, and I want to involve the committee in this work. Indeed, I have committed to reporting back to you on what stakeholders are saying and reflecting on whether any changes need to be made before the new model is rolled out.

The Convener: Cabinet secretary—I am sorry; I mean minister. I was promoting you there. Can you give the committee any steer on the location for the two test sites, one of which will be urban and the other rural?

Shona Robison: We have not really reached that stage. Our commitment is to have one urban and one rural test site, but we have not yet identified any locations.

That said, we have decided to locate one of the test sites in a rural area to ensure that issues such as rurality and remoteness do not impact on the system and lead to concerns over, for example, delays. As soon as we have identified the areas, we will come back to the committee.

The Convener: I might challenge that comment by pointing out that rurality and remoteness are not one and the same thing. Rural areas, such as the one that I represent, and remoter parts such as the Shetland Islands might have separate issues and very localised difficulties. Moreover, the evidence from the faith groups that we have just taken, which I am sure the minister heard, raised a number of issues that I think should be considered with regard to the urban test site.

Helen Eadie (Dunfermline East) (Lab): I welcome the minister's comments about increasing the number of level 1 checks by 25 per cent, because the committee has felt some unease in that respect. We will certainly need time to reflect on the matter.

In response to Ross Finnie, you touched on an issue that I was going to ask about. In their written submissions, the Convention of Scottish Local Authorities and the City of Edinburgh Council suggest that the wider public will deem the £30 charge to the registry office as a "death tax". Those are their words, not mine. The preference in the submissions from a variety of people—not only the City of Edinburgh Council and COSLA—was for the money to continue to be paid to funeral directors, not the registrar, as that would help to remove the perception that this is a £30 death tax. At the moment, the charge for the basic certificate is £9 and the public would view an increase from £9 to £30 as a big jump, although we know from others that some people end up paying £30 because they want a full certificate. What is your comment on all of that?

Shona Robison: At the moment, the vast majority of people pay £147, because there are more cremations than burials. There is a real inequity in that—it has been described as the ash cash issue. The proposed new charge will deal with that, as everyone will pay £30. For the vast majority who currently pay £147, it will be a vast improvement. You also have to consider the cost of some of the alternative systems. For example, in the English medical examiner model, the cost will be £100 plus £70 to £80 for the inspection of the body, so bereaved families in England face a bill of £170 to £180. You have to put the matter in context.

The question of who collects the fee has been an issue for the committee. The truth of the matter is that representations have been made on behalf of registrars that they do not want to collect the fee, for a number of reasons, and, similarly, the funeral directors have said that they do not want to collect it. Nobody is exactly falling over themselves to volunteer, so a choice has to be made and we need to look at the arguments for and against. I will not go to the wall on this one; the judgment is for the committee. There are a number of reasons why our preference is for the registrar. All deaths have to be registered. Registrars are used to dealing with the bereaved. There are registrars in all 32 local authorities, so there is a system in place. It is not necessary to use a funeral director to arrange a funeral, so there will always be some cases that fall outwith the funeral director. It also seems odd that a statutory fee for a public service should be collected by a commercial organisation. Funeral directors do not want to collect an admin charge for a service that they are not providing—I am sure that they have expressed that view strongly. There is also the danger of significant additional bureaucracy. Hundreds of funeral homes across Scotland would have to be registered and brought into some kind of monitoring and audit scheme. We would probably have to legislate to force them to collect the fee.

Having heard all the disadvantages, I was put into the position of having to choose between two reluctant fee collectors. In the end, I came down on the side of the registrars. The list of disadvantages for a system where funeral directors are the collectors is longer than the list of disadvantages for registrars doing that.

The Convener: It is certainly a long list.

Helen Eadie: That was a helpful explanation. I have a final question on registrars. We have heard evidence, including from Jewish and other faiths this morning, about the problem of contacting a registrar, for example when a death falls at the weekend. We have heard that people at times resolve these issues only through local knowledge in having home numbers. People of faith for whom the burial has to take place on the same day as the death have told us that the issue needs to be addressed. Legislation may not be required to do that. What is your thinking on the issue?

Shona Robison: These issues are very important. We need to reassure faith communities that there would not be a delay, because that is a significant issue for them. The main thing to understand is that the review can happen concurrently with the registration at the discretion of the medical reviewer. We want to ensure that that happens. We would also highlight to the General Register Office for Scotland the need to ensure that there are no delays in the system. The test sites will be important because they will give us an opportunity to monitor and, if required, to make adjustments at that stage, before further roll-out. We recognise the sensitivities and we would certainly not want to create difficulties for our faith communities.

The Convener: As a supplementary to that, I would like to clarify something while it is fresh in my mind. Somebody else might have asked about the point that Leah Granat raised about registration and disposal being talked about as if they were one and the same thing. In the bill and the explanatory notes, that is not the case. Can you address the issue of parallel registration and review? We have issues about registration being timeous, but we also have issues about definition.

Shona Robison: Frauke Sinclair will respond to that.

Frauke Sinclair (Scottish Government Chief Medical Officer and Public Health Directorate): When registration is complete, disposal can take place and form 14, which is the disposal certificate, can be issued. The bill does not need to be changed in that regard, but I take the point that the faith groups made earlier. We can make the position clearer in the accompanying documents, but the bill does not need to be changed. That is already taken care of.

The Convener: You are satisfied that we do not need anything in the bill—

Frauke Sinclair: Absolutely. We discussed that situation when we drafted the bill.

The Convener: Hmm—I am making my "hmm" noise because I will have to think about that one. I am not sure about it. I do not say that I disagree, but I will have to think about it a little bit more because I do not know whether what you said resolves the question. What does the committee feel?

Michael Matheson (Falkirk West) (SNP): Is it entirely clear that the disposal of the body can take place while the medical reviewer is still carrying out a review?

Frauke Sinclair: No. The point that we are making is that, once registration is complete, they want disposal to take place, and the concern was that that is not the same thing. However, I made the point the last time that I gave evidence that they are the same thing in effect because—

Michael Matheson: No. Let us be clear here. The concern that has been raised is that the bill refers to the fact that the review can take place while the registration is occurring, but that registration is not the same as disposal of the body. Under the bill, if registration has occurred but the review is still taking place, can the disposal of the body occur?

Frauke Sinclair: Once the review is complete, registration can be completed.

Dr Simpson: The answer to Michael Matheson's question is no.

Michael Matheson: The answer must be no, then.

Dr Mini Mishra (Scottish Government Primary and Community Care Directorate): In the expedited procedure, when somebody makes an application, the MR, apart from screening out the vexatious requests, will communicate with the registrar after cursory, superficial scrutiny to say that, in his view, there will be no need to retain the body and that registration and disposal can go ahead while he deals with the more detailed aspects of the certification process. Another point that was made was that the disposal documents might require an MCCD and that that could tie in while the funeral arrangements are being made in the expedited procedure, bearing it in mind that getting the notes and doing about a three-hour review should all tie into an expedited burial as well. In the expedited scenario, there is provision for the MR to say that registration and disposal can go ahead while they carry out a concurrent review.

Shona Robison: But it would only be at the stage where the medical reviewer had satisfied himself or herself that there were no outstanding issues. It would not happen automatically but would have to be at the say-so of the medical reviewer. In effect, it would be a judgment made by the medical reviewer. If the committee is uncomfortable with that, we can certainly explore it

further. We felt that it was important for the discretion to be kept.

12:00

Michael Matheson: We are just trying to respect the position of different faith groups, particularly the Jewish and Muslim faiths. We want to ensure that the system does not unduly delay disposal of the body and that that is clear in the bill. From the discussion that we have had, I have been left a little uncomfortable about whether it is entirely clear on that. We need to ensure that the expedited process reflects the faith needs of certain groups in society.

Shona Robison: We had envisaged that being in the guidance, but we can certainly consider the committee's concerns if you feel that we need to do more than that.

The Convener: What happens just now when there is a faith burial within 24 hours of death? Must registration of death take place before disposal if it has to be within 24 hours?

Mike Palmer (Scottish Government Chief Medical Officer and Public Health Directorate): Yes, registration must take place before disposal.

The Convener: Is that in any circumstance?

Mike Palmer: Yes.

The Convener: So we are back to the same thing, except that we have the problem that, if we were trying to do a parallel review and registration, that might delay it. That is the point that is being made.

Mike Palmer: As the minister said, we can make that crystal clear in guidance and the secondary legislation. Section 24 of the bill says:

"The Scottish Ministers may by regulations made by statutory instrument—

(a) specify the certificates or other documentation required for the interment, cremation or other disposal of the body".

That gives ministers discretion to lay out exactly in the secondary legislation which forms and certificates would be necessary. We envisage that, under the expedited procedure, simple confirmation of registration would be required. That is form 14, which the registrar issues. We can make that absolutely clear in the relevant set of regulations so that we can reassure the faith groups about the ambiguity over disposal versus registration. [*Interruption*.]

The Convener: I think that a counter discussion or sub-discussion is taking place between Helen Eadie and Mary Scanlon. Are you ready, ladies? It is you now, Mary. Is it a collaborative question?

Mary Scanlon: I welcome what the minister said about doubling the random sample of cases from 500 to 1,000 and the level 1 reviews on 15,500 deaths—I think that that is what she said—each year. I ask her to put that in the context of Stewart Fleming's evidence. He said:

"Each doctor in Scotland would only have on average one certificate reviewed every 5-10 years."

Given the changes that you announced today, how often on average would each doctor in Scotland have a review? Would it be once every four years?

Shona Robison: I am not sure that we will be able to answer that today. We can certainly try to work that out and come back to you.

Mary Scanlon: Given that the random sample will be doubled, instead of saying:

"Each doctor in Scotland would only have on average one certificate reviewed every 5-10 years",

we are now saying that it would be every two and a half to five years. Would it, therefore, be accurate to say that a doctor would have one certificate reviewed every four years?

Dr Mishra: It really depends on the number of certificates that a doctor signs. It is difficult to make an average because a doctor in a remote area might sign few certificates, whereas a doctor who looks after a care home might sign many. We can categorically say that one certificate in four will be reviewed, but the link between the certificate and the doctor is quite tenuous.

Mary Scanlon: Professor Fleming was able to come up with that figure in his written evidence before seeing you and I wonder what impact your announcement will have on the average that he was able to come up with.

It would be helpful to know that, because paragraph 2 of the policy memorandum—I take what Ross Finnie said—says that the bill is

"to examine the processes governing death certification following the inquiry into the case of Dr Harold Shipman."

That means more robust reviews than each doctor having one certificate reviewed every eight years, on average. Could you write to us to say how the changes that you have just announced will impact on the average that Stewart Fleming came up with?

Shona Robison: We can do that, although the whole raison d'être of the review system, including both level 1 reviews and level 2 reviews, is to drive up the quality of MCCDs in general, so that every certifying doctor is ensuring that the quality improves—unlike in too many cases at the moment. That is a very important part of the new system.

The issue is not just how many certificates each doctor might end up having scrutinised; it is more about driving up the general quality of those certificates across the board.

Mary Scanlon: I appreciate that, and you mentioned the quality improvement system.

Many of our witnesses were less than impressed with the bill. For example, Ishbel Gall of the Association of Anatomical Pathology Technology wrote:

"AAPT do not think that the proposed changes to Death Certification proposed in the Bill ... will work in practice and that there will be no improvement to ... quality".

Is there anything that you have announced today that would provide some assurance that you have improved the quality of death certification?

Shona Robison: The system that we propose to introduce is about doing exactly that: ensuring, through the system of level 1 and level 2 reviews, that quality remains very much a part of what goes down on the certificate. In addition, it will be possible to take an in-depth look at practice in certain areas of Scotland—for example, groups of care homes, GPs or hospitals—and consider whether there are statistical anomalies that require to be further investigated. Furthermore, there is an education and training element, in which medical reviewers will play an important part.

Looking at the package, quality improvement comes through all that. The quality of the completion of the certificates should improve—I very much believe that it will—because of all the elements of the system.

Mary Scanlon: My final question is on false certification and the underlying causes of death. The matter has been raised by many witnesses in both written and oral evidence. I return again to Stewart Fleming's evidence. He pointed out that in cases in which patients die of liver failure, it is only upon further examination that it might

"become evident that these were cases of suicidal paracetamol poisoning"

or of mesothelioma. There could be false certification merely through human error. Professor Fleming said that such cases

"would not be detected by the systems proposed."

He goes on to ask:

"Would the public be reassured by a process which allows hundreds of unnatural deaths to pass undetected?"

I have also raised a point about underlying causes in relation to diabetes. Someone could die of a heart attack, but it might not be recorded that one of the main contributory factors was diabetes or, for example, hospital-acquired infection. Will quality be improved? Will there be more information? Will more focus be given to contributory factors? Will the information be more accurate?

Shona Robison: I believe so, as quality will be driven up. Unfortunately, at the moment some death certificates still say that a person died of old age. That is completely unacceptable in this day and age.

The Convener: Our GPs are wincing—they will intervene.

Shona Robison: We must recognise that the current system does not detect the issues that Mary Scanlon has outlined and ask ourselves what we are trying to do. We are trying to drive up quality. The level 1 and level 2 checks will drive up the quality of completion.

The nub of Mary Scanlon's question is whether there is any system that we could put in place that would detect some of the issues that have been mentioned. That would be a difficult task. Unless a post mortem is conducted and a toxicology report is produced for every one of the 50,000-plus deaths in Scotland each year, we will not necessarily be able to get at some of the issues that she raised. However, we can have the best and most proportionate system that includes a sufficient level of deterrence. There has been wide recognition that it would be difficult to put together a system that was completely foolproof and that could always detect a Shipman-type scenario. The best that we can do is ensure that the level of deterrence is strong enough, that any statistical issues that arise are detected—the national statistician has a hugely important role—and that the quality of completion of death certificates improves. I believe that the system that we propose will do that. That is the best and most proportionate approach—affordability is an issue. The bill establishes the best system for doing all the things that we want to do.

Mary Scanlon: The points that I am making are not my own—they are taken from the evidence of learned professors and others.

Can you give me one example to assure people that, once the bill is passed, there will be less false certification and that, where appropriate, more factors that underlie and contribute to death will be mentioned on death certificates? Most of the written submissions that we have received have suggested that certificates will become more vague, rather than providing better quality information.

Shona Robison: I will give you an example of how the position will be strengthened. Under the new system, families will be able to raise with the medical reviewer concerns about the cause of death, which is not the case at the moment. You mentioned health care acquired infection. At the moment, families have no mechanism to say in an

easy way that they are concerned that something about the cause of death has been omitted from a death certificate. Under the new proposals, a family will be able easily to contact the medical reviewer to say that they are not happy, which will allow the reviewer to look into the case. At the moment, that mechanism does not exist, but it will be part of the medical reviewer's role. That is an important additional element for families that will enable them to raise their concerns.

Mary Scanlon: If the family initiates the process, is there anything in the medical profession that will lead to the information being provided?

The Convener: An interested person may initiate the process.

Shona Robison: Yes, it does not have to be the family—any interested person can raise concerns. I was referring to the fact that the family may not be happy. The proposed arrangements really strengthen their position.

The Convener: I was thinking of whistleblowers who want to raise issues.

Dr Simpson: I have some quick questions. First, I take it that we will get a new financial memorandum. Clearly, the costs will now go up, and the charge has not been included; I presume that we will get that.

Shona Robison: Yes.

12:15

Dr Simpson: Secondly, Professor Fleming gave a ballpark figure for the current system, saying that in 20 to 30 per cent of post mortems the initial determination of death was inaccurate. No one is suggesting that we go back to having massive numbers of post mortems—although it has been suggested today that we should consider the alternative scanning methods that are being piloted in England. Even if not today, it would be good to hear the minister's and the department's reflections on that suggestion.

My main concern is quality. The public have to be confident in the system, and the minister has gone a long way towards answering that point today with the 25 per cent level 1 review. That helps enormously. However, certificates are often signed by junior doctors. For cremations, a doctor cannot sign a death certificate unless they have been qualified for X years and unless they have gone through a module of training. The minister has repeatedly referred to the need for training. If a junior doctor has the experience and has completed a module of training in death certification, that will drive up quality. Did you consider specifying a level of experience and training?

Electronic processes are used in part of the system at the moment: once the registrar has registered the death, it will be electronically transmitted to the medical adviser—currently Colin Fischbacher—in ISD Scotland, who then undertakes checks and writes to the doctors. We have heard about the number of letters and about the poor response rate—about 70 per cent. Have you considered an electronic system? Such a system would tighten your data set considerably. If you have only drop-down menus on which to operate, you can devise software to ask questions—and Professor Fleming referred to that in terms of the renal review register. That allows you to get to nuances in the certification process that you cannot get to at the moment.

If you feel that death by old age is something that we elderly GPs are wrong to write—

The Convener: You asked for that on your death certificate—"old age"—which is a long way away.

Dr Simpson: Thank you. I know I did. I hope I do die of old age, and that a revolutionary doctor will put it down as "old age". However, if that is not acceptable—and I understand the need for epidemiology and so on—we will need a system that will prompt the doctor. Any modern system that does not have an electronic approach to take this out from the back end, where it is at the moment, and put it in at the front end, is losing a massive opportunity.

A change to the bill may not be required; it may be that regulations will have to be developed. However, I would like an assurance that nothing in the bill will confine us to the old-fashioned paper system that has served us so badly over the years, and that we will have the opportunity to move forward.

Shona Robison: I will write to the committee about scanning methods; that would be the best way of answering that question.

Dr Simpson raises a number of important points about quality. I will ask Frauke Sinclair to respond on the training and certification of doctors. At the moment, the requirement for who may certify death is any registered doctor supervised by an educational supervisor consultant. I will pass to my colleagues the question whether consideration was given to whether it should be specified that a doctor has a certain level of training or qualifications.

Dr Mishra: The question was considered. Any registered doctor who is beyond F1—that is, who is in F2 onwards—can certify death. If we are restricted to people who have more than a certain amount of experience, two issues arise. One is that doctors in training do not get that training, and the other is that we will not have enough doctors

to do the certification, which would lead to delays and other problems.

We spoke to educationists, who feel strongly that junior doctors should have a role in certifying deaths, but that they should be supervised by their seniors, which is what is meant to happen. That is also relevant to general practice, where GP registrars should be supervised by their trainers.

That is the way that deaneries would like us to go. They would like us to emphasise the educational supervisors' role in death certification, just as in other activities, such as operations.

Dr Simpson: I am interested that you use operations as a parallel—I would use something else. Supervision is extremely patchy—people are left to do death certification at weekends when no consultants are in. If we genuinely want to drive up quality, we must have an experience qualification or—if we accept your argument about delays, which are important—junior doctors should have to do a training module. Postgraduate training is now all about modules. Junior doctors should not be allowed to sign a death certificate unless they have been signed off by the deanery as having undertaken a module.

Shona Robison: We will certainly reflect on that.

You have previously raised the issue of an electronic system, which we have examined in detail. I reassure you that nothing in the bill confines practice to a paper-based system. My only note of caution is that introducing new information technology systems is costly.

We will certainly continue to consider the suggestion. I suspect that it might be difficult to have a system up and running for the test sites, but we would always consider where IT solutions could help. On your main point, I reassure you that nothing in the bill requires the system to be paper based, so it is future proof.

Ian McKee: I congratulate the minister on the excellent level 2 proposals and especially on giving interested parties and relatives a formal way to have a death investigated further. However, I have concerns about the new level 1, which you can perhaps help me with. I gather that the proposal is that 25 per cent of deaths—or perhaps 23 per cent, if we leave out the 2 per cent—

Shona Robison: That would be additional.

Ian McKee: For 25 per cent, a telephone conversation will take place between the reviewer and the doctor who signed the certificate.

Shona Robison: The medical reviewer will check the MCCD and will then speak to the certifying doctor by phone to obtain background clinical information. If the reviewer becomes concerned at any point and for whatever reason, they will be able to escalate the review to a level 2 comprehensive review.

I do not claim that a level 1 review will be at the same level as a level 2 review, because it will not be, but the system will be designed to cast the net wider, so that a check—albeit a fairly straightforward one—is done. Should any alarm bells ring, that check could be escalated. Through the test sites, it will be interesting to monitor how many cases are escalated. That should begin to paint a picture for us of whether issues are being picked up and escalated from level 1 and, if so, to what extent. I am keen to examine that once we have that real-time information.

Ian McKee: I return to what happens today. I am a bit confused about information that Dr Mishra gave me yesterday, which she can put on the record now, about the statutory basis of the certificate that is given for cremation forms. Will she expand on that?

Dr Mishra: The cremation forms are specified in legislation—a statutory requirement applies. On top of that, crematoria place conditions in bold or in red—they have local variations on the statutory forms. Crematoria insist on doctors filling in some parts, but those extra requirements have no statutory basis.

Ian McKee: What information is required in statute?

Dr Mishra: Statute requires five questions to be asked, but none of those questions needs to be answered in the affirmative.

Ian McKee: So doctors can be asked whether they have done a post mortem, whether they have spoken to the relatives, whether they have spoken to the doctor who signed the certificate and so on, put no to all those questions and have fulfilled their statutory obligation?

Dr Mishra: Yes, on form C, at the moment. However, those are the current cremation regulations.

Ian McKee: I have in front of me the form that is used by the City of Edinburgh Council at Mortonhall crematorium. It says that the certificates are statutory and that all questions must be answered fully.

Dr Mishra: I have that Edinburgh form as well. It says, in red ink, that one question should be answered in the affirmative. Glasgow asks for two questions to be answered in the affirmative. Each area has different requirements.

Ian McKee: Does any cremation body say that none of the questions need be answered in the affirmative?

Dr Mishra: I have not trawled the whole system, but I went through Edinburgh's forms and I have them here. I also found out from Glasgow, the other of the two biggest cities, what its custom is. There are areas on the forms that are highlighted in bold or red. They are not specified in statute, but they are required by local authorities.

Ian McKee: Taking practice as it exists rather than concentrating on the theoretical, you probably agree that most doctors who get a form that says a certificate is statutory and that the questions must be fully answered will, according to custom and practice, answer at least one of the questions in the affirmative—if that is what they are asked to do. Do you agree with that?

Dr Mishra: Yes I am sure they will, otherwise the form will be rejected.

Ian McKee: So, the system at the moment is that 60 per cent of all deaths in Scotland require the completion of a two-part cremation form. In practice, part 2 is signed by a doctor—not the doctor who signed the first part—who questions the first doctor and either another doctor who was involved or the relatives or people nursing the deceased at the time of death. Is that right?

Dr Mishra: That is what they affirm.

Ian McKee: Minister, do you think that the public will be convinced that we have a better procedure when, instead of 60 per cent of all deaths requiring the first doctor to be interrogated by a doctor who has no financial or professional interest in the workings of the first doctor and the relatives or people who were nursing the deceased having to be questioned, 25 per cent of all death certifications require a telephone conversation between a central doctor and the doctor who is to sign the certificate?

Shona Robison: The question is really about the purpose of what we are trying to achieve. The review group, which debated those issues for two years, concluded that there was little to be gained for the public purse or for public reassurance from the current system. That is why we are sitting here debating a new system to replace it. The old system was seen as out of date and unnecessary.

Two options were proposed for our consideration. We are talking about one of them. The other, which represented more of a minority view in the review group, was for a medical examiner model. We have chosen to take the route that we are discussing. The system will not be the same. I would not claim that it is the same. We are having this discussion because the old system was not found to be fulfilling any particular purpose and it was extremely costly to the bereaved family. We could not continue to justify the ash cash issue, which has caught the public's attention, and times and understanding have moved on from when that system was established medical practice.

Ian McKee: You have doubled the number of level 2 investigations. What effect will that have on the number of medical reviewers who will be appointed?

12:30

Shona Robison: We estimate that the number of medical reviewers will rise to 10. That is not set in stone, so we can make adjustments if required, but we estimate that there will be 10 full-time equivalents—there might be some part-time people. However, they will have administrative assistance to help with some of the paperwork, so it is not as if they will have to do all the paperwork themselves. We believe that that will be adequate but, again, we will be able to find out for sure through the test-site model.

Ian McKee: My next question is on education. You kindly provided us with figures that show that approaching 20,000 doctors in Scotland are able to sign certificates. It was explained to us that the medical reviewers will spend half their time on an education function. I mentioned in a previous evidence-taking session that a few medical reviewers educating 20,000 doctors in a part-time capacity seems a huge task. Obviously, the deans and the postgraduate organisations will be involved and, as my colleague Richard Simpson says, it would be good to have a module, but how exactly do you envisage the medical reviewers fulfilling their education function as opposed to that function being part of ordinary postgraduate training?

Shona Robison: Both will be important. The medical reviewers will have the opportunity to have some strong local links with the professionals in their areas. I envisage that they will take the opportunity, particularly in the early stages of the new system, to hold educational sessions locally. However, the most important aspect will be the on-going relationship. The medical reviewer should develop a relationship with the doctors in their area so that they can lift the phone, for example, should anything require to be clarified, particularly in the early stages of the new system. Some of the work might indeed involve formal input—obviously, that will have to be manageable time-wise—but some of it might be more informal, such as doctors checking on the phone with the MR that they understand the system correctly.

Frauke, do you want to say anything more about education?

Frauke Sinclair: Yes. We do not expect the medical reviewers personally to undertake the training of, as you rightly said, nearly 20,000 certifying doctors. That would not be feasible. We

have had initial talks with educational bodies and, for example, the postgraduate deans. Their view is that the education supervisors have a responsibility to ensure that there is quality in this area.

The medical reviewers will carry out their education and training functions in a number of ways. We will particularly look for the senior medical reviewer to take a leading role in the area. For example, they will be expected to contribute to training through seminars, making links with the deans and talking to boards. The regional medical reviewers will have one day a week, not half their time, in which to carry out their training and education role. They will mainly focus on the scrutiny and review role. I just wanted to clarify that.

Ian McKee: Oh, right. Sorry—I thought we were told it would be half their time.

Finally, I have a question on the diagnosis of old age on death certificates. The convener has prompted me several times to raise the issue. In defence, the fact is that lots of people die when they are old and it is often not easy to establish a specific cause of death. One of my friends died in that situation last week. I appreciate that it would look a lot more accurate if we could put down "heart attack", "stroke" or some other diagnosis that makes total medical sense, but it is debatable whether it is good to push doctors into putting down a diagnosis to fit some coding when they are not in the slightest bit certain that it caused the death. In many cases it is not obvious what the cause of death is but there is nothing suspicious about the death. If someone who is 97 goes to bed and they are dead when they are found in the morning, how do we get over that? Are you really just wanting the diagnosis of the week to be chosen, which you will vary, or what? What your statistics show will depend on what you choose. If you choose myocardial infarction every time, there will be a lot more myocardial infarctions in Scotland at the end of the year.

Shona Robison: I should probably not have raised the point about old-age diagnosis.

The Convener: I would like a definition of old age. I think that you will regret the phrase, "diagnosis of the week". I am told that the definition of old age is "older than the doctor".

Dr Mishra: As some of you may know, the guidance for completion of the MCCD is provided by the General Register Office for Scotland, but it is supplemented by more detailed guidance that has been agreed by doctors through the chief medical officer for Scotland. When the new legislation comes through, that guidance will be reissued and updated. It takes doctors through different scenarios and sets out when certain diagnoses are appropriate and not appropriate. We had hoped to help doctors through that in guidance.

Ian McKee: What do you do when everyone agrees that no firm diagnosis can be made, but there is nothing suspicious? You do not want a post mortem of someone who is in their 90s. What do you ask the doctor to put on the certificate?

Dr Mishra: In those circumstances, it is acceptable under the current guidance to specify "old age" in people above the age of 80—

Ian McKee: So I can be vindicated in what I said about the diagnosis of old age, despite what the minister said.

Shona Robison: You have done that very well.

The Convener: I have a final question on an issue that I raised previously. It is small but important and relates to section 26 and the stillbirth declarations. I note that there is apparently a change. The explanatory notes state that section 26 amends the Registration of Births, Marriages and Deaths (Scotland) Act 1965, which

"provides for a declaration that the child was not born alive and that no medical practitioner or midwife was present",

so that there is a mandatory referral to the procurator fiscal. Such circumstances are extremely difficult for any grieving mother; her baby may have died in utero before she ever got to the hospital, where it was born. My understanding is that many GPs can tell that there was nothing suspicious. My concern is that every mother in that situation will now find that the death is reported to the procurator fiscal. That could be extremely distressing. Is it not too big a step? Should the death not be referred to the procurator fiscal only when it is reasonable to do so? Why make it mandatory?

Shona Robison: I certainly understand the sensitivities you are referring to.

Frauke Sinclair: That relates to a form that currently applies only when no doctor or midwife was present at the birth. It is applicable in less than 1 per cent of cases; it hardly ever applies. We are not really changing many circumstances here. The number of stillbirths in Scotland in 2009 was 317, so we are talking about a couple of cases. Referral of stillbirths to a procurator fiscal is very rare.

The Convener: From my point of view, a couple of cases is a couple of cases too many if there is no reason for referral. I do not know why it is necessary. I appreciate that we are talking about a few people, but these are people who find out that their baby is dead, there was nothing suspicious about it and yet, I presume, they are told that the

death is being reported to the procurator fiscal. I have concerns about that.

Dr Mishra: Any doctor who is asked to certify a stillbirth will always say, if they were not present at the death, that it was a sudden death. On that basis, they would refer the stillbirth. If it was a death in utero, the mother would in most cases deliver in a hospital setting. In that case, somebody would be present at the birth. What we are really looking at is sudden deaths where a young girl delivers a baby—a concealed pregnancy or whatever—and the baby is found dead. In those circumstances I think that the doctor would be required to refer to the procurator fiscal, because the cause of death is uncertain.

The Convener: I am not totally satisfied by that. I think that the professional would exercise his or her professional judgment and discretion and say, "I am concerned about this, so I'll refer it." My concern is that the whole thing is now mandatory and, in those circumstances, one such case is one too many in my book.

Frauke Sinclair: We have consulted the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, which are content with the proposals.

The Convener: And what about procurators fiscal?

Frauke Sinclair: And the procurators fiscal, too.

The Convener: I do not know. I think I would also have asked mothers who had had stillbirths about their feelings about such a proposal.

Shona Robison: We will certainly reflect on that, convener.

The Convener: Thank you very much. That concludes the evidence session. There will be a pause to allow for a changeover of witnesses for the next item of business, which is consideration of subordinate legislation, but we will all stay nailed to our chairs.

Subordinate Legislation

Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010 (Draft)

12:42

The Convener: The next item of business is an oral evidence session on an affirmative Scottish statutory instrument. Members will have received a copy of the draft regulations and the clerk's cover note, which includes, for information, the Subordinate Legislation Committee's comments. Remaining nailed to her chair is Shona Robison, the Minister for Public Health and Sport, and we have been joined from the Scottish Government by Mary Cuthbert, head of the tobacco, sexual health and HIV team, chief medical officer and public health directorate, and Rosemary Lindsay, principal legal officer in the solicitors health and community care division, legal directorate. A motion that the committee recommend that the instrument be approved has been lodged and will be debated under the next item on the agenda. Once the debate has begun, the minister's officials will not be able to participate.

I ask the minister briefly to outline for the committee the purpose of these draft regulations.

Shona Robison: I will be brief. The draft regulations underline the Scottish Government's commitment to implementing the Tobacco and Primary Medical Services (Scotland) Act 2010 and, if approved, will ensure that the required information is supplied on people who wish to sell tobacco from moveable premises. They also provide details of the fixed penalty scheme set out in the 2010 act. As members will note, the draft regulations have been adjusted to take account of some minor drafting points that the committee's legal advisers have raised.

The regulations are an important component of our plans in the 2010 act to establish a tobacco sales registration scheme. The act also introduces a fixed penalty scheme. The registration scheme will come into effect on 1 April 2011 and retailers will have a full six months, until 1 October 2011, to register. An important point is that, as we pledged during the Parliament's consideration of the Tobacco and Primary Medical Services (Scotland) Bill, registration will be simple and free.

Regulations 2, 3 and 4 set out the information that will be required from applicants to the register who intend to sell tobacco from moveable premises, while regulations 5, 6 and 7 set out information and detail about the new fixed penalty scheme. As these measures will help significantly in regulating sales of tobacco products and will

form an important part of our efforts to curb illicit sales, I hope that the committee will support the draft regulations.

12:45

The Convener: Do members have any questions? No? Well, that is fine. That ends the evidence session.

We now move to the debate on the motion to approve the draft regulations. If no member wishes to speak, I will ask the minister to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the draft Sale of Tobacco (Registration of Moveable Structures and Fixed Penalty Notices) (Scotland) Regulations 2010 be approved.—[*Shona Robison*.]

Motion agreed to.

The Convener: I thank the minister for her evidence.

Sale of Tobacco (Prescribed Document) Regulations 2010 (SSI 2010/406)

Sale of Tobacco (Register of Tobacco Retailers) Regulations 2010 (SSI 2010/407)

Community Health Partnerships (Scotland) Amendment Regulations 2010 (SSI 2010/422)

The Convener: The next item of business is consideration of three negative SSIs. Do members have any recommendations to make?

Members: No.

The Convener: With that, I close the meeting.

Meeting closed at 12:46.

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