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Pàrlamaid na h-Alba

Official Report

PUBLIC PETITIONS COMMITTEE

Tuesday 4 October 2011

Session 4

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PUBLIC PETITIONS COMMITTEE
5th Meeting 2011, Session 4

CONVENER

*David Stewart (Highlands and Islands) (Lab)

DEPUTY CONVENER

*Sandra White (Glasgow Kelvin) (SNP)

COMMITTEE MEMBERS

*Neil Bibby (West Scotland) (Lab)
*Mark McDonald (North East Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Bill Walker (Dunfermline) (SNP)
*John Wilson (Central Scotland) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Joan Fletcher (Association for Glycogen Storage Disease UK)
Alastair Kent (Rare Disease UK)
Dr Lindsay Mitchell (NHS Lanarkshire)
Peter Morris
Gil Paterson (Clydebank and Milngavie) (SNP)
Anna Robertson (Aberdeen Law Project)

CLERK TO THE COMMITTEE

Anne Peat

LOCATION

Committee Room 2

Scottish Parliament

Public Petitions Committee

Tuesday 4 October 2011

[The Convener *opened the meeting at 14:03*]

New Petitions

Orphan Diseases (Access to Therapy) (PE1398)

Pompe Disease (Access to Therapy) (PE1399)

Paroxysmal Nocturnal Haemoglobinuria (Access to Therapy) (PE1401)

The Convener (David Stewart): Good afternoon, ladies and gentlemen, and welcome to the fifth meeting of the Public Petitions Committee in session 4. No apologies have been received. I remind everyone to switch off their mobile phones and all other electronic devices.

I welcome our visitors from the Republic of Ireland's Joint Committee on Investigations, Oversight and Petitions, who are in the public gallery, and I thank them for coming along to our session this afternoon.

Item 1 is consideration of new petitions. There are five new petitions to consider today, the first three of which will be considered together. PE1398 is on access to therapy for orphan diseases; PE1399 is on equitable access to therapy for Pompe disease; and PE1401 is on access to therapy for paroxysmal nocturnal haemoglobinuria. Members have the notes from the clerk, the Scottish Parliament information centre briefings and the petitions.

I welcome our witnesses: Alastair Kent, chair of Rare Disease UK; Joan Fletcher, family support officer with the Association for Glycogen Storage Disease UK; and Dr Lindsay Mitchell, a consultant at Monklands hospital in Airdrie. I thank you all for coming along today.

I invite Alastair Kent to make a short presentation of around five minutes, after which we will move to questions.

Alastair Kent (Rare Disease UK): Thank you for the opportunity to talk to the committee about access to therapies for rare diseases.

I begin by assuring you that we are not here to demand a blank cheque. We realise that health resources are limited and that we need a system that is fair and rational in the allocation of those resources. The national health service is based on an assumption that treatment will be delivered according to need rather than according to the individual's ability to pay. Patients who have rare diseases are in a situation in which, if a therapy is available for them, it is likely to be expensive because of the small number of people who are affected.

People with rare diseases do not choose to have a rare disease. There is no kudos attached to having something that is difficult to diagnose, expensive to treat and about which little might be known. It is a tribute to the success of the European Union's orphan medicinal products policy that we now see therapies becoming available for diseases that have hitherto been untreatable and have led to prolonged and severe ill health and the loss of quality and quantity of life.

Getting a therapy on the market is one thing, but getting it into the patient so that they can benefit from it is another. Many of the orphan drugs—the therapies for rare diseases that we are talking about—are life changing. They move a disease from being rapidly progressive and life limiting to one with which a more normal quantity and quality of life can be expected. The problem in Scotland is that patients are not able systematically to access some of those therapies in the way in which they can elsewhere in the United Kingdom and Europe.

Our contention is that the mechanisms that are in place in Scotland, either through the Scottish Medicines Consortium or through the individual patient treatment request system, are not fit for purpose. They are more likely to deny patients access to effective therapies than they are to allow it. If there is a notional ceiling of £30,000 per quality-adjusted life year, and a treatment costs perhaps £100,000 per patient, it does not take a complicated sum to work out that the acceptance box is unlikely to be ticked. In the individual patient treatment request system, the practical need to demonstrate exceptionality with small populations that are all pretty well at the same level of need is not fair, reasonable or doable.

Some of the treatments might make a small physical difference to the patient but a huge difference to their quality of life. I know one young woman who has an inborn error of metabolism. She receives enzyme replacement therapy, and her lung function has increased by 4 per cent, which for us is a short intake of breath. For her, it means that she can come off artificial respiration for most of the day and that she can go out of the house and be confident that she is not dependent on a machine that might break down at any minute and leave her stranded. It means that when she kisses her partner and it leaves her gasping, it is the emotion and not asphyxiation that produces the reaction. It means that she can think about having a job for the first time.

Many other patients who get the benefit of such life-saving therapies gain similarly from the impact on the quality of their lives, even if the physiological changes that they experience from the therapy are objectively quite small.

You can imagine the frustration and anguish that families experience when they see a therapy appear and get licensed and they see it working in families in similar positions but they are denied access to it, not on biologically sound grounds or clinically sound determinations between one patient and another, but on economic grounds. Our contention is that Scotland and Scottish patients are getting a raw deal because the system in place to allow such people access to such a therapy is more likely to deny than approve the opportunity for them to get it.

The chairman of the National Institute for Health and Clinical Excellence, Mike Rawlins, once said that sometimes you just have to bite the bullet and pay the cost. Sometimes a lot of money simply has to be spent because that is the measure of our civilisation, care and commitment to meeting the needs of every family and patient through the national health service. However, it is not just about the absolute expenditure of cash on the therapy; the opportunity that is created and the waste of money on ineffective interventions that is avoided need to be factored in.

Scotland has taken the lead in providing high-quality NHS services in ways that are often looked to by the rest of the UK and further afield—one need think only of the work of the national services division as a model for many—but, unfortunately, the Scottish system is more likely to say no than yes to access to therapies for rare diseases. Our contention is that the system needs to be looked at to ensure that there is a rational framework that can legitimately distinguish between therapies that will achieve significant changes in patients' quality or quantity of life and those that will not, and which is based on medical and social needs rather than just the cost of the treatment.

The Convener: Thank you very much, Mr Kent. That was a helpful introduction. I will kick off with a couple of questions. The other two witnesses should feel free to get involved at any time.

Do you notice any differences among health boards' approaches? Do we have a postcode lottery here? Is there an issue about consultants making good, strong decisions and health board bureaucrats saying no, or is that a simplistic analysis of where the problem lies?

Alastair Kent: It would be appropriate to ask my two colleagues to comment on those issues.

Joan Fletcher (Association for Glycogen Storage Disease UK): We have definitely found that some health boards have accepted treatments for patients whereas others have not. We have three patients in Scotland on treatments, but two other patients have been refused them and four applications are pending. Therefore, we have found that there is a postcode lottery.

Dr Lindsay Mitchell (NHS Lanarkshire): I work in the Scottish PNH outreach clinic in Monklands, which all Scottish patients with rare diseases can be referred to for access to specialist advice. We give advice to referring haematologists throughout Scotland, including advice on whether we think that the patient should be treated with a therapy, although our recommendation does not automatically mean that the patient will access it.

Seven patients are on treatments in Scotland, three patients for whom we recommended treatment have been refused it, and one application is pending. It is difficult to say whether there is definitely a postcode lottery, but things are, of course, very difficult when we recommend a therapy for a patient that is then refused by the health board in whose area the patient resides.

The Convener: Thank you. That is very useful.

Sandra White (Glasgow Kelvin) (SNP): I welcome the witnesses to the committee.

Three petitions that refer to similar issues have been submitted. My question is about PE1398. Paragraph 11 of paper PPC/S4/11/5/1 from the clerks says:

> "As part of the process NHS Boards were"

not so much ordered but were

> "to have written policies in place for dealing with such requests".

That was mentioned in Alastair Kent's introductory remarks. Have all the NHS boards achieved that?

Alastair Kent: To be honest, I am not sure, but I do not think so. We certainly do not have copies of those policies from all the boards.

14:15

Dr Mitchell: We certainly have a policy in Lanarkshire. My understanding is that, in most health boards, if a policy is not in place, one is about to be ratified and will be in place.

Sandra White: That leads me to the observation that, if we were to continue the petition, we would want such information to be brought to the committee, as there are no particular dates by which the written policies should be in place. I would like the committee to follow up that issue.

I will leave it at that, as I know that other members want to come in.

Nanette Milne (North East Scotland) (Con): I have a question for Mr Kent. I am particularly interested in point 3 in the background information to the petition on the “Assessment of Orphan Medicines” and the role of the advisory group for national specialist services in England. Can you elaborate on AGNSS and its work? I know that that work is taking place in England. Do you see it moving into Scotland? Do you know whether there is any intention for such a system to be adopted in Scotland?

Alastair Kent: The advisory group for national specialist services is a multidisciplinary group, which has been set up to advise the Secretary of State for Health in England on not only medicines but all forms of intervention that come before it for services that affect fewer than 500 patients in England. Those are highly specialised interventions for very small numbers of patients.

The system works because it recognises that, in dealing with either very rare conditions or very complicated interventions, the evidence base that you could expect in dealing with a much bigger population is unlikely to exist. You therefore have to make an evaluation and a judgment based on the evidence that you have, in the expectation that you can put further steps in place to evaluate the impact of the intervention as the data is concluded.

Among the issues are clinical effectiveness; the scientific rationale for the intervention; the input from different stakeholders, including patients and families, on the impact of the disease or condition on the patient’s quality and quantity of life; the aspects of the disease that will be ameliorated by the proposed treatment; the cost of the intervention; and the cost of other available services. Whether or not patients get the treatment, they will have expectations of services from the NHS.

The advisory group—AGNSS, as we know her—makes a recommendation based on a case that has been put to it, usually by a lead clinician with the support of colleagues. The secretary of state is then minded either to accept or not to accept. As you know, proposed changes to the system in England are currently before Parliament but, if the secretary of state retains the power under the new system, he will be able to dictate to the national commissioning board that a service be provided. Otherwise, the case may go to the national commissioning board with a recommendation for provision.

That system means that patients can expect a uniform standard of service across England. There may be designated centres that provide the service, as with, for example, the inborn errors of metabolism. In that situation, patients have to go to an expert centre to access the service, which means that the quality of service, the cost implications and so on can be controlled. The system does not require the same volume of evidence as a NICE single technology or multiple technology appraisal, because it reflects the reality of knowledge about the situation and the condition.

Joan Fletcher: Patients in England with the condition are treated in various centres that are overseen by AGNSS. All patients in England with Pompe disease have access to treatment, which is available at the request of the treating consultants. About 90 or so patients in England are being treated, as were the patients in Scotland. However, there are quite a few who cannot access the treatment.

Nanette Milne: Thank you for that. Given that there would be significantly fewer patients with orphan diseases in Scotland, could AGNSS easily translate into the Scottish scene?

Alastair Kent: There is already input from the Scottish health department in that regard, as it sits as an observer on AGNSS, so you would not have to reinvent the wheel and carry out an adaptive process in Scotland from scratch. You could take the information from AGNSS and transpose it into a Scottish context in a relatively straightforward manner.

Nanette Milne: Are the observers from Scotland from the SMC or are they specialists in various diseases?

Alastair Kent: They are from the Scottish Government’s health department.

Mark McDonald (North East Scotland) (SNP): I have several questions, but I might not need to ask some depending on the answers. The QALY limit tends to be set at £30,000. How many of the available treatments would fall within the £30,000 QALY for these rare diseases?

Alastair Kent: Most of them tend to come above the £30,000 per QALY limit because they are usually novel therapies that have developed at the edge of research and require innovative technologies to be delivered. They will have been developed with a high investment in research and development. A couple of the ultra-orphan conditions may come under the £30,000 limit, but the majority of them come above that threshold.

Mark McDonald: If the QALY was to be increased for the treatment of these diseases, what would be a realistic upper limit?

Alastair Kent: The QALY is not an appropriate model to use as a threshold. The rhetoric is that a QALY provides an opportunity for comparing across interventions and diseases. Our problem with the QALY methodology is that it assumes that there is evidence at the point of evaluation or that it is relatively easy to generate the evidence in order to compare apples and oranges or fish and fowl.

NICE looked at the possibility of extending the QALY system—its QALY evaluation process—particularly to the ultra-orphan conditions, which are the ones that we are looking at. It said that, although the process was theoretically applicable, the quality and quantity of the data would require such huge assumptions that no conclusions could be confidently based on the outcome of the process.

We need to move away from the idea of using a model that is driven by assumptions of health technology appraisal, which can produce hard and objective data about what a particular intervention does or does not do. Instead, we need to broaden the criteria and look at the clinical context, the biological knowledge about the disease and the intervention, such as it is known, the social impact of the condition on families and on patients' broader confidence that the NHS will be there for them, and the economic cost of doing nothing or carrying out ineffective interventions.

The Convener: I am sorry to cut you short, Mr McDonald, but we are running out of time.

Mark McDonald: I will try to encapsulate everything in my final question. Is the concern that if you were to remove or adjust the QALY threshold people would start asking why other areas in which treatments are beyond the £30,000 limit could not be considered? Do you contend that, because of the rarity of the diseases that you are talking about, an exception could be made without the worry of setting a precedent for other disease treatments?

Alastair Kent: Yes. That is exactly the case. For any one of the ultra-orphan conditions, we are probably talking about between one and a couple of dozen patients throughout Scotland. We need to take such patients outside the mainstream system and find a way of responding to their absolutely legitimate expectation that the NHS is for them as well as for everyone else, without opening the floodgates to expectations that the NHS will provide whatever we want whether or not it works, which is clearly unreasonable.

Bill Walker (Dunfermline) (SNP): We are talking about rare conditions that involve patients in their twos and threes—or maybe fives and sixes. I have a business background in medical technology. Are there opportunities for economies of scale? Can we get health boards to bring in more patients? Is there scope for the unit cost per treatment to be brought down below the limit? If we measure things in ones and twos, the costs are high, but if we bring everyone together from different sources the unit costs should drop.

Alastair Kent: I am not qualified to talk about the price of the product, which is a matter for negotiation with the company that manufactures it. However, in Scotland there are centres of expertise in the care and management of particular rare diseases. The introduction of the European Union cross-border healthcare directive presents an opportunity to create the critical mass of expertise that would potentially bring patients with specified rare diseases from all over Europe. Those patients would bring with them the resource that would help to sustain the particular Scottish infrastructure for the care and management of the conditions.

I do not know whether the manufacturers of particular therapies would be prepared to do a deal on the price—I am not qualified to comment on that—but there is certainly an opportunity to build on Scotland's expertise and create economies of scale.

The Convener: That was an interesting point. We might write to procurement Scotland, which has the job of trying to find the most efficient way of accessing drugs, to ask for more information on policy in the area.

We have run out of time, but I ask Mr Kent to stay with us for a second. Members have seen the paper by the clerk, which sets out options. Some members have said that it would be useful to continue our consideration of the petition and write to the Scottish Government. Does the committee agree to do that?

John Wilson (Central Scotland) (SNP): I agree that we should write to the Scottish Government. I suggest that we also write to the Scottish Medicines Consortium to ask for its views on the petition, in light of the petitioner's comments. I was going to say that we should write to a number of health boards but, having read the accompanying material, I suggest that we seek the specific views of NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran on the petition.

The Convener: Is the committee agreed?

Members *indicated agreement.*

Nanette Milne: I suggest that we also ask the Government officials who observed AGNSS's work for their views on the group's operation and whether such an approach would work in Scotland.

The Convener: Thank you for that.

Bill Walker: It would be worth while investigating procurement. If we can achieve economies of scale, we should do so, because it would mean more treatments.

The Convener: So we should send a letter to procurement Scotland.

Bill Walker: Indeed.

Sandra White: We should also write to NHS boards to find out how many of them have put in place the written policies. Moreover, given that under a European directive plans for rare diseases need to be in place by 2013, we should in our letter to the Government ask whether it will follow the recommendation from the Council of the European Union in that respect.

The Convener: That is a good point. Is the committee agreed?

Members *indicated agreement.*

The Convener: In conclusion, the committee has agreed to continue this very important set of petitions and to write to the various bodies that have been identified. I thank our three witnesses for attending the meeting and providing some helpful evidence. We will continue the petition in order to get more information, and our officials will keep you informed of progress.

I suspend the meeting for a couple of minutes to allow our next witnesses to take their places.

14:31

Meeting suspended.

14:32

On resuming—

Victims of Crime (Support and Assistance) (PE1403)

The Convener: The fourth new petition under consideration is PE1403, on improving support and assistance to victims of crime and their families. Members have the clerk's note, the SPICe briefing and the petition itself. I welcome to the meeting Peter Morris, who is accompanied by Anna Robertson of the Aberdeen Law Project. I invite Mr Morris to make a short presentation of around five minutes, after which we will move to questions.

Mark McDonald: Before Mr Morris makes his presentation, I should declare an interest. As members who have read the petition will note, I have provided support to Mr Morris in the course of his submitting the petition.

The Convener: Thank you very much for that notification.

Peter Morris: Good afternoon. I am the chief proposer of the petition, which seeks to stop victims of crime suffering a life sentence. I introduce Anna Robertson, who is a student with the Aberdeen Law Project and who will act as a witness for the petition.

I am grateful to the Public Petitions Committee for receiving the petition with such speed. I presented it to the convener just over two weeks ago and I believe that the committee's swift response shows that it resonates not only with the thousands of people who signed it, but here at Holyrood.

It is my task not only to prove the credibility of the headline but to examine the issues that underlie it. I believe that the category "victim" should cover all those who are affected by crime, including the direct victim, family members, friends and witnesses. All those people find themselves in positions that are not of their creation and it is important that we recognise crime's far-reaching ripple effects.

I also acknowledge that in recent years the situation of victims of crime has improved somewhat. However, the facts suggest that they have merely progressed from being third-class citizens to being second-class citizens. With appropriate consideration, I believe that we can ensure that these very special people become first-class citizens.

Having set out those principles, I will break down the petition into three main categories. The first is investigation and police involvement with victims of crime, the second is the court case and how it relates to victims of crime and the third is conclusions, effects and recovery of victims post court case.

The first category deals with police involvement with victims from an investigation's inception. The titles and the language that the police use do not always endear them to families. For example, the title "family liaison officer" is very official and is sometimes off-putting for families. I suggest that the police should assign a "case companion" to families, which would indicate to families that they have someone who is on their side, who is a friend and who does not work just for police purposes. Communication levels between the police and victims and assessments of victims are also concerns, as are victims' access to information and the availability of information following a trial.

The second category—the court case and how it relates to victims of crime—is about issues that surround the court case. Just one example is that the accused is allowed to occupy the same space as victims. The category also deals with issues such as the court, the media, expenses and compensation.

The third category—conclusions, effects and recovery of victims post court case—addresses victims' needs at the end of a case and beyond, examines the need for more post-case care and addresses legal issues for victims.

I was first told in February 2008 about the reinvestigation of my sister's death. The court case started in February 2011, and I went through the three and a half months of the longest single-accused court case in Scottish history, through conviction and sentencing until now, so I have had a number of experiences through the years that I believe qualify me to talk on the subjects that I have raised.

For all the categories, I can amplify the need for change and I have constructive and positive solutions, on which I shall be happy to answer the committee's questions. Anna Robertson is happy to answer the committee's questions about Aberdeen Law Project's involvement with the petition and about her views.

The Convener: Thank you for outlining your petition. I will kick off with questions and then bring in my colleagues in a few minutes. If Anna Robertson wishes to speak, she should please let me know.

Is there a case for having minimum standards for victims?

Peter Morris: The police need to rethink their strategy from an investigation's inception for dealing with families—especially with bereaved families in murder cases. The police go round to impart to a family the news that a loved one has been murdered. They have created the position of family liaison officer—that has been around for about 15 years, since the Stephen Lawrence inquiry. In my experience, such officers are there not for the family but to collect statements for the police and to collate information.

The police need to improve many areas, including communication; they need to stay in touch with victims. I suggest that there should be a phone call at least once a week while the investigation takes place, just to check on victims' families' wellbeing. There were times when I did not see or speak to my family liaison officers for months. Some questions that I asked were not answered for several days. The truth is a natural prerequisite for justice, and when you are waiting for the truth about your loved one, one thing that is very frustrating and which causes mistrust is when an eternity is spent getting an answer to a question. I am not talking about questions that the police cannot answer for legal reasons or whatever; I am talking about very simple practical questions, such as "How am I going to get to court?"

I genuinely believe that the police have to reduce formality—I will give an example of how overformal they were with my family. On four occasions before an arranged police visit to my 86-year-old mother's home, I had to take her to the accident and emergency department because she had extremely high blood pressure. She did very well and managed to complete a statement, but after a while I made an agreement with the FLOs that they would pass information through me and I would gently disseminate it to her. Many times throughout the process—it was a long process—I genuinely thought that she was not going to survive it. The police need to take a much more victim-friendly approach.

The Convener: Thank you, Mr Morris. I will bring in Sandra White.

Sandra White: Welcome to the committee, Mr Morris. It is very brave of you to come here today and relive some of the hurt, so thank you for coming.

I want to touch on communication and access to information. The petition is about assistance to victims of crime and their families, so this is not so much a question as an agreement. As MSPs, we have lots of cases that go to the public prosecutors and so on, and I find that the lack of communication and lack of access to information is a sticking point for victims and their families.

Peter Morris: It is horrendous.

Sandra White: I know that we are considering the introduction of a bill for victims, which I absolutely agree with. Could you enlighten me on what would be the best way forward for the PF's office to be more involved? How would it work with a victims' rights bill if the PF's office had to be brought in with the police and others?

Peter Morris: First, people going through the procedures are passed from pillar to post far too much. During the investigation they have an FLO, during the court case they have a victim information and advice officer and, when the court case is finished, they have no one. I believe that there should be the continuity of having the same person running from the inception of the investigation, through the period of charging, to the court case and beyond, which is why I suggest that there be case companions. That would be family friendly—"family liaison officer" is an official term. The language that the police use is very important.

The police have made improvements—I am not saying that they have not. The situation is much better than it was before the Stephen Lawrence case, but the process still needs to be much more sensitive to families' needs. At the moment, it is based on police needs. I also suggest that families have the opportunity to assess the officers who are assigned to them and, if there is poor rapport or communication with them, to ask for them to be changed. A lot of families have good relationships with the officers who are assigned to them, but if they do not, they should have the opportunity to ask for them to be changed. At the moment, the officers are decided purely by the senior investigating officer.

Sandra White: That is why I wanted to follow on with the question that I asked. If we had a victims' rights bill, it would not just involve the police: the Crown Office and the PF's office would be involved, too. I was just asking—

Peter Morris: Sorry, what is the PF's office?

Sandra White: It is the procurator fiscal's office. Would it be preferable if that office and the Crown Office, rather than just the police, oversaw the system in a victims' rights bill?

Peter Morris: Their inclusion would be well worth while. For example, the procurator fiscal's office would probably tell you that its VIA officers are far too thinly spread. I had positive things to say about my VIA officer in Glasgow High Court—she was absolutely wonderful—but the amount of time that she could spend with me was limited because she had so many people to deal with. That is an area in which there could be improvement, although I am not saying that the VIA officers would have to work on a one-to-one basis. To answer your question, I think that the inclusion of the Crown Office and PF's office in the discussion is vital.

Sandra White: Thank you.

14:45

Mark McDonald: Welcome back to Edinburgh, Peter. I am interested in the post-court-case gap that has been identified—Anna Robertson might want to comment on the work that the Aberdeen Law Project has done on that. From a victim's perspective, how did you feel when the court case finished? It was an extremely high-profile case, which would have been quite emotionally draining, given the length of time that passed between your sister's death and the eventual conviction of Malcolm Webster. How did you feel at the end of it? What would have helped in the way of post-trial support?

Peter Morris: I joined some forums for people who had been through similar experiences. For example, I went on the SAMM forum—SAMM stands for Support after Murder and Manslaughter, which is a charity. When I went on those forums, the most common comment that I read was, "Joe Bloggs has got 15 years for killing my Johnny, but I'm suffering a life sentence." I read that time and again, so it occurred to me that there is a massive gap between justice and recovery. I think of the situation as being like two cliff edges with a big gap in the middle. Something needs to bridge that gap, which a lot of people fall down. A woman in London lost her son—he was murdered in a stairwell. She went to court and she got justice, but she did not go out of her house for five years. I propose that justice without recovery is pointless. We need to help people to recover.

I am going to be critical here. I read a report by Louise Casey, the Commissioner for Victims and Witnesses in England and Wales, in which she said that when her organisation did a survey of 400 murder trials, the vast majority of people wanted to be left alone. To me, that showed a complete lack of empathy with the subject that she was addressing. Of course they wanted to be left alone—they were in pain—but you would not leave a cancer victim alone because they were in pain; you give them every possible opportunity for treatment to help them to recover.

I believe that the same course of action is appropriate for victims of crime who have to go through what is probably the most traumatic experience of their lives—attending a court case, at which they come face to face with someone who has murdered one of their family, and having to keep their self-control in the court house. In my case, the murderer was behind me in the canteen queue on four occasions, and he used to sit outside my little room. I genuinely believe that, in his own clever way, he was trying to provoke me, but I managed to put up an emotional brick wall to him, and I taught other family members, when they came up, to do the same. I fully respect the fact that the accused is innocent until proven guilty, but I genuinely think that they should be kept in a separate part of the court house, because the potential for the trial to be jeopardised as a result of someone's inappropriate actions is quite high.

The Convener: Do you wish to add anything at this stage, Anna?

Anna Robertson (Aberdeen Law Project): Yes. The Aberdeen Law Project has done research on what help, support and assistance can be given to victims. We found that counselling is missing throughout—from the start, when someone is originally victimised, through to the post-trial period. We feel that even having some sort of meeting, at which a victim could have mentors and in which other victims could be involved so that they could help each other through the situation, would be good.

The convener mentioned minimum standards. We agree with the bill proposal that there should be minimum standards that the organisations that are being funded should have to meet, even if that might involve publishing what they wish to achieve. I understand that the existence of minimum standards could seem quite official, but there is no point in giving money to those organisations—which are doing a brilliant job so far—unless minimum standards are met for the people who are affected by crimes.

John Wilson: Good afternoon. My question is linked to what Ms Robertson just said. Who would be best placed to provide follow-up support? As Ms Robertson said, a range of services provide support to victims. The family liaison officer is the first port of call after a serious incident. The court services then intervene and then we have Victim Support Scotland. Who should provide comprehensive support and back-up, particularly to the families of victims of serious crime? We need to examine what would be the best way forward, rather than just pass victims of crime on from family liaison officers or—as Mr Morris has dubbed them—case companions, because we put a lot of funding into support services for victims of crime.

Peter Morris: I will let Anna Robertson answer, but I want to jump in first. There was a time during the three-year period between reinvestigation and trial when I tried to get therapy for myself. I went to my doctor, explained what was going on and said that it was causing me angst, depression and all the rest of it. I got therapy 10 months later—inappropriate cognitive behavioural therapy. I will let Anna give her opinion, but I believe that that is another area where somebody being assigned to a family would be able to speed things up and highlight the need for the individual concerned to get the therapy that they need. That is why I believe that there should be a case companion right through the process. Trauma can be experienced pretrial, during the investigation, during the trial itself and afterwards.

Anna Robertson: I agree with Peter Morris that there should be a case companion or liaison officer to take people through to the post-trial period. Organisations such as Victim Support, which the Government funds, should take on that work and they should work in partnership. I understand that a lot of Victim Support's work is partnership based and involves the police, the PF and so on. There should be a partnership that includes everyone in order to provide the best possible support and assistance.

Bill Walker: I have great sympathy for what can happen during a court case, where people are basically just milling around. It is not right; it is just not fair to victims or potential victims because, at that time, you do not know what will be the outcome of the case. It is quite wrong and I know of it happening myself.

My question is a bit of a devil's advocate question—I suspect that I know the answer. Is there, in this process of victim support and recovery, a role for restorative justice involving the guilty person?

Peter Morris: As far as I am concerned, the definition of "recovery" is when the thought of the criminal no longer affects you. People have often asked me about the word "forgive". I prefer to think of the word in its original Hebrew state, which meant "let go". Once you can let go of the person who has committed that heinous crime against you, you are way down the road to recovery. I believe that I have done that with Malcolm Webster. The other day I heard comments about a newspaper article, and someone asked me whether I had seen that he had been beaten up in prison. I said that I didn't care. What matters to me now is what I can do for other people who have to go through such situations. I am passionate about this. I could not care less about any talk about Malcolm Webster now: for me, that is the definition of recovery.

The Convener: Thank you. I am afraid that we are running out of time again. The committee will now consider the options that are available—the clerk has prepared a paper that outlines the options.

Mark McDonald: I agree that we should write to the Government and to Victim Support Scotland. We might also write to People Experiencing Trauma and Loss, which does a lot of victim support work. It might be worth getting its views on the petition.

John Wilson: We should also write to the Association of Chief Police Officers in Scotland and the Scottish Court Service. Mr Morris raised the important issue of witnesses, members of the victim's family and people who are facing conviction milling about in the same building and even, in some cases, the same waiting rooms. It would be good to get the views of ACPOS and the Scottish Court Service on that.

Nanette Milne: Is there any knowledge yet of the timing of the victims' rights bill?

The Convener: That is a legitimate question for us to ask the Government.

Nanette Milne: Once we know that, it might be appropriate to refer the petition, along with our findings so far, to the Justice Committee.

The Convener: That is in the clerk's recommendations.

Neil Bibby (West Scotland) (Lab): I do not know whether it would be appropriate to do so, but points were raised about changes that could be made in the language that the police use, so we could contact the police about that.

Peter Morris: Mark McDonald mentioned PETAL; I am having a meeting with Joe Duffy in about 15 minutes.

I should also inform you that Gary Cox—who is, I believe, connected with Kenny MacAskill—has asked me to write to him with my positive suggestions on the victims' rights bill, which I have done, in accordance with what I am doing here with you.

The Convener: Are members content that we continue the petition and write to the various agencies that have been mentioned?

Members *indicated agreement.*

The Convener: I thank Peter Morris and Anna Robertson for coming along. Your evidence was helpful.

We will suspend for two minutes to allow the witnesses to leave.

14:57

Meeting suspended.

14:58

On resuming—

Adult Attention Deficit Hyperactivity Disorder (Diagnosis and Treatment) (PE1402)

The Convener: PE1402 concerns a strategy and policy for diagnosing adult attention deficit hyperactivity disorder. Do members have any views on the issues that are raised by the petition?

Sandra White: I found this to be an interesting petition. Like others, I have dealt with children with ADHD, but I have never really carried it forward. The petition raises a number of issues. Paragraph 11 of the clerk's paper says that Lothian NHS Board has set up an adult ADHD clinic at the Royal Edinburgh hospital, and that it is developing further services for adult ADHD. Our paper says that it

> "may also accept patients who are referred from other areas of Scotland".

We should write to NHS Lothian to find out exactly how many patients are seen by its adult ADHD service.

Nanette Milne: I would like us to write to the Government to find out its view on developing a strategy and policy for the diagnosis of ADHD.

Neil Bibby: The Scottish Government produced a draft strategy on mental health, which we might flag up as part of the discussion.

Mark McDonald: I agree with everything that has been said. There was a big article in the *Sunday Herald* at the weekend, in which Rory Bremner talked about the issues that he has faced. It would be interesting to find out what individual NHS boards are doing. If they do not have specialised services, do they know how many individuals they are treating? Perhaps we can ask the Government to source that information, rather than write to all boards ourselves.

Bill Walker: I agree. I did not see the article at the weekend. I had not realised that there is such a thing as ADHD in adults; I associated it with children. We can find out more. [*Interruption*.]

The Convener: The clerk has pointed out that the information with the petition mentions that a freedom of information request has been sent to health authorities; the petitioners have done some work on that. If there are no further comments, do members agree to continue the petition and seek information, as members suggested and as is proposed in the clerk's paper?

Members *indicated agreement.*

Current Petitions

School Bus Safety (PE1098 and PE1223)

15:01

The Convener: We will consider 10 current petitions today. Members have a note by the clerk on PE1098 and PE1223, which we consider together.

Nanette Milne: There has been some progress on PE1098, which is about seat belts—I think that there is acceptance on the issue. However, I am concerned about progress on PE1223. I do not think that Mr Beaty is here today, but he has been to virtually every meeting at which the committee has discussed PE1223. He contends that school buses should display school-bus signs only when pupils are on board. It is clearly the case at the moment that empty buses and buses that are not carrying children display such signs, so there really has been no progress on that. We should keep the petition open and push a bit harder.

John Wilson: As Nanette Milne is, I am deeply concerned about how the petitions have been handled. We have two petitions before us. PE1098 is on seat-belt provision and safety for children who travel on buses and coaches. The response from Transport Scotland is not at all encouraging. Although the number of local authorities that require coach operators to fit seat belts on all school transport vehicles has increased, there is still no such requirement in almost two thirds of local authorities. Those authorities have not moved forward on seat-belt safety in school transport. Some local authorities have set aside funds to enable coach operators to fit seat belts in coaches that are used for school transport, but it is clear that we are not moving quickly enough to tackle the problem.

On PE1223, which is on signage and general safety to do with school buses, the Public Petitions Committee in the previous session took evidence from the then Minister for Transport, Infrastructure and Climate Change and from the Parliamentary Under-Secretary of State in the UK Department for Transport, who said that the UK Government would look at transferring powers to the Scottish Government to allow it to progress matters to do with school buses. That has not happened, despite the assurances that we were given that the objective was fairly straightforward. We were assured that there could be discussions between the UK Department for Transport and the Scottish Government to allow the Scottish Government to acquire powers and to introduce further safety measures. I am disappointed that those measures do not seem to be any further forward.

I, too, put on record my thanks to Ron Beaty for his contribution to the debate, and I hope that we can resolve the matter much more quickly.

Mark McDonald: I am new to the committee, but I know that PE1223 has gained a great deal of publicity over the piece, particularly in the north-east, where Ron Beaty comes from. There have been high-profile cases in that region.

It is disgraceful that some local authorities still do not insist in contract tenders that buses, whether they are for primary or secondary schoolchildren, must have seat belts. Some local authorities seem to make a distinction and think that seat belts should be in place for primary schoolchildren but not necessarily for secondary schoolchildren. Most parents would not want that distinction to be made.

I know that the issue is complicated because the matter is, essentially, reserved. We often find that it can be difficult to get the UK Department for Transport to make real moves on reserved matters that are particular to Scotland, but I cannot envisage that the issue is not relevant in England. There are bound to be, as there are in rural Scotland, significant issues in rural England where bus transport is relied on, so I cannot understand the apparent heel-dragging in resolving the matter.

We must keep the petition open. We should write to the Department for Transport to ask it why exactly it is taking so long to address what is probably quite a small issue for it, but which would, if it were addressed by the department, resolve a difficulty and give many parents a much more satisfactory conclusion.

Nanette Milne: I absolutely agree with that. We should also put more direct pressure on the minister.

The Convener: It is clear that colleagues are very concerned about the issue. Obviously, members agree that we should continue in line with the clerk’s report. In particular, we will write to the Secretary of State for Transport, Philip Hammond, and to Keith Brown. There is, of course, an argument about power being delegated from Westminster to the Scottish Government. Members have made their points strongly and well. Do members agree that we should continue the petitions?

Members *indicated agreement.*

Bill Walker: Has the issue dragged on because it is one of the things that are wrapped up in the Scotland Bill and the discussion about the Scottish Parliament getting more powers?

The Convener: I do not think that the issue has been caught up in the Scotland Bill changes, but for safety we will check the point that Mr Walker has raised. We will write to the ministers. It is clear that both will deal with such points in their replies. I think that there are a number of mechanisms to resolve the issue, so we will pursue it urgently.

I thank members for their comments.

St Margaret of Scotland Hospice (PE1105)

The Convener: Members have a note on PE1105 by the clerk.

I welcome to the meeting Gil Paterson, who wants to make a brief statement about the petition. If members agree, we will start with him; members may then ask questions.

Gil Paterson (Clydebank and Milngavie) (SNP): I thank the committee for allowing me to speak.

I know that PE1105 has been with the committee since 2007, and I fully appreciate that members may want to get it off the books.

Things have moved forward in a positive way since the petition was lodged, but the main issues that it raises are on-going. There has been no settlement on finance for the hospice, nor is there a contract for the continuing care beds. However, I am hopeful that there will be an outcome to which all parties can sign up. I thank the committee for assisting the petitioners. It is a positive thing that the petition is still live, because that puts pressure on our moving towards the outcome that we seek.

The committee has correspondence from a supporter of the hospice that spells out some of the difficulties and the matters on which we have not yet reached conclusions. I reiterate that a good outcome is possible, but to assist in that process, I ask the committee to keep the petition open in case the petitioner and I need to come back and speak to you in a different tone.

The Convener: I thank the local member for coming along and presenting the case. Members will have read the paperwork, but I will flag up a couple of issues. First, we have considered the petition on 13 occasions, and secondly, there is a contrast between the general nature of the petition and the issue regarding that particular hospice. That does not detract from Mr Paterson’s comments, but members should be aware of those things.

Mark McDonald: I hear what Gil Paterson, as the local member, is saying to the committee. However, there is a difficulty. Although the committee was generous in broadening the scope of the petition and considering it on a national basis, it appears from the correspondence that the petitioner disagrees with that approach and wants us to be extremely local in our deliberations.

That means that the petition would probably fall outside the committee’s remit and abilities, in that we would be considering a particular local circumstance rather than a wider national issue. I would be concerned if the petitioner wanted us to take a narrow view of the issue, because we are probably not able to do that.

John Wilson: Although I hear what Mark McDonald has to say, I emphasise the petition’s importance in assisting the wider debate. He is right to say that the focus has narrowed, but it is a supporter of the campaign and not the petitioner who wants to localise the issue. The petitioner has not responded.

I have a couple of concerns about how we will move forward, and I would like the committee to keep the petition open on the following basis. We have received a letter from the health and healthcare improvement directorate that says that the report “Living and Dying Well: Building on Progress” was published in January 2011, and goes on to say that the review group report has been published and that there are on-going discussions with the Scottish Partnership for Palliative Care and representatives of hospices.

The difficulty is that the letter that we have from a supporter of the campaign mentions that meetings have been held without representatives of the hospice sector being present. I would like the committee to continue the petition and to write to the Government to ask it to answer the specific points in the letter. We should ask whether discussions are taking place and how they are progressing, with reference to the letter’s allegation that meetings are taking place to discuss future provision without the hospice sector being represented. If we are considering how the sector can deliver a meaningful service, that has to be done in conjunction and discussion with the hospices so that we get right all the factors in delivery of the service.

15:15

Sandra White: I was not on the Public Petitions Committee when the petition first came before it, but I have listened to Nanette Milne, John Wilson and others who were.

I come at the matter from a different angle. My involvement has been in the clash between St Margaret of Scotland Hospice and Blawarthill hospital. The letter mentions an agreement between the local health board and a nursing home. I know that the nursing home in question is a Four Seasons Health Care nursing home—those homes are being sold off all over the place. I am concerned that we are talking about something that is different to normal all-encompassing palliative care. St Margaret of Scotland Hospice and Blawarthill hospital offered similar care and now that the Four Seasons Health Care nursing home has gone into receivership, an awful lot is going on that we do not know about yet, especially if there are going to be beds in Blawarthill or St Margaret's. I do not want the petition to be continued forever, but I would like clarification on what was being discussed about nursing homes. We need to see an end to the issue. We need to find out whether St Margaret's is going to be viable because of what the health board is going to give it towards its costs. We also need to know how Four Seasons Health Care's going into receivership will affect the situation. That is why I would like the petition to continue.

Perhaps Gil Paterson could at our next meeting update us on the Four Seasons situation so that we can make up our minds then.

Bill Walker: My concern is the business of discussions and decisions being made without consultation of those who should have been consulted; I believe that allegations have been made about that. Unfortunately, that kind of thing happens in local government, where I have been working, and I would certainly like questions to be asked about what has been going on. I would like the petition to be continued for at least one more meeting.

Nanette Milne: We are treading a fine line between what we are competent to do for a petition on a local issue and for one that has national relevance. We have continued the petition for quite a long time despite our knowing that. Gil Paterson gives the impression that there might be a solution in the relatively near future; can you put a timescale on that?

Gil Paterson: This is very much a local issue about how the system impacts on a given facility. The issues should not be confused. Mark McDonald is quite right that one part of the matter is funding for hospice units throughout Scotland. However, the other aspect is that beds were being removed from St Margaret's: although that threat has been lifted, no long-term contract has been put in place. For that reason alone it would be an advantage if the petition were kept open.

There has been dialogue, but it has been very slow. I have been at meetings and in direct conversation with the health board on the matter. I do not want to put my neck on the line, but with a little bit of foresight and common sense, we could come to a satisfactory conclusion. The matter has been on-going since 2007—the committee will understand that the only thing that has changed in that time is the lifting of the threat of removal of beds from St Margaret's—so I cannot give the committee a timescale.

I make a plea to the committee that if the committee looked at the matter in a month or at the next meeting, that might be a bit too early. We might need a bit more manoeuvrability.

The Convener: Thank you, Mr Paterson.

I do not want to make heavy weather of this, but there are a couple of issues. First, the petition refers to the Scotland-wide position and, as an example, refers to St Margaret's hospice. Secondly, there was a change in the petitioner. There is nothing wrong with that, but we must bear it in mind. Jean Mitchell is the advocate who has now taken over the petition.

There are obviously differing views on the committee. My feeling is that the committee must draw a line at some stage, having considered the petition 13 times. Having said that, I know that members who want to continue the petition feel that we should at least have a timescale.

Neil Bibby: I also think that we should continue the petition. We need to keep a watching brief over what is happening.

I note from the background information that St Margaret's is the biggest hospice in Scotland. Its not having been involved in discussions about the future of hospices is, therefore, concerning. I support continuing the petition, bearing in mind Gil Paterson's points and the other points about when that would be—

The Convener: I am sorry for cutting you off, Mr Bibby.

Do members agree that we will write to the Scottish Government on the so-called secret meetings and that, when we get a response, we need to grapple with the issue and make a decision about closing or continuing the petition? Is that an acceptable compromise?

Members *indicated agreement.*

Gil Paterson: Thank you very much for your time.

The Convener: Thank you for coming along. We appreciate that.

Blood Donation (PE1135)

The Convener: The next petition is PE1135, on the reviewing of guidelines to allow healthy gay and bisexual men to donate blood. Members have a note by the clerk. Although I will, of course, invite contributions from members, I note that the Government has changed its policy, so it is currently accepting blood from healthy gay and bisexual men. I believe that there is an argument for closing the petition on the basis that the petitioners have achieved their objective, but I would welcome the views of other members.

Nanette Milne: Clearly, the expert advice has changed. A lot of work has been done on the issue over the past few years. The Government is bound to take expert advice and I do not think that we can disagree with it. Given that the situation has changed as a result of that advice, the petition has no future with us. It has achieved its ends and we should close it.

Mark McDonald: There are mixed feelings in the gay community about whether the new guidelines go far enough. The question is whether it is the committee's role to adjudicate on that. Given that the guidelines have changed, we should probably close the petition. Those who are not satisfied might wish to petition us again in the future. That could be done separately rather than as a continuation of the current petition, given that its objectives have, on the face of it, been achieved.

The Convener: That is a reasonable point. My understanding is that the petitioners asked for, and got, a review and that the review changed the policy.

Do members agree that we should close the petition under rule 15.7, on the basis of the clerk's report, which is that the existing guidelines in respect of the exclusion criteria for blood donors have now been reviewed and the criteria revised to allow men, whose last sexual contact with another man was more than 12 months ago, to be blood donors subject to meeting other donor selection criteria?

Members *indicated agreement.*

Magazines and Newspapers (Display of Sexually Graphic Material) (PE1169)

The Convener: Our next petition is PE1169, on the display of sexually graphic magazines and newspapers. Members have a note by the clerk. I invite contributions from members.

Sandra White: I was a member of the Equal Opportunities Committee when the issue arose. We held an inquiry about magazines being on the proper shelf, so that kids could not reach them. I note the amount of work that has been done on the issue, but the practice continues. I do not think that we can continue the petition, because we are not going anywhere with it. The Equal Opportunities Committee could have a full inquiry on the issue, so it would probably be best to refer the petition to that committee.

Mark McDonald: I agree with Sandra White, in that it would do the petition more justice to forward it to the Equal Opportunities Committee, which might want to take a broader look at the issues and perhaps instigate an investigation. Given our workload, we probably cannot do justice to the petition in the way that the Equal Opportunities Committee could. I support the referral of the petition to that committee.

Bill Walker: I am sympathetic to the petition, but I wonder whether the Equal Opportunities Committee has the powers to deal with the issue. Is it a devolved matter on which we can properly take a view, convener?

The Convener: It is valid for us to discuss the petition with the Equal Opportunities Committee. We will refer the petition to the Equal Opportunities Committee and, if there are any issues surrounding that, I will feed back to the committee at our next meeting. Is that agreed?

Members *indicated agreement.*

Independent Vehicular Ferry Routes (PE1192)

The Convener: The next petition is PE1192, on the promotion of independent vehicular ferry routes. Members have a note from the clerk on the petition. Members will recall that we heard oral evidence from the petitioner Neil Kay on a separate petition and that we agreed to refer the issue to the Infrastructure and Capital Investment Committee, which has responsibility for transport. It makes sense to be consistent and to refer this petition to that committee, too. Are members happy with that?

Members *indicated agreement.*

Geodiversity Duty (PE1277)

The Convener: The next petition is PE1277, which is on geodiversity duty. Members have a note from the clerk, and I invite comments on the petition.

Nanette Milne: From the petitioner's letter, it seems that he has not achieved everything that he wanted to, but I believe that the petition has achieved its ends. The Scottish Natural Heritage joint study with the British Geological Survey concluded that the geodiversity duty should not be regarded as essential. That is the point of disagreement, but the petitioner is obviously very pleased with the progress that has been made despite that. I think that we should close the petition.

Mark McDonald: I agree. There is nothing to be gained by keeping the petition open. It is not for us to adjudicate in a potential dispute—albeit a minor one—between the petitioner and the organisations involved. We should close the petition.

The Convener: Do members agree with that suggestion?

Members *indicated agreement.*

The Convener: We are closing the petition under rule 15.7.2, in terms of the clerk's note in the action sheet.

Youth Football (PE1319)

The Convener: The next petition is PE1319, on improving youth football. Again, members have a note from the clerk and a Scottish Parliament information centre briefing on the petition. Members will be aware that the predecessor Public Petitions Committee had a big interest in this area and took extensive oral evidence on it. There is, of course, nothing to prevent this committee from having another look at the area. I invite comments from members.

Mark McDonald: As somebody who was a youth football coach before being elected as an MSP, I am particularly interested in this issue and I think that the committee would benefit from holding a wider investigation. We could call for evidence from groups and organisations. An organisation that does not seem to be mentioned in the information on the petition but from which I think that we should seek evidence is the Scottish Professional Footballers Association—it is the union for footballers in Scotland. We should definitely seek its views and invite it to the committee to give evidence.

I realise that Scottish football tends to be viewed through an old firm prism, but I wonder whether we should hear from a broader cross-section of Scottish clubs, including non-Scottish Premier League clubs which, after all, have their own youth programmes and youth club operations. Indeed, at a dinner the other week, I was speaking to a man who runs Ayr United's under-19 team.

15:30

The Convener: Perhaps I should declare an interest as a trustee of Inverness Caledonian Thistle Football Club. However, I will not say anything about its youth strategy.

The Scottish Trades Union Congress gave evidence to the previous committee on this petition and certainly we need to examine a number of employment issues. Indeed, there have been a number of test cases in that respect with Mr Rooney et al. It is a very interesting area. Is there anyone else we should invite?

Sandra White: Perhaps I am casting the net very wide now, but I love football and am a great supporter of Partick Thistle—and, when I lived in the area, St Mirren. I know that a number of clubs including St Mirren have a community club and I wonder whether there are any differences between the two in this respect.

How do clubs such as FC Barcelona treat their young players? Is it outwith the scope of the committee to write to other European clubs?

The Convener: The clerk has just reminded me that the previous committee wrote to the royal Dutch football association, although I am not sure that we received a response. It is a good point, though.

Mark McDonald: Further to Sandra White's comments, I know that an SFA fact-finding mission visited IFK Gothenburg in Sweden to look at its system; indeed, the club with which I was involved sent a representative. I certainly think that it would be of benefit to look more widely at what is happening in Europe.

Sandra White: I would like to cast the net wider because the employment issues that the convener highlighted are very important. After all, we are talking about the future of young kids who have been—if you will pardon the pun—caught in this net. I think that we should write to Barcelona and other such clubs—

The Convener: I am sorry, but the clerk has just reminded me that the normal procedure is to write to everyone suggested and then decide which groups should give oral evidence after we have received their written responses. However, that is more of a procedural point and does not cut across members' suggestions.

Bill Walker: I am interested in getting closer to the actual consumers of this activity—in other words, the boys in question and their parents—and hearing their views. After all, a lot of this is driven by the boys—and, indeed, a number of girls these days—who want to get involved with clubs.

Sandra White: The girls are better than the boys.

Bill Walker: I am sure they are. Perhaps we should seek responses from parent-teacher associations, school councils or anyone else who can represent youngsters' views. As I say, the youngsters want to do this and perhaps when parents sign contracts on behalf of their children they do not quite know what they are doing.

The Convener: That is an important point. We could write to the Scottish Youth Parliament, which is pretty well clued up on these things.

Although it has already provided written evidence, RealGrassroots has, as members know, submitted additional material. It is certainly worth flagging that up.

Mark McDonald: We should remember that, as well as the SFA, there are the Scottish Youth Football Association and the Scottish Schools Football Association. It would be worth writing to those organisations because, although the SFA has an oversight role, they deal with the school teams and local youth clubs whose players go on to professional clubs. They can reply on behalf of individual clubs and set out some of the parental and player views that Bill Walker seeks.

The Convener: That is helpful. Are members happy with the course of action that has been outlined?

Members *indicated agreement.*

The Convener: It has been suggested that we continue with the petition; write to all the agencies and organisations that members and clerks have identified; and, once we get those responses, select individuals to provide oral evidence. Are members happy with that?

Members *indicated agreement.*

Institutional Child Abuse (Victims' Forum and Compensation) (PE1351)

The Convener: PE1351 is on the establishment of a time for all to be heard forum. Members have received the clerk's note and I invite their suggestions.

Sandra White: Although the petition has been on-going for quite a while in various guises, it is nevertheless very important and relates to an issue that I and others care very deeply about. It needs to be continued, because the responses that the committee and the petitioner have received are not sufficient and do not go far enough to meet the petitioners' aims. For a start, we need to find out exactly what is happening with the time bar that the then minister Fergus Ewing was working on. There are also concerns over whether we are going to adopt the Irish model.

John Wilson: As Sandra White has pointed out, some of us have been following this petition with a great deal of interest. Given that the Scottish Human Rights Commission's report on an acknowledgement and accountability framework addresses some of the issues that we are trying to deal with, we should ask Professor Alan Miller and the SHRC for views on the petition and the way in which the inquiry into the findings of the Shaw report on childhood abuse in homes has taken the issue forward.

The Convener: Are you suggesting, as per the clerk's recommendation, that we have an oral evidence session with the Scottish Human Rights Commission and then with ministers?

John Wilson: Yes. I support that suggestion.

Neil Bibby: I agree with that course of action. The SHRC offered to give oral evidence in the previous session, but that offer was not taken up. Given the complexity and number of issues that are raised in the petition, it would be helpful for the commission to give that evidence and the committee to have the chance to ask the appropriate questions.

The Convener: Do members agree to continue the petition and to have an oral evidence session with the SHRC and ministers?

Members *indicated agreement.*

The Convener: The clerks will organise that. I thank members for their comments.

Wild Land (Protection) (PE1383)

The Convener: PE1383 is on better protection for wild land. Members have received the clerk's note and I invite their comments.

Nanette Milne: We should keep the petition open and write to SNH to find out how it is getting on with mapping wild land and whether it has a timetable for publishing that work. As I recall, the previous committee was quite keen to continue the petition until we learned the outcome of all that.

The Convener: Do members agree to continue the petition and seek further information from SNH?

Members *indicated agreement.*

Witness Expenses

15:39

The Convener: Item 3 is on witness expenses. It is usual practice to invite the committee to agree to arrange for the Scottish Parliamentary Corporate Body to pay, under rule 12.4.3 of standing orders, witness expenses and to agree to delegate such matters to the convener other than for air travel or other non-standard costs. Are members content to delegate the arrangements to me?

Members *indicated agreement.*

The Convener: Before I close the meeting, I thank members for attending and particularly thank the members of the Irish Joint Committee on Investigations, Oversight and Petitions for joining us. I wish them well in their deliberations.

Meeting closed at 15:39.

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