The Scottish Parliament

Health and Sport Committee

2nd Report, 2008 (Session 3)

Stage 1 Report on the Public Health etc. (Scotland) Bill

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The Scottish Parliament

Health and Sport Committee

Remit and membership

Remit:

To consider and report on (a) health policy and the NHS in Scotland and other matters falling within the responsibility of the Cabinet Secretary for Health and Wellbeing and (b) matters relating to sport falling within the responsibility of the Minister for Communities and Sport.

Membership:

Helen Eadie
Ross Finnie (Deputy Convener)
Christine Grahame (Convener)
Rhoda Grant
Michael Matheson
Ian McKee
Mary Scanlon
Dr Richard Simpson

Committee Clerking Team:

Clerk to the Committee
Tracey White

Senior Assistant Clerk
Douglas Thornton

The Scottish Parliament

Health and Sport Committee

2nd Report, 2008 (Session 3)

Stage 1 Report on the Public Health etc. (Scotland) Bill

The Committee reports to the Parliament as follows—

INTRODUCTION

Procedure

1. The Public Health etc. (Scotland) Bill (SP Bill 3, Session 3) ("the Bill") was introduced in the Scottish Parliament on 25 October 2007 by Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing. The Bill is accompanied by Explanatory Notes (SP Bill 3-EN, Session 3), which include a Financial Memorandum, and by a Policy Memorandum (SP Bill 3-PM, Session 3) as required by the Parliament's Standing Orders. On 31 October 2007, the Parliament agreed to designate the Health and Sport Committee ("the Committee") as lead committee for the purposes of considering and reporting on the general principles of the Bill.

Purpose of the Bill[1]

2. The Bill, if passed, would restate and amend the law on public health, setting out the duties of the Scottish Ministers, health boards and local authorities to continue to make provision to protect public health in Scotland; replacing current arrangements for the notification of infectious diseases and the reporting of organisms with a system of statutory notification of suspected or diagnosed infectious diseases, of health risk states and of organisms; defining a "public health investigation" and setting out the powers available to investigators and how they may be appointed, and defining the public health functions of health boards and local authorities.

3. The Bill would also specify statutory duties on health boards and local authorities with regard to the provision of mortuary and post-mortem facilities; enable the Scottish Ministers, by means of a regulation-making power, to give effect to the International Health Regulations 2005, as they affect Scotland; give a

[1] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

power to the Scottish Ministers to require, by regulations, operators of sunbed premises to provide information to the users of those premises about the effects on health of the use of sun beds, and amend existing legislation in respect of statutory nuisances.

4. The Bill would also create a number of offences and penalties regarding failure to comply with certain provisions.

Scottish Government consultation[2]

5. A consultation on proposals to consolidate and update public health legislation was undertaken by the former Scottish Executive Health Department between 27 October 2006 and 12 January 2007. There were 98 responses to this consultation, an analysis of which was published on 30 March 2007. Additionally, a series of five public seminars was held, comprising presentations on the background and key proposals and open question-and-answer sessions. 180 people took part in the seminars.

Consideration by the Health and Sport Committee

6. The Committee issued an open call for written evidence on 31 October 2007, with a closing date of 18 January 2008. The Committee also wrote to a range of experts seeking views on specific aspects of the Bill. 53 submissions were received in total.

7. On 12 December 2007, the Committee agreed to appoint Dr John Curnow as its adviser on the Bill.

8. From January 2008, the Committee undertook a programme of oral evidence on the general principles of the Bill. As early advice from the Scottish Government indicated that it planned to lodge amendments to the Bill at stage 2 to incorporate some of the aims of Ken Macintosh MSP's proposal for a bill to require sunbed and tanning salons to be licensed, the Committee included this issue in its evidence taking. Oral evidence sessions were held as follows—

9 January

Molly Robertson, Bill Team Leader, Stella Smith, Legal Directorate, Dr Sara Davies, Medical Adviser, and David Wallace, Air, Noise and Nuisance Team, Scottish Government;

Ken Macintosh MSP;

Kathy Banks, the Sunbed Association, Professor James Ferguson, the Photobiology Unit, University of Dundee, and John Sleith, Council Member, Royal Environmental Health Institute of Scotland.

[2] *Public Health etc. (Scotland) Bill – Policy Memorandum*, SP Bill 3–PM

16 January

A round-table discussion with—

Dr Charles Saunders, Chair, Scottish Consultants Committee, BMA Scotland; Dr Christopher McGuigan, Chair, Consultants in Public Health Medicine (Communicable Diseases and Environmental Health Group); Ron Culley, Policy Manager, COSLA; Garrick Smyth, Policy Manager, COSLA; Dr Martin Donaghy, Medical Director, Health Protection Scotland; Rona Broom, Minute Secretary, Scottish Group, Infection Prevention Society; Dr Eric Baijal, Director of Public Health and Health Policy, NHS Highland; Dr Alison McCallum, Director of Public Health and Public Policy, NHS Lothian; Tom Bell, Chief Executive, Royal Environmental Health Institute of Scotland; Ken Jones, Head of Environmental Health, Scottish Borders Council; Dr Andrew Riley, Scottish Directors of Public Health Group; Robert Howe, Head of Environmental and Strategic Services, South Lanarkshire Council; and Fraser Thomson, Society of Chief Officers of Environmental Health in Scotland

30 January

Dr Martin Donaghy, Medical Director, Health Protection Scotland;

Dr Robert Carlson, College of Medicine and Veterinary Medicine, University of Edinburgh;

George Jamieson and Michael Clancy, Law Society of Scotland, and Ranald Macdonald, Legal Adviser, NHS Central Legal Office.

20 February

Shona Robison MSP, Minister for Public Health, Molly Robertson, Bill Team Leader, Stella Smith, Legal Directorate, Dr Sara Davies, Medical Adviser and Duncan McNab, Air, Noise and Nuisance Team, Scottish Government.

9. Extracts from the minutes of all meetings at which the Bill was considered are attached at **Annexe A**. Where written submissions were made in support of oral evidence, these are reproduced, together with the extracts of the Official Reports of each of the relevant meetings, at **Annexe B**. All other written submissions are reproduced in **Annexe C**.

10. The provisions within the Bill for making subordinate legislation were considered by the Subordinate Legislation Committee. Its report to the lead committee is attached at **Annexe D**.

PART 1: PUBLIC HEALTH RESPONSIBILITIES

Designation of competent persons by health boards

Background

11. Section 3 would require health boards to designate a sufficient number of persons, to be known as “health board competent persons”, for the purpose of exercising the functions conferred upon boards by the Bill. This is comparable with consultants in communicable disease control in England, the majority of whom are

medical consultants with accredited training. Their teams are multi-skilled but a clinician is available throughout working hours. A non-clinical individual may be "on call" out of hours.

12. The criteria for appointing a person or class of persons as health board competent persons are to be set out in subordinate legislation. Correspondence from the Scottish Government[3] indicated that, following the deliberations of an expert working group of key stakeholders set up to recommend the qualifications and experience of such competent persons, Scottish Ministers have agreed the proposed content of draft regulations on this issue. The criteria proposed would require that the person be an employee of a health board and one of the following—

- a registered medical practitioner on the General Medical Council's specialist register for public health medicine, with a minimum of 6 months' work experience (full-time equivalent/whole-time equivalent) in health protection; or

- a registered medical practitioner having held a substantive consultant post in the UK NHS in public health medicine prior to 1 January 2008; or

- a nurse, registered with the Nursing and Midwifery Council, with a minimum of 2 years' work experience in health protection; or

- accredited as a public health specialist on the UK Public Health Register, having gained access to the Register by the training route, with a minimum of 6 months' work experience in health protection; or

- accredited as a public health specialist on the UK Public Health Register, having gained access to the Register by the portfolio route, with a minimum of 2 years' work experience in health protection.

Definition of competent person

13. Several witnesses argued that there is a need for professional accountability of the competent person by a central body such as the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC), particularly with regard to quarantine and medical examination. In written evidence, Consultants in Public Health Medicine expressed a strong view that, to fulfil this role safely, the health board competent person "needs to have both clinical and public health skills, knowledge and experience and to be working within the accountability frameworks of the GMC or NMC"[4].

14. This position was echoed by BMA Scotland, whose representative explained its firm view that, because of the "potential adverse effects on individuals, decisions should be made only by somebody who has experience of working with people when they are at their most vulnerable—for example, patients—and a professional obligation to do so properly, and who can be removed from their professional register if they fail to do that". It was the BMA's firm belief that "that

[3] Scottish Government, supplementary written evidence, 6 February 2008
[4] Consultants in Public Health Medicine, written evidence

essentially means a registered doctor or a registered nurse with appropriate experience".[5]

15. This view was not supported by the representative from NHS Highland, who stated—

> "…using the definition "competent person" is helpful to us in the north of Scotland, where we deal with population supersparsity. There are something like six people or fewer per square kilometre there, compared with the Scottish average of 66 people per square kilometre. To maintain a service to people in outlying areas, we need multiskilled, pluripotential people, so the definition "competent person", which would ensure that people have the appropriate competence, is helpful."[6]

16. The Scottish Directors of Public Health and the Faculty of Public Health's joint representative stated that it is correct to focus on how to define the duration and type of clinical experience that a health board competent person needs to have but also pointed out that, in England, non-medical public health specialists are becoming involved.[7] The representative from Health Protection Scotland pointed out that important functions of health board competent persons would include assessing the risk to public health, assessing whether the means of controlling that is proportionate and communicating that in the legal process and to the public. He added that "the Faculty of Public Health, which trains professionals in those competences, has reached the view that being a doctor is not necessary to discharge those functions and receive specialist training" and that, in England, "specialist training in those functions is being developed for people who are not doctors".[8]

17. As noted above, correspondence from the Scottish Government indicated that its plans are that health board competent persons would be required to be a registered medical practitioner, be a registered nurse or be accredited as a public health specialist on the UK Public Health Register. The letter explained that the UK Public Health Register provides professional regulation to specialists in public health who come from a variety of backgrounds and that registration is designed to ensure that multidisciplinary specialists in public health are appropriately qualified and competent. The letter also explains that, as it enables individuals to be considered eligible for consultant posts within the NHS, registration on the UK Public Health Register is comparable to registration with the GMC specialist register for public health medicine for public health physicians or the General Dental Council specialists list in dental health for dentists".[9]

18. This issue was raised in oral evidence with the Minister for Public Health. In response, she referred to the fact that the Faculty of Public Health of the Royal Colleges of Physicians, the body responsible for setting standards in the public health profession, "has recognised that public health specialists need not be

[5] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 442
[6] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 442-3
[7] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 444
[8] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 444
[9] Scottish Government, supplementary written evidence, 6 February 2008

doctors if they can show a similar level of knowledge and competency and can meet accreditation requirements that are equivalent to those that the GMC sets for doctors as specialists". She also referred to the expert working group and acknowledged disagreement in respect of the criteria of eligibility as a health board competent person via the training route and the portfolio route, as opposed to eligibility based on a clinical background. According to the Minister, the group's majority view was that individuals who are on the public health register through the training route should be treated the same as doctors and that individuals who are on the public health register through the portfolio route should be able to demonstrate two years' work experience in health protection. She added that "the important point is that such people will have to demonstrate their competence through experience".[10]

19. The Minister for Public Health went on to add that, whilst she holds to the "established principle that there are people who have the qualifications and competence who are not necessarily doctors", having considered the outcome of the working group, she will consult with a number of stakeholders on the draft qualifications and experience set out in the letter to the Committee dated 6 February.[11]

20. The Committee notes the points raised in evidence and accepts that there is a need for a balance between (a) the clinical and public health skills, knowledge, experience and accountability required to fulfil the role safely and (b) flexibility to be able to adapt the role of the competent person to different local needs and changing circumstances within professions over time. **The Committee is satisfied that defining the health board competent person in secondary legislation is appropriate. However, the Committee also welcomes the Minister for Public Health's decision to consult further on the detail of this matter.**

Designation of competent persons by local authorities

21. In a similar way to that set out for health boards in section 3, section 5 would require local authorities to designate a sufficient number of persons, to be known as "local authority competent persons", for the purpose of exercising the functions conferred upon local authorities by the Bill.

22. The criteria for appointing a person or class of persons as local authority competent persons are also to be set out in subordinate legislation. Written and oral evidence to the Committee was in favour of this position being held by environmental health officers. The Scottish Government's correspondence of 6 February indicated that the Scottish Ministers have agreed the proposed content of draft regulations on this issue and that the criteria proposed would therefore require that the person be an environmental health officer, be accredited by the Royal Environmental Health Institute of Scotland or equivalent body and have a minimum of 2 years' experience working as an environmental health officer.[12] This

[10] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 576
[11] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 576
[12] Scottish Government, supplementary written evidence, 6 February 2008

was reiterated by the Minister for Public Health in oral evidence to the Committee.[13]

23. **The Committee is satisfied that defining the local authority competent person in secondary legislation is appropriate and that the Scottish Government's plans in this regard are reasonable in current circumstances.**

Joint public health protection plans

24. Section 7 would place a duty on each health board to prepare joint public health plans in consultation with the relevant local authority or authorities. The Society of Chief Officers of Environmental Health in Scotland raised a concern about the difference between the way that joint health protection plans would be drawn up under the Bill and the way in which they are drawn up currently—

> "At present, for joint health improvement plans, health boards go well beyond simply consulting local authorities; it is very much a joint approach. Could that be reflected, rather than just a provision that boards will consult us, which means that they could listen to us and then choose to go in a different direction if they felt it appropriate?"[14]

25. This view was supported by the Scottish Directors of Public Health and the Faculty of Public Health's joint representative.[15]

26. **The Committee invites the Minister for Public Health to reflect on the proposal for joint public health protection plans to be prepared by health boards in consultation, rather than collaboration, with local authorities, in the light of the concerns raised by witnesses that this could represent a retrograde step compared with the current arrangements.**

PART 2: NOTIFIABLE DISEASES, NOTIFIABLE ORGANISMS AND HEALTH RISK STATES

Notifiable diseases

Background

27. Section 13 would place a duty, on a registered medical practitioner with reasonable grounds to suspect that a patient has a notifiable disease (i.e. a disease listed in Schedule 1, Part 1), to notify the health board of that area in writing not later than 3 days after forming the suspicion. The notification would be required to include the patient's name, address and postcode, occupation (if considered relevant), sex, date of birth, the disease that the patient is suspected of having and the patient's NHS identifier.

28. A registered medical practitioner who has reasonable grounds to suspect a notifiable disease and who considers that, in the context of factors specified by the Bill, the case is urgent must notify the health board orally as soon as possible.

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[13] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 576
[14] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 478
[15] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 478

29. There is a subsequent duty on health boards, on receipt of a notification from a medical practitioner, to relay the information to the Common Services Agency (in practice, Health Protection Scotland).

Discontinuation of notification fees for general practitioners

30. BMA Scotland raised concerns regarding the proposal to discontinue the existing fee associated with notifying diseases, stating that, to ensure effective reporting of notifiable diseases, robust systems are necessary in GP practices, requiring resources not currently provided under the new General Medical Services contract.[16]

31. Asked about this issue, the Minister for Public Health stated that she did not believe that the withdrawal of fees would have any impact on the Bill's workability. She explained that—

> "…the majority of current payments relate to the notification of chicken pox and food poisoning, which will no longer be notifiable under the bill. Any current problems with levels of notification are more to do with the number of unnecessary diseases on the list and a lack of awareness about the system, which is outdated. Notification should be undertaken as part of the general duty of care on GPs or medical practitioners. They do not always claim fees at the moment anyway so, although the BMA raised the matter, generally speaking it has been a small issue."[17]

32. **The Committee notes the Minister for Public Health's explanation that the withdrawal of fees for general practitioners in respect of notification of diseases will not affect the workability of the Bill.**

Information to be reported

33. The Bill would require, under section 13, subsection 6, that the medical practitioner, when notifying a suspicion of a notifiable disease, report the suspected disease and the patient's name, address and postcode, occupation if considered relevant, sex, date of birth and NHS identifier.

34. The Committee discussed this provision with witnesses to ascertain whether a patient's rights, for example, to confidentiality were being given due consideration and whether it would be necessary always to report all of these details. Health Protection Scotland's representative responded that there might be circumstances in which such information is crucial but that it would be very difficult to determine that without having the information.[18]

35. In relation to the same matter, the Minister for Public Health pointed out that although all of those details would be reported by the practitioner to the health board, the patient's name would not then be communicated, under section 15, to Health Protection Scotland and would not, therefore, be subject to wider circulation.[19]

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[16] BMA Scotland, written evidence
[17] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 580
[18] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 539-540
[19] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 577

36. The Committee also noted that there was no requirement to report the patient's school or place of work, although this might be relevant information in terms of responding to a situation. This was accepted as being a "fair point"[20] by Health Protection Scotland and the minister agreed to reflect on the issue[21].

37. A number of further points were raised by the Information Commissioner's Office (ICO) in written evidence to the Committee, in the context of privacy impact assessments and the interaction between the Data Protection Act 1998 and the information that will be required under the Bill. These points included that the ICO would advocate that a privacy impact assessment be included as part of the formative development stages of regulations and guidance proposed within the Bill. The submission added that, whilst there is no need to reproduce data protection legislation on the face of the Bill, guidance on the extent to which exemptions could be used to process personal data without the consent of the individual concerned would be useful and that the Bill needs to strike a "delicate balance between public interest and the rights of the individual". The submission also advocated a "presumption of anonymisation" in line with a "minimalist approach to data processing".[22]

38. On a related matter, the minister was asked whether an application to the sheriff court would appear on the court rolls, which would make it publicly known who was up on application.

39. The Minister for Public Health agreed to reflect on that point and on all of the points raised by the ICO before stage 2.[23]

40. The Committee noted that the definition of the NHS identifier is given as being—

> "(a) the patient's National Health Service identification number;
>
> (b) the patient's community health index number; or
>
> (c) any other number or other indicator which from time to time may be used to identify a patient individually."[24]

41. The Committee took the view that practitioners reading the list would choose the first number if they could and would only revert to the second number on the list if they have to. The first number given should, therefore, be the number that the health service and others are primarily using at this point in time, which the Committee understands to be the community health index number, currently second on the list. The Minister for Public Health agreed to take that point into account.

42. **The Committee is satisfied with the explanations in relation to this matter and, notwithstanding the minister's subsequent letter of 28 February,**

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[20] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 540
[21] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 577
[22] Information Commissioner's Office, written evidence
[23] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 577
[24] Public Health etc. (Scotland) Bill, section 13, subsection 8

invites the Minister for Public Health to reflect further on whether the patient's school or place of work should be reported, on the order of items included in the definition of the NHS identifier and on the issues raised by the Information Commissioner's Office.

Health risk states

Background

43. The definition of a health risk state in the Bill includes highly pathogenic infections (i.e. infections highly likely to cause a serious disease) and exposure to any contamination, poison or other hazard that constitutes a significant risk to public health. A patient would be deemed to have been exposed to a health risk state following either—

- physical contact with or contamination by a health risk state; or
- physical contact with or contamination by a person or object that has been in physical contact with or been contaminated by a health risk state.[25]

44. The Bill would require medical practitioners to notify in writing any suspicion of a patient having been exposed to a health risk state within three days of forming such a suspicion.

Definition

45. Concerns were raised in evidence about the definition of health risk states. For example, BMA Scotland felt that there would be issues concerning the practicalities and implications of carrying out the duty to notify health risk states as, in the association's view, it would be "very much dependent" on patients identifying the risk themselves. BMA Scotland explained that the nature of a health risk state as defined in the Bill would make it unlikely that an individual would be showing any clinical signs or symptoms and that it would consequently be entirely at that individual's discretion whether to reveal information such as having been in close contact with another person who was subsequently diagnosed with a communicable disease. In BMA Scotland's view, if such a patient understood that revealing such information could directly result in quarantine or detention in hospital, the patient might avoid doing so and, therefore, could increase the risk of serious illness in that individual and increase the risk of infection to the wider public.[26]

46. The BMA's representative, in outlining this concern in oral evidence, described the provision as "unworkable", the definition being "so vague as to be unusable". He went on to add that a further concern could be that medical practitioners would be expected to notify all cases of "a vast number of highly pathogenic infections that are not easily transmissible from one person to another" and that this would result in "much noise in the system that the provision would not pick up what it is intended to pick up". He explained that BMA Scotland would

[25] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

[26] BMA Scotland, written evidence

prefer the Bill to refer to conditions defined by the Scottish Ministers as and when necessary. [27]

47. However, the Scottish Directors of Public Health and the Faculty of Public Health's joint representative considered that the definition should perhaps be expanded, giving the example of the case of polonium poisoning in 2007, which "took a great deal of time to identify but was most definitely a health risk state".[28]

48. Dr Rob Carlson, from the University of Edinburgh, gave oral evidence to the Committee on the ethical aspects of the Bill. He felt that a health risk state should be defined as "something that must be unexpected, unforeseen or out of the ordinary" in order to prevent use of the Bill for something for which it was not intended—

> "…for example, the introduction of a system such as one that operates to an extent in the United States, which restricts the number of unvaccinated children who enter the school system. I could not find anything in the definition of "health risk state" that would exclude the legislation's being used for such a purpose."[29]

49. **The Committee notes the concerns raised regarding the practicalities of notifying health risk states, the workability of the definition and implications for the future and invites the Scottish Government to reflect on the definition of health risk state and consider whether any amendment to it is necessary.**

Notifiable organisms

Background

50. The Bill would place a duty on the director of a diagnostic laboratory where a notifiable organism is identified (i.e. an organism listed in Schedule 1, Part 2) to provide written confirmation of the presence of the organism to the relevant health board and Health Protection Scotland no later than 10 days after identification. If the director of the diagnostic laboratory considers that the case is urgent, oral notification to the relevant health board is required as soon as possible. In determining whether a case is urgent, the director must have regard to the nature of the organism, the nature of the disease caused by that organism, the ease of transmission of that disease or organism, the patient's circumstances (such as age, sex and state of health, where known), and any guidance issued by the Scottish Ministers. Section 17 of Bill would make it an offence for the director to fail without reasonable excuse to comply with this duty. [30]

51. A director of such a laboratory is defined in the Bill as—

> "(a) the clinical microbiologist, consultant pathologist or other registered medical practitioner in charge of, or providing medical supervision in, a diagnostic laboratory; or

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[27] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 449
[28] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 449
[29] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 544
[30] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

> (b) any other person working in the diagnostic laboratory to whom the function of making a notification under this section has been delegated by the person mentioned in paragraph (a).”[31]

52. A diagnostic laboratory is defined as “an institution (or facility within an institution) which is equipped with apparatus and reagents for the performance of diagnostic tests for human infections”.[32]

Definition of director and diagnostic laboratory

53. Health Protection Scotland was in favour of amending the definition of director of diagnostic laboratory to include scientists or senior managers. The organisation’s representative explained in oral evidence that there are laboratories run by scientists who have professional qualifications similar to those of a doctor and that it is therefore possible for a laboratory to be run by scientists without any doctors being present. In such a case, he believed, “there would be nobody mentioned in section 16(8)(b) to whom a doctor could delegate that responsibility, because there is no doctor”[33]. He went on to say—

> “People in different positions in the NHS are increasingly being drawn from a wider range of professional disciplines, and it is entirely possible that, in 20 or 30 years' time, a great many laboratories inside and outwith the NHS might not have a doctor working in them. Section 16(8)(a) and section 16(8)(b) therefore do not encompass the range of current or future possible ways of operating a laboratory.”[34]

54. BMA Scotland raised a related concern in the context of the offence that would be committed by failure to notify within the 10-day limit. The association pointed out that most clinical microbiologists and virologists do not have managerial control over laboratories in the NHS and reported that some of its members work within organisational and resourcing constraints that can impede turnaround time and lead to backlogs. Whilst accepting that it would be “entirely reasonable” to penalise an individual staff member who failed to meet the target owing to incompetence, the BMA submitted that it would be “unjustifiable to hold an individual member of staff to account for any delay which occurred as a result of organisational issues outwith their control” and that this should be reflected in the Bill by placing the duty on the owner or manager of the diagnostic laboratory.[35]

55. Health Protection Scotland also suggested that the definition of diagnostic laboratory be reviewed with a view to including laboratories carrying out tests on samples of food and/or water where the detection of a pathogen can also indicate a risk to public health.[36] The following example was given in oral evidence—

> “…there was a recent episode involving chocolate in which we became aware of the risk to public health because of tests that identified salmonella in specimens of chocolate. If we had not known about that, we could not have

[31] Public Health etc. (Scotland) Bill, section 16, subsection 8
[32] Public Health etc. (Scotland) Bill, section 16, subsection 8
[33] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 538
[34] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 538
[35] BMA Scotland, written evidence
[36] Health Protection Scotland, written evidence

> intervened to prevent further cases of infection. I am aware that the testing of food and notification of results are covered by food safety legislation, but currently that legislation does not provide for notification for public health purposes."[37]

56. The Committee raised these concerns in its oral evidence session with the Minister for Public Health, who indicated her intention to amend the Bill at stage 2 to take some of the concerns about the definition of directors into account[38]. In relation to the suggestion that laboratories testing samples of food and water should be included in the legislation, the Minister for Public Health responded that the Scottish Government was consulting the Food Standards Agency on that issue and that the matter would be given further consideration.

57. **The Committee welcomes the Minister for Public Health's intention to amend the definition of director of a diagnostic laboratory and notes that the Scottish Government is giving further consideration, in consultation with the Food Standards Agency, to whether laboratories testing food and water samples should be covered by the Bill**.

10-day time limit for notification

58. With regard to the period for reporting of notifiable organisms by diagnostic laboratories being set, under section 16(2), at 10 days or, when the organism has public health implications, as soon as possible, the Committee noted that concerns had been raised about exactly when the clock for that starts ticking for the purposes of this provision. The Committee understands that, often, when a sample is analysed, a presumptive result is obtained and then a confirmed result. The time between those two results might be fairly limited, but it has been suggested that the clock should start ticking at the first one so that early action can be taken.

59. Asked whether that aspect of the Bill should be amended to clarify when the clock starts ticking in relation to the 10-day rule, the Minister for Public Health acknowledged that the point at which the clock starts ticking might need to be defined more clearly, although it was also stated that the expert working group on laboratory directives had indicated that 10 days was a workable period—

> "For example, in the case of meningitis, one would see an organism under a microscope but one would need a further few days finally to confirm which organism it was. The time between when the organism is defined and when it is reported needs to be practicable."[39]

60. **The Committee was satisfied with the Scottish Government's explanation of the 10-day rule for notification by laboratories**. **Further, the Committee asked how the provisions of the Bill would apply in respect of tests performed in a laboratory that is not within Scottish jurisdiction and welcomes the Minister for Public Health's agreement to look into the matter**.[40]

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[37] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 538
[38] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 581
[39] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 581
[40] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 584

61. With regard to the list of notifiable organisms set out in Schedule 1 of the Bill, the Committee noted that the last item on that list is—

> "Any other clinically significant pathogen found in blood".

62. The Committee was concerned that, whilst it would be clear to a director of a laboratory that, if one of the organisms listed were found, notification would have to be made, the words "clinically significant pathogen" would call for a degree of clinical decision-making. Members were concerned that this form of words could give rise to problems if, for instance, a conference of directors of laboratories decided that chlamydia or HIV should be reported in future. This would compromise reassurances being given to people with certain sexually transmitted diseases that confidentiality would be maintained. Moreover, the Committee felt that a director of a laboratory, being aware of the risk of committing a criminal offence if an organism were not reported, might err on the safe side by reporting every organism that could be considered to be clinically significant.

63. The Committee raised this issue in the oral evidence session with the Minister for Public Health, expressing the view that, as organisms could be added to the list by subordinate legislation at fairly short notice, it is unnecessary to include "any other clinically significant pathogen found in blood" on the list.

64. In response, the Minister for Public Health acknowledged that the Committee had identified an important issue. She explained the rationale behind the decision to include it but recognised that the description is wide and could include organisms that perhaps should not be reported. She went on to inform the Committee that, in the light of the reservations that had been expressed, the Scottish Government now planned to lodge amendments, at stage 2, to remove the final item on the list of notifiable organisms.[41]

65. **The Committee welcomes the Minister for Public Health's commitment to lodge amendments at stage 2 to remove "any other clinically significant pathogen found in blood" from the list of notifiable organisms set out in schedule 1**.

Biosecurity

66. Further to the Scottish Government's letter of 6 February to the Committee, which provided a summary of biosecurity arrangements for laboratories, the Committee asked the Minister for Public Health whether the Government is reflecting on biosecurity arrangements in light of the breach of biosecurity that occurred in summer 2007 at the Pirbright laboratory. In response, the Minister for Public Health reminded the Committee that the House of Commons' Innovation, Universities and Skills Committee launched a UK-wide inquiry into biosecurity at the end of 2007 and stated her expectation that the inquiry will highlight any additional requirements to be met. She submitted that work is on-going to consider what lessons need to be learned from the incident and, more generally, what more can be done to ensure that security is as good as possible. [42]

[41] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 582
[42] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 583-584

67. The minister subsequently informed the Committee by correspondence that the inquiry is due to report to the UK Parliament by mid-May, at which time any potential implications for Scotland will be considered.[43]

68. **Further, the Committee asked about biosecurity arrangements in respect of tests performed in a laboratory that is not within Scottish jurisdiction and welcomes the Minister for Public Health's agreement to look into the matter**.

PART 3: PUBLIC HEALTH INVESTIGATIONS

Appointment of an investigator

Background

69. This part of the Bill outlines five circumstances in which, where there are reasonable grounds to suspect that the circumstances are likely to give rise to a significant risk to public health, a "public health incident" would exist. It also defines the powers and parameters of a "public health investigation", i.e. an investigation into the causes of a public health incident.

Appointment of a public health investigator

70. During its oral evidence session with the Minister for Public Health, the Committee sought clarification on the interaction of this part of the Bill with the provisions on competent persons in part 1 of the Bill. Specifically, the Committee noted that there appears to be no connection between (a) the clear purpose of part 1 to have competent persons to drive the process and (b) the appointment of investigators under part 3 by the Scottish Ministers, Health Protection Scotland, health boards or local authorities, instead of it being for the competent persons to determine whether an investigation is needed.

71. In response, the Minister for Public Health referred to national guidance on managing incidents that would be produced to update existing guidance in order to reflect the provisions of the Bill. It was further explained that the intention was to "achieve flexibility"[44], for example in cases where an outbreak covers a number of health board areas.

72. **However, the Minister for Public Health acknowledged the concerns raised by the Committee about the relationship between the provisions to appoint a public health investigator and the earlier provisions to appoint local authority and health board competent persons and agreed to reflect upon the matter. The Committee notes the Minister for Public Health's subsequent letter, dated 28 February, giving a rationale for the section 21 provisions on the appointment of public health investigators, but believes that there is a need for more clarity and encourages the minister to reflect further on the matter.**

[43] Scottish Government, supplementary written evidence, 6 February 2008
[44] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 590

Primacy of joint investigators

73. In written evidence, the City of Edinburgh Council was concerned that more than one investigator might be appointed, leading to situations where two or more investigators would act together, but with "no clear primacy role" being defined to establish who would take the lead in a joint investigation.[45]

74. In response, the Scottish Government explained that, at the time of an outbreak, it would be for an incident control team, composed of competent persons from health boards and local authorities, to agree jointly whether an investigation would be required and whether to appoint a lead investigator. The Committee notes the Minister for Public Health's reassurance that, "essentially, things will go on as they do at the moment".[46]

Public health investigation warrants

Background

75. Section 27 of the Bill sets out the circumstances in which a sheriff or justice of the peace would, "on the summary application of the investigator", be able to grant a warrant authorising an investigator to enter premises for the purposes of a public health investigation. The section also outlines what conditions must be satisfied before such a warrant may be issued – for example, that the investigator has been refused entry to the premises.

Summary Application Procedure

76. Evidence from the Law Society of Scotland outlined concerns that the provisions in the Bill "do not always accurately reflect current Scottish civil procedures" and, if enacted as drafted, would "result in some significant inconveniences as a result of misunderstanding the relevant procedures".[47] It was explained that it is not usual for a sheriff to be asked to grant warrants of this nature by way of summary application and that summary application procedure does not currently involve justices of the peace. The Law Society of Scotland's representative suggested that, if the intention was to find a "simple and speedy process to the sheriff", it would not achieved via the summary application route because, although it is a truncated process, it nonetheless would require to have a court writ, to serve the action on a defender and to have a hearing. [48] In the society's view, "reference to such a procedure is not appropriate" because a public health investigation would often have to be carried out at very short notice, perhaps requiring that a sheriff be contacted out of hours and because the investigator might not necessarily be skilled or experienced in drawing up such a formal court application as a summary application.[49] Furthermore, it was stated that a sheriff or justice of the peace could simply issue the warrant without recourse to a court procedure such as the summary application procedure.[50]

77. This issue was raised in oral evidence with the Minister for Public Health, who stated—

[45] City of Edinburgh Council, written evidence
[46] *Official Report*, *Health and Sport Committee*, 20 February 2008;c 594
[47] Law Society of Scotland, written evidence
[48] *Official Report*, *Health and Sport Committee*, 30 January 2008;c 555
[49] Law Society of Scotland, written evidence
[50] *Official Report*, *Health and Sport Committee*, 30 January 2008;c 555

> "…we have taken on board the requirement to amend the bill to ensure that the court procedures are suitable in relation to fulfilling the bill's policy intentions. A modified summary application procedure is required, rather than the full summary application procedure, with the detail to be set out in court rules, as is normal practice. That will ensure that the warrants and orders that are applied for under parts 3, 4 and 5 may be granted as a matter of urgency, if necessary, and that the applications and orders are user friendly, which is always a good thing."[51]

78. Some further explanation was given of what would be involved, namely that forms of application for warrants could be prescribed by Scottish Ministers, that orders and warrants could come into force immediately and that the Bill would refer specifically to the Court of Session's power to make court rules, enabling the provisions of the Bill to be supplemented with amended sheriff court rules.[52]

79. The Committee was concerned that the proposed solution to this problem appeared not to be in line with the proposal by the Law Society of Scotland. The Minister for Public Health responded that, in her view, the Scottish Government's proposal "is in accordance with the Law Society of Scotland's suggestion" and indicated that the society "is content" with it.[53] She went on to agree to write to the Committee with clarification on the matter.

80. **The Committee notes with surprise that court procedures referred to in the Bill are not competent; is dismayed that a Bill could reach the stage of introduction in the Parliament with incorrect provisions; is disappointed that it is not clear whether the Scottish Government's proposed course of action with regard to this matter is as simplified as the proposal by the Law Society of Scotland; notes the Minister for Public Health's reassurances, and awaits with concern further correspondence clarifying the matter. Further, the Committee reserves the right to seek further evidence on this matter at stage 2, should the Bill progress to that stage.**

Compensation

Background

81. Section 30 specifies the circumstances under which compensation could be paid by those appointing investigators. Compensation would be paid for any loss or damage caused by an investigator or any other authorised person in exercising powers as part of a public health investigation, unless the loss or damage is due to the fault of the person who sustained it and unless the unoccupied premises that have been investigated have not been left secure.[54]

82. A single arbiter appointed by agreement between the person who appointed the investigator and the person claiming loss or damage, or, if agreement cannot be reached, by the President of the Lands Tribunal for Scotland, would settle any

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[51] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 591
[52] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 591-592
[53] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 593
[54] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

dispute as to a person's entitlement to compensation and the amount of such compensation.[55]

Appointment of an arbiter

83. The Law Society of Scotland's written submission suggested that the wording of section 30(4) may be ambiguous. The subsection currently states that any disputes about entitlement to or the amount of compensation are to be determined—

> "…by a single arbiter appointed by agreement between the person who appointed the investigator and the person claiming loss or damage or, if agreement cannot be reached, by the President of the Lands Tribunal for Scotland."

84. The Law Society of Scotland conjectured that this provision is intended to mean that, if the parties cannot reach agreement on the appointment of the person to act as arbiter, the President of the Lands Tribunal for Scotland will appoint the arbiter. The society suggested that the wording of this provision be revisited in order to provide that the Lands Tribunal for Scotland be empowered to act as arbiter, which would not be possible under the Bill as drafted owing to the reference to a "single arbiter". This was expanded upon in oral evidence to the Committee—

> "We are making the somewhat technical point that people should be able to select the Lands Tribunal as an arbiter, or the president should be able to appoint another person to be the arbiter. The main point concerning access to justice is that there is no legal aid for arbitration but, if someone is given the option to go to the Lands Tribunal, they may have the right to legal aid."[56]

85. **The Committee notes that the Minister for Public Health acknowledged, in supplementary written evidence, the point made by the Law Society of Scotland that people should be able to select the Lands Tribunal for Scotland as an arbiter for compensation cases relating to public health investigations. The minister advised that the Law Society of Scotland's suggestions are being considered further and the Committee welcomes her commitment to lodge amendments at stage 2 if appropriate.[57]**

PART 4: PUBLIC HEALTH FUNCTIONS OF HEALTH BOARDS

Duty to give explanation

Background

86. Under this part of the Bill, a health board proposing to apply to have a person medically examined, quarantined, detained in hospital or detained in hospital long-term or where a health board competent person is proposing to make an exclusion order or a restriction order, the health board would be required to explain the action to that person. The explanation would have to convey that there is a

[55] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

[56] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 564

[57] Scottish Government, supplementary written evidence, 28 February 2008

significant risk to public health, the nature of that risk and why the board found it necessary to take the proposed action. This requirement would not need to be complied with, however, if the risk to public health were such that the action would need to be taken "as a matter of urgency".

Exemption from the duty to give explanation

87. The Committee noted with concern that section 31, subsection (5) of the Bill would enable health boards entirely to dispense with the requirement to give an explanation of the action being taken for reasons of urgency. In light of the qualification in subsection (3) that the explanation must be given "in so far as it is reasonably practicable to do so", it was felt that it would be unacceptable to include a further, explicit catch-all exemption from giving explanation.

88. In response, the Minister for Public Health acknowledged that it is "hard to envisage a situation in which that information would not be given" but gave as an example a scenario involving a fast-moving and difficult situation in which the person's language was not English and in which the time that might be taken to find a translator to explain the situation might not comply with the timescale for getting an order.[58] In response, the Committee reiterated its view that such a situation would be covered by the qualification in subsection (3).

89. **Furthermore, the Committee suggested that any exemption to the requirement to give an explanation should be subject to the caveat that, in situations where a requirement had not been given, it should be required that the explanation be given as soon as practically possible. The Minister for Public Health agreed to give further consideration to the issues raised by the Committee about the exemption from the duty to give explanation.**

Medical examinations

Background

90. Sections 33 to 35 of the Bill would allow for applications to the sheriff court to have a person medically examined, where the health board knows or suspects that a person in its area has an infectious disease, has been exposed to an infectious organism that causes such a disease, is contaminated or has been exposed to a contaminant; where it appears to the health board that, as a result, there is or may be a significant risk to public health, and where it is necessary, to avoid or minimise that risk, for the person to be medically examined.[59]

Application procedure

91. The NHS Central Legal Office raised a concern in relation to section 33, subsection (2), which enable a health board to make an application to the sheriff for the area in which the board has its principal office, suggesting that this could be unduly onerous on the person in respect of whom the order is being sought – for example, NHS Highland would be entitled to apply to the sheriff court in Inverness in respect of a person resident as far away as Campbeltown.

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[58] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 601

[59] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

92. The Scottish Government recognised this issue and indicated its intention to lodge an amendment to the Bill to the effect that a health board could address the problem by applying to any sheriff court in its area.[60]

No right of appeal

93. BMA Scotland was particularly concerned about the lack of a right of appeal in respect of compulsory orders for medical examination. The BMA felt that, "at the very least, there should be a mechanism for the individual to request to present his or her case to the sheriff as part of an abbreviated appeal process in an emergency".[61]

94. In relation to this point, the Law Society of Scotland explained that, under the normal law relating to summary applications, there is no need to provide for an appeal to the sheriff principal because, as a matter of normal court process, there can, in any case, be an appeal to the sheriff principal. However, the Law Society of Scotland's representative acknowledged that, where – as is the case in this Bill – a right of appeal is specifically provided for in respect of some applications but not others, there is a risk of it being interpreted that a right of appeal is implicitly excluded from those other applications.[62]

95. During the evidence session with the Minister for Public Health, it was explained that the rationale for there being no right of appeal was that an urgent medical examination would be required in situations where a person might have a fatal, contagious disease but refuse to comply with the examination voluntarily. Once the compulsory order had been granted, the medical examination would go ahead before an appeal right could be exercised. The Committee pressed this point further on the basis that, even where a compulsory medical examination had gone ahead, an individual might seek to appeal against the decision to allow the examination to take place, the appeal process serving to establish whether the sheriff's decision was appropriate given the facts and the circumstances and to set a test for other sheriffs.

96. The Minister for Public Health acknowledged the point made by the Committee regarding the need for a right to appeal in respect of a decision by a sheriff authorising the medical examination of a person. She agreed to reflect further on the matter.

97. In subsequent correspondence, the Minister for Public Health explained that appealing the decision after the examination had taken place would serve no practical purpose other than enabling that individual to obtain compensation but that there are pre-existing legal remedies that would allow an individual to obtain compensation – namely, depending on the circumstances of the case, suing the health board for damages and/or obtaining a remedy under the Human Rights Act 1998 by judicial review if the individual's contention was that the sheriff had breached his or her human rights by making the order.

[60] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 602
[61] BMA Scotland, written evidence
[62] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 559

98. The Minister for Public Health's letter also argued that, as any appeal would be restricted to the facts and circumstances of a particular case, it would therefore be unlikely to provide a test for other cases.

99. **The Committee is not satisfied with the Minister for Public Health's position that there would be no practical purpose in appealing a sheriff's decision to authorise the medical examination of a person other than to enable the individual to obtain compensation: suing for damages is a separate issue and seeking a remedy via judicial review under human rights legislation would be a very long and expensive process. Furthermore, the Committee does not accept the suggestion that an appeal would be unlikely to provide a test for other cases on the basis that any appeal would be restricted to the facts and circumstances of a particular appeal – the Committee believes that, if those facts and circumstances were similar to a prior appeal, the outcome of that prior appeal would be relevant to the appeal under consideration. Accordingly, the Committee urges the Minister for Public Health to reconsider the position on this matter and to lodge amendments to the Bill to include a specific right of appeal following a decision to proceed with a compulsory medical examination, whether or not the examination has taken place.**

Exclusion and restriction orders

Background

100. Section 37 of the Bill would enable a health board competent person to make exclusion orders, prohibiting a person known to have an infectious disease, be contaminated or have been exposed to an organism or contaminant "from entering or remaining in any place". Similarly, section 38 would enable a health board competent person to make restriction orders, prohibiting such a person from carrying on a specific activity.

101. The NHS Central Legal Office questioned why such orders would be able to be made without a sheriff's authority, whereas other orders, such as for quarantine, would not.[63] The NHS Central Legal Office's representative expanded on this point in oral evidence—

> "The drafting of the bill perhaps reflects the current procedure whereby local authorities may make such orders at their own hand. However, in drafting a new bill, it seems better to have a consistent format for dealing with the rights and liabilities of individuals. This might not be an issue in dealing with schoolchildren, but I question whether it is right that, in restricting the activities of an adult or a vulnerable adult, the competent officer of the health board should be able to say, "You may not go to your place of work for the next 14 days." The person will have the right of appeal during that period, but that seems a fairly strong process for an individual in a health board to undertake at their own hand. The health board's lawyers will be available to advise the competent officer, but the bill makes no provision for a third party,

[63] NHS Central Legal Office, written submission

> such as a sheriff, to revisit the process and double-check that the rights of the individual against whom the order is made are properly protected."[64]

102. The Committee raised this point with the Minister for Public Health on the basis that exclusion and restriction orders would restrict liberty and should therefore be subject to the same authority as quarantine orders. The Minister for Public Health explained that the provisions of the Bill set out a legal underpinning for an existing process. She went on to explain her view that the difference in restriction of liberty between exclusion and restriction orders and quarantine orders—

> "In one, someone would be excluded from their workplace or from whatever place was deemed necessary. With quarantine and detention, their liberty to go anywhere would be restricted. Those are different restrictions, which is why there are different requirements for approval from a sheriff."[65]

103. The Minister for Public Health's letter of 28 February reiterates this view, explaining that the Bill proposes a continuation of the current practice whereby designated medical officers of health boards, acting on behalf of local authorities in the exercise of their statutory public health responsibilities, exclude individuals from work, or exclude children from school, if they have an infectious disease or have been exposed to an infectious disease. Where, however, the risk is judged to be "sufficiently high that measures more restrictive of individual liberty are required e.g. quarantine and detention orders", then in the Scottish Government's view, it is "appropriate that these more restrictive orders are made by a sheriff"[66]. The letter goes on to state—

> "To make exclusion and restriction orders subject to a sheriff's order would undermine the aims of the Bill and the work of public health professionals, who currently assess risk and impose these orders on a routine basis in order to protect public health. It would create unnecessary bureaucracy, have significant resource implications (including for the courts), and would probably discourage health boards from using the powers available to them under the Bill. Of course, those subject to an order can appeal, first to the sheriff and then through the judicial hierarchy."[67]

104. **The Committee notes the Minister for Public Health's explanation of the difference in the extent of restriction to a person's liberty by exclusion and restriction orders compared with quarantine orders and understands the need for rapid action. Nevertheless, the Committee has some sympathy with the views expressed in the legal submissions. The Committee also recommends that the provision should refer to an order prohibiting persons from entering or remaining in "specified places" rather than in "any place", which could be considered confusing**.

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[64] *Official Report*, *Health and Sport Committee*, 30 January 2008; c 566
[65] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 600
[66] Scottish Government, supplementary written evidence, 28 February 2008
[67] Scottish Government, supplementary written evidence, 28 February 2008

PART 5: PUBLIC HEALTH FUNCTIONS OF LOCAL AUTHORITIES

105. This part of the Bill outlines the functions of local authorities relating to the disinfection, disinfestation and decontamination of things and premises for the purpose of the protection of public health. Each local authority would be required to provide, or ensure the provision of, facilities for its area for the disinfection, disinfestation or decontamination of things and premises and for the destruction of things that are infected or contaminated, and the means for transporting such things to such facilities.[68]

106. The Bill would give local authorities the power to serve notice on the owners or occupiers of premises to undertake disinfection, disinfestation or decontamination, where premises (or things on premises) are infected or contaminated and it is necessary for this action to be taken in order to prevent the spread of infectious disease or contamination. This may result in one of the following outcomes—

- the owner or occupier may undertake the work themselves;
- if the owner or occupier does not undertake the necessary disinfection, disinfestations or decontamination, etc., then local authorities may carry out the work with the permission of the owner or occupier; or
- if the owner or occupier does not undertake the necessary work, the relevant local authority may undertake the work itself. If the local authority encounters obstruction or resistance, it may apply to a justice of the peace or a sheriff for a warrant to undertake the work, where it is necessary in order to prevent the spread of infectious disease or contamination.[69]

107. In addition, where the premises which are involved are dwellinghouses, local authorities will have the power to enter them, but only with occupiers' consent, having given 48 hours' notice. However, if a local authority considers that there is an emergency, then it may enter premises or dwellinghouses at any time. If premises or a dwellinghouse are unoccupied at the time of entry, then the authorised officer must leave the premises or dwellinghouse as effectively secured against unauthorised entry as when the premises or dwellinghouse was entered. Where unnecessary damage is caused during disinfection, disinfestation or decontamination of premises or things under these powers, local authorities will be liable to compensate persons for such unnecessary damage.[70]

108. Notwithstanding consideration of resources for local authorities to carry out functions under this part, which are dealt with later in the report as part of consideration of the Financial Memorandum, **the Committee is content to note the provisions setting out the public health functions of local authorities**.

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[68] *Public Health etc. (Scotland) Bill – Policy Memorandum*, SP Bill 3–PM
[69] *Public Health etc. (Scotland) Bill – Policy Memorandum*, SP Bill 3–PM
[70] *Public Health etc. (Scotland) Bill – Policy Memorandum*, SP Bill 3–PM

PART 6: MORTUARIES ETC.

Context

Current arrangements

109. The policy memorandum on the Bill explains that there is currently no statutory duty for the provision of mortuaries or post-mortem facilities. Under existing legislation, dating from 1897, local authorities may provide and fit up a proper place or places for the reception of dead bodies before interment and may make byelaws on their management and charges for their use. The memorandum explains further that the arrangements that have evolved since 1897 are complex, with city mortuaries in Aberdeen, Edinburgh, Dundee and Glasgow. The first two are still owned and run by the local authorities, the latter two being owned, staffed and run by local police forces/joint police boards. In areas with no city mortuary, NHS hospitals provide mortuary and post-mortem facilities (and are paid a flat-rate fee by the Crown Office and Procurator Fiscal Service for their use).[71]

Statutory duty to provide or ensure provision of mortuary facilities

110. Part 6 of the Bill sets out the statutory duty on health boards and local authorities to provide or ensure provision of mortuary and post-mortem facilities. A duty is placed on health boards to provide or ensure the provision of mortuaries and post-mortem facilities for hospital-related deaths and a duty on local authorities to provide or ensure the provision of mortuaries and post-mortem facilities for all other deaths, including those reported to procurators fiscal. The Bill also provides a duty of co-operation between health boards and local authorities to comply with this provision.[72]

111. In oral evidence to the Committee, Scottish Government officials explained that, in health board areas where there is not currently a city mortuary, "where there is a hospital, there is a mortuary" and that the intention is that local authorities would only be expected to ensure that the hospital is dealing with deaths in its area.[73]

Protection of public from risks arising from bodies

112. In order to reduce the risk to public health, the Bill would also update current legislation regarding the handling of dead bodies. It confines provisions to those areas where it is considered that there is most risk. If a health board considers the body of a person who died of an infectious disease, or who was infectious or contaminated, is a significant risk to public health, the board could direct that the body must not be removed from a hospital without its written authorisation, and may be removed only for the purpose of immediate disposal, including preparation for disposal. Separately, if a body is retained in premises and there is consequently a significant risk to public health and if the local authority considers that appropriate arrangements have not been made for the disposal of the body, the local authority could apply to the sheriff for an order to remove the body to a mortuary and to dispose of it by burial or cremation.

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[71] *Public Health etc. (Scotland) Bill – Policy Memorandum*, SP Bill 3–PM
[72] *Public Health etc. (Scotland) Bill – Policy Memorandum*, SP Bill 3–PM
[73] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 404

Information for undertakers and others required to handle dead bodies

113. The Bill also seeks to take into account the concerns of undertakers and those required to handle dead bodies that they are informed of the risks involved and are able to take the necessary precautions to prevent any threat to public health. Health boards would have a duty to inform persons handling the body of a person who has died from an infectious disease or contamination (or was infected or contaminated at time of death) of that fact. This would enable those handling the body to take necessary precautions to reduce the risk to their (and public) health.

Consideration by the Committee

114. Notwithstanding consideration of resources for local authorities to carry out functions under this part, which are dealt with later in the report as part of consideration of the Financial Memorandum, **the Committee is content to note the proposals in the Bill putting onto a statutory footing arrangements for the provision of mortuaries**.

PART 7: INTERNATIONAL HEALTH REGULATIONS

115. This Part of the Bill would create a regulation-making power to give effect to International Health Regulations 2005 ("IHR 2005") and subsequent amendments. The purpose and scope of IHR 2005 are to prevent, protect against, control and respond to the international spread of disease while avoiding unnecessary interference with international traffic and trade. They are updated from International Health Regulations (1969), which addressed only cholera, plague, yellow fever and smallpox.[74]

116. The Scottish Ministers are required to implement IHR 2005 and the Bill proposes that this be achieved by means of subordinate legislation subject to affirmative procedure. As such, this proposal was examined by the Subordinate Legislation Committee and is considered later in the report under the heading "Subordinate Legislation".

PART 8: INFORMATION ON HEALTH EFFECTS OF SUN BEDS

Context

Bill as introduced

117. Part 8 of the Bill as introduced contains only one section. Under that section, the Scottish Ministers would have the power to require, by regulations, operators of sun bed premises to provide to the users of those premises information on the effects on health of using sun beds.[75]

118. The Scottish Government indicated to the Committee at an early stage that it was still considering options in respect of part 8, which it described as a "marker provision", included in the Bill with a view to amendment at stage 2 to incorporate some of the provisions contained in the proposal for a bill by Ken Macintosh MSP.

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[74] *Public Health etc. (Scotland) Bill – Policy Memorandum*, SP Bill 3–PM

[75] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

It was stated that the Government was working in collaboration with him to develop amendments for him to lodge at stage 2.

Proposal for a member's bill

119. On 22 May 2007, Ken Macintosh MSP lodged a proposal for a bill to require sun bed and tanning salons to be licensed. The member's consultation on the bill proposal stated that the licensing conditions would be set so that local authorities could—

- prevent the use of sun beds by children;
- protect adults from over-exposure to sun beds;
- ensure that sun bed users are supervised;
- end the use of coin-operated machines;
- ensure that sun bed sessions are monitored and limited;
- provide health risk information in sun bed parlours; and
- inspect premises.[76]

Possible amendments at stage 2

120. In anticipation of amendments being lodged at stage 2 as a result of collaboration between Ken Macintosh MSP and the Scottish Government, the Committee opted to take evidence on the likely content of those amendments from Mr Macintosh. The Committee also took oral evidence from the Sunbed Association, the Photobiology Unit of the University of Dundee and the Royal Environmental Health Institute of Scotland.

121. Ken Macintosh MSP explained that, following initial discussions with the Scottish Government, he expected to propose "three simple measures"—

- to ban the use of sun beds by the under-18s;
- to outlaw stand-alone or unstaffed coin-operated machines; and
- to ensure that operators provide advice on the risks of using sun beds.

122. The member added that the measures would be enforced by local authority environmental health officers. He referred to the fact that eight local authorities have already introduced their own local licensing schemes. Whilst he commended those initiatives, he accented a desire for "one clear unambiguous message—one law covering the whole of Scotland—that lets people know the dangers and risks involved in using sun bed salons".

123. The proposals as outlined by Ken Macintosh were echoed by the Minister for Public Health who confirmed that the Scottish Government has agreed to support the proposed provisions at stage 2.

[76] Ken Macintosh MSP, *The Regulation of Sunbed Parlours Bill – A consultation*

Proposals

Duty of inspection

124. The member's written submission stated that no mandatory inspection regime was envisaged but that local authorities would be provided with a power to enter premises with the aim of ensuring that the provisions set out in the Bill are adhered to and that a provision was planned for criminal sanctions and fines to be imposed where an operator breached any of the conditions set out in the Bill.[77] He expected that there would be no inspection regime but explained that he was keen for there to be a "duty of inspection". He added that compliance would be monitored and enforced by local authority environmental health officers.

125. The representative from the Royal Environmental Health Institute for Scotland stated that environmental health officers would "welcome" the task of inspecting sun bed parlours as they have "experience, knowledge and skills in dealing with public health legislation in many other areas".

Training for sun bed operators

126. The Committee, concerned that sun bed operators might be disinclined to turn business away, asked how staff would be trained to give advice. Ken Macintosh MSP responded that this issue was currently under discussion with the Scottish Government, emphasising his belief that training is essential and that it is important that salon staff understand why they are to ask certain questions of customers.

Effectiveness of advice

127. Asked about how giving advice on the amount of time to be spent on a sun bed would impact on an individual's pattern of use and, in particular, what obstacle there would be to an individual who felt insufficiently tanned from one visit to a tanning salon simply visiting a different salon, Ken Macintosh MSP pointed out that there is currently nothing to prevent people from visiting multiple salons or otherwise using sun beds to excess. He underlined that his proposals would not ban the use of sun beds but would "flag up the fact that using sun beds is an inherently risky activity and allow adults to make an informed choice". He also expressed a hope that responsible operators would monitor usage but said that it would be for individuals to decide how often to attend salons.

Banning unstaffed sun bed machines

128. In respect of the proposal to ban unstaffed sun bed machines, Ken Macintosh MSP linked this to the intention to ban use of sun beds by under-18s and compared this with the availability of alcohol and tobacco—

> "We would not expect to have cigarette machines or alcohol-vending machines available in unattended premises on the high street with only a simple sign saying, "Under-18s, please do not use." The message for sun bed salons should be similar. We are talking about something that can cause

[77] Ken Macintosh MSP, written evidence, 9 January 2008

> grave damage and can even kill, so we should not underestimate the dangers."[78]

129. The member supported this point of view by reference to examples of children gaining access to coin-operated machines—

> "…there was a case in Stirling in which an 11-year-old boy and a 13-year-old boy went into a coin-operated machine, pumped money into it, burnt themselves badly and had to be taken to hospital. At the time, environmental health officers could not take any action against the premises, because there was no law against having unstaffed coin-operated machines."[79]

Causality

130. The Committee asked about the degree of certainty regarding a specific link between sun beds and the incidence of skin cancer. Ken Macintosh responded that many of the links between skin cancer and sun beds are established through epidemiology and are, therefore, difficult to identify. He drew an analogy with the early stages of the process by which the link between tobacco and lung cancer was established, pointing out that, whilst it took "many years to establish a definitive direct link between the two", it became clear at an early stage that they were linked. He added that, to his knowledge, "no one now denies that there is a link between ultraviolet radiation and skin cancer".[80]

131. The aspects of risk to health were developed in evidence by Professor James Ferguson of the University of Dundee. He explained that there has been a recent trend towards sun beds emitting shorter-wavelength rays and that it is known that these newer machines are "definitely more carcinogenic than the older, long-wavelength UVA beds"[81].

132. The Minister for Public Health further supported the view that the link between melanoma and use of sun beds has been established, referring to "numerous" international studies that back up the evidence. Specifically, she cited a study on the use of sun beds and sunlamps and the incidence of malignant melanoma in southern Sweden that "found a generally increased risk of malignant melanoma for people who had used sun beds".[82]

Existing legislation and standards

133. In respect of existing legislation and standards, Ken Macintosh MSP explained that there is a difficulty in so far as health and safety and trading standards are outwith the legislative competence of the Parliament. He suggested that enforcement of those standards does not always take place and that legislating in line with his proposals would encourage the existing law to be applied more rigorously.[83]

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[78] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 416
[79] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 416
[80] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 417
[81] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 422
[82] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 610-611
[83] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 418-420

134. This view was supported by the Royal Environmental Health Institute's representative who believed that the Bill, if amended as proposed, would "add fresh impetus to the regime of inspecting sun bed salons" and "make local authorities re-examine what they do". He recognised that it would depend on the content of subsequent regulations or codes of practice but was certain that environmental health officers "would discuss good practice on enforcing and implementing the legal provisions" through existing "good networks and liaison groups".[84]

135. With regard to this point, the Sunbed Association's representative explained that it is a requirement of membership of the association that members work to its code of practice, which incorporates the European trading standard and the Health and Safety Executive's guidance note on UV tanning equipment.[85] She acknowledged, however, that only around 75 sun bed operators in Scotland are members of the association.[86]

136. Notwithstanding existing provisions, Ken Macintosh MSP believed that there would still be a need for the measures that he proposes because health and safety legislation seeks to protect operators of machinery and not to identify risks associated with use of the equipment—

> "It is worth reflecting on the fact that the UK Government is currently considering very similar measures. The health risks that are posed by sun beds go far beyond health and safety risks. We should be identifying that using the bill."[87]

137. The issue of existing standards and the role of the UK Government was raised with the Minister for Public Health. She reiterated that the thrust of the Bill is "to persuade people not to use sun beds, to ensure that they are fully informed about the risks if they do, and to restrict their use by certain groups of people". She acknowledged, however, that "product safety is an important aspect of that". She stated that she would raise the Committee's concerns, suggesting that the UK Government may "need to consider the status of the approved code of practice and whether to tighten it up" and undertaking to inform the Committee of the response that the Scottish Government receives.[88]

No proposed licensing scheme

138. Ken Macintosh MSP informed the Committee of his expectation that his collaboration with the Scottish Government would lead to a proposal that did not take forward the intention to create a licensing regime as contained within his bill proposal. He explained his view that the benefits of having the Government's support for a public health measure would outweigh the benefits that a licensing scheme might have had.[89]

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[84] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 430
[85] *Official Report*, *Health and Sport Committee*, 9 January; c 423
[86] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 432
[87] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 421
[88] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 609
[89] *Official Report*, *Health and Sport Committee*, 9 January 2008; c 411-413

139. The Minister for Public Health described the proposed provisions as "proportionate" and as setting the "correct balance between regulation by Government and an individual's personal responsibility to make choices that minimise the risk to their health".[90] With regard to the original proposal for a licensing scheme, the Minister for Public Health gave the following explanation for being "unconvinced" of the merits of such an approach—

> "Although licensing would control access to commercial sun bed premises, it would not prevent individuals from hiring or buying a sun bed, nor would it prevent exposure to the sun. In addition, it is not clear that introducing a requirement to record and monitor customers' sun bed use would be effective. It would therefore be unlikely to prevent abuse. In my view, licensing moves the balance too far away from the need to allow individuals to make their own informed choices."[91]

140. She added, however, that nothing in the proposals would stop local authorities from continuing local licensing schemes if they wished to do so.[92]

Next steps

141. **The Committee acknowledges that the collaboration between Ken Macintosh MSP and the Scottish Government is an on-going process and is grateful to them for alerting it to their plans at an early stage, allowing evidence to be taken at stage 1. However, given that the evidence taken so far has unavoidably involved examining proposals without the benefit of sight of the proposed legislative provisions, the Committee reserves the right to seek further evidence once the amendments have been lodged, which may include licensing. Nonetheless, the Committee welcomes the principle of the proposals outlined in the evidence at stage 1.**

PART 9: STATUTORY NUISANCES

Context

142. Statutory nuisances are set out in Part III of the Environmental Protection Act 1990 and include smoke, fumes, gas and noise that are considered to be prejudicial to health or a nuisance. Local authorities are under a duty to inspect their areas for any statutory nuisances and to serve an abatement notice if they are satisfied that a nuisance exists. A notice could—

- require a person to reduce or lessen the nuisance;
- prohibit or restrict the nuisance;
- require a person to carry out other works or steps to abate the nuisance.

143. Non-compliance could lead to the local authority carrying out any works itself or seeking prosecution.

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[90] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 606-607
[91] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 607
[92] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 611

Additions to the list of nuisances

144. The Bill would amend the list of statutory nuisances to add—

- any insects emanating from premises;
- artificial light emitted from premises or any stationery object;
- any land covered with water in such a state as to be prejudicial to health.

145. Insects and light have been listed as statutory nuisances in England and Wales for some time but, according to the policy memorandum, this is the first primary legislative opportunity that has arisen to bring Scotland into line. In recognition of the potential need to amend the list of nuisances in the future, the Bill would also give ministers the power to make regulations to add to the list or change the conditions associated with existing nuisances.

Enforcement

Background

146. The Bill would give local authorities the option of issuing fixed penalty notices for failure to comply with an abatement notice. Fixed penalty notices would impose a penalty of £400 when served on industrial, trade or retail premises and £150 in all other cases.

Effectiveness of the fixed penalty approach

147. In oral evidence to the Committee, the Society of Chief Officers of Environment Health's representative suggested that using fixed penalty notices could cause a problem for local authorities. He explained that local authorities are used to applying fixed penalties to situations where there is an immediate effect, "such as people dropping litter or a speeding fine in cases where no one is injured." He felt, however, that the situation could be different in cases of public health—

> "Sometimes, the consequences at the start of the situation are no longer evident later on. A local authority may serve a fixed penalty notice on an owner or business. If they pay the penalty, they are relieved of further legal action. A public health situation could expand and might damage the local community, which could then expect some sort of justice to take place through the courts. Unfortunately, that would not be available to the local authority if—with the best of intentions—it had previously served a fixed penalty notice. That is an area of concern among some local authorities."[93]

148. In oral evidence, the Scottish Government explained that, as a voluntary alternative to prosecution, the fixed-penalty notice regime offers flexibility in dealing with non-compliance with an abatement notice, giving a warning to offenders and offering them an opportunity to avoid prosecution. If the abatement notice is breached and the nuisance is not abated, a fixed-penalty notice will be offered. It was added that "detailed guidance will accompany the regime, including

[93] *Official Report*, *Health and Sport Committee*, 16 January 2008; c 473

information on how fixed-penalty notices can be issued". The Government added that further notices could subsequently be issued and the offence "could, ultimately, lead to prosecution".[94]

149. **The Committee notes the Scottish Government's explanation of how fixed penalty notices will work in relation to statutory nuisances. However, the Committee remains concerned that the wording of the Bill would offer an offender "the opportunity of discharging any liability to conviction" in respect of an offence by payment of a fixed penalty and welcomes the Minister for Public Health's commitment to consider this matter.**

PART 10: GENERAL AND MISCELLANEOUS

Equal opportunities

Background

150. The Bill would require the Scottish Ministers, health boards and local authorities, in carrying out their functions under the Bill, to do so in a manner that encourages equal opportunities and the observance of equal opportunities requirements, as defined in the Scotland Act 1998.

Religious and cultural considerations

151. In its oral evidence session with the Minister for Public Health, the Committee asked how the Bill takes into account religious and cultural considerations, referring specifically to the submission from the Scottish Council of Jewish Communities, calling for facilities in mortuaries for any relatives who wish to stay with the body until after the burial and explaining that there should be more than one such area so that, for example, "families of different religions, or of none, would be able to occupy separate spaces, so as not to disturb each other's ritual and the start of the grieving process".[95]

152. In response, the Minister for Public Health explained that the presumption would be for as little interference as possible with bodies. In relation to the question about mortuaries, she stated that Scottish Government would expect those concerns to be dealt with under standards of provision.[96]

153. The minister added that cremation has arisen in discussions with various faith groups—

> "Of course we want to respect the wishes of faith groups as far as possible, but overriding public health concerns may sometimes require cremation to be considered as the only option. That is unfortunate, but it is the reality when dealing with potentially contagious diseases. Clearly, however, that option will be a last resort."[97]

[94] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 613
[95] Scottish Council of Jewish Communities, written submission
[96] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 616-617
[97] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 617

Disclosure of information

Background

154. Section 98 would provide for the circumstances in which information can be disclosed by a relevant authority. Disclosure to another relevant authority would be allowed where required to facilitate the functions of either authority under the Bill, or any other legislation, for the protection of public health. Disclosure to any other person would be allowed if the authority considered it necessary for the protection of public health. Disclosure by or to a relevant authority would include disclosure by or to an employee of the authority or person authorised by the authority.[98]

Consent

155. Under the Bill as introduced, information may only be disclosed "if the individual consents". The Committee considered that there might be circumstances in which the individual does not consent but one authority needs to refer information to another body. The Committee raised this point with the Minister for Public Health, who divulged the Scottish Government's intention to amend the Bill at stage 2 to take into account that issue.

156. **The Committee welcomes the Scottish Government's undertaking to lodge amendments to the Bill to take into account situations where an authority may need to disclose information about an individual without that individual's consent.**

Regulations and orders

Background

157. Section 102 sets out the procedure under which the Scottish Ministers would be able to exercise the powers to make subordinate legislation conferred upon them by the Bill.

Consultation

158. The Committee noted that section 102 is silent with regard to consultation. The Committee considered that some sections of the Bill, such as 19(1), 56(6), 89(1), 95(11) and 98(8), call for a requirement to consult appropriate stakeholders before regulations are drawn up. The Committee suggested to the Minister for Public Health that this could be covered in section 102 with a general requirement to consult, in line with some other primary legislation. The Minister for Public Health responded that, in practice, there would be consultation with appropriate stakeholders but that the position with regard to other primary legislation was inconsistent. However, she agreed to give the matter further consideration.[99]

159. **The Committee welcomes the Minister for Public Health's agreement to consider whether to include in the Bill a general requirement to consult appropriate stakeholders before regulations are drawn up.**

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[98] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

[99] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 615-616

Crown application

Background
160. Section 107 confirms that the Crown would be bound by the Bill and any regulations made under it. The Crown would not be held criminally liable for contravening any provision but the Court of Session would, on application by any public body or anyone responsible for enforcing a provision of the Bill, be able to declare a contravention by the Crown as unlawful. Although the Crown itself cannot be held criminally liable, individuals in the service of the Crown can be.

161. Under subsection (5), the powers of entry conferred by the Bill would not be exercisable in relation to any Crown premises where the Scottish Ministers certified that it appeared to them necessary or expedient in the interests of national security that those powers of entry should not be exercised.[100]

Reserved powers
162. The Committee noted the powers that section 107 (5) would confer upon the Scottish Ministers. The Committee considered that there may be a difficulty with this section in so far as it would be only the Scottish Ministers who could determine what constituted "interests of national security" but, as these might include defence interests, this provision might encroach on the defence and national security powers reserved to the UK Government under the Scotland Act 1998.

163. The Committee raised this issue with the Minister for Public Health by correspondence. The minister's response notes the issue and states that the Scottish Government is currently "in discussion with the Home Office and the Office of the Solicitor to the Advocate General of Scotland with a view to clarifying the position and resolving any potential legislative competency issues prior to stage 2 of the Bill."

164. Although this matter was raised following the completion of evidence-taking and, consequently, the Committee was unable to scrutinise it fully, the Committee agreed that, as it concerned issues of competence between the UK Government and the Scottish Government, it should be included in this report.

FINANCIAL MEMORANDUM

Background[101]

Costs arising from the protection of public health
165. The Financial Memorandum (FM) states that no additional costs on central government or on local authorities are anticipated and that consultation on the Bill and discussions with stakeholders have suggested that additional costs to other organisations will not be significant. It goes on to explain that the health protection powers transferred from local authorities to health boards would rarely be used

[100] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN
[101] *Public Health etc. (Scotland) Bill – Explanatory Notes (and other accompanying documents)*, SP Bill 3–EN

and that, consequently, "attempting to identify a *typical* case and its associated costs is very difficult".

166. It is also explained in the FM that the NHS Central Legal Office (CLO) will provide advice and guidance to health boards regarding applications to sheriff courts—

> "Because CLO already provides advice regarding continued use of life support systems, and on mental health legislation, it is unlikely that providing information specific to applications regarding medical examinations, quarantine, or removal and detention of an individual in hospital will pose any additional financial burden. CLO have not provided any estimates of potential costs for additional training requirements. It is expected that any necessary training will be integrated into existing training schedules at no extra cost."

167. The FM also outlines an estimated £50,000 per year (for all health boards in Scotland) arising from proposals to extend and transfer to the NHS powers of quarantine, removal, and detention, including any legal fees incurred in making applications to the sheriff, and potential costs from appeals. There would also be a further administrative cost of maintaining an adequate pool of appropriately trained competent persons estimated in the region of £16,000 per year (for all health boards in Scotland), on the assumption of 75 competent persons across health boards in Scotland at any time.

168. Health boards will be responsible for providing compensation on proven loss to individuals excluded from work or who voluntarily comply with constraints required by their local health board. The compensation arrangements, which previously fell on local authorities, would apply only to isolated cases rather than epidemics (which would be covered by civil contingency legislation). Local authorities estimate that, currently, compensation payments in respect of exclusions from work are rare. However, the NHS Employers Management Steering Group has estimated that compensation to individuals could reach £60,000 per year (for all health boards in total), based on the assumption of providing compensation to 150 people over the course of a typical year.

Costs relating to statutory nuisances

169. In relation to costs on the Scottish Government, the FM refers only to guidance to local authorities on the statutory nuisance provisions of the Bill, to be issued electronically.

170. In relation to costs on local authorities, the FM refers to evidence from England and Wales showing the volume of additional cases since extending the statutory nuisance regime there to include insect infestations and artificial light has been minimal. Additional nuisances proposed for the statutory nuisance regime in Scotland are not, therefore, anticipated to result in the need for additional trained environmental health officers and, on that basis, any costs should be able to be met from existing sources.

Savings

171. The FM states that the Bill will not result in significant direct savings, except in relation to the notification of diseases. It is explained that, currently, general

practitioners may retrospectively claim a fee of £3.50 per notification. Whilst this is not always claimed, the Bill would discontinue the fee, resulting in a small annual saving to health boards and relieving them of a more significant potential liability.

172. However, health boards will be relieved of the requirement to compile annual returns under the AIDS Control (Scotland) Act 1987, which is to be repealed. The FM states that, whilst there will be no direct staff cost saving because staff are not employed solely to compile these returns, the repeal would enable staff to be released to undertake other tasks.

173. Finally, the FM outlines an expectation that the introduction of a fixed penalty regime in respect of statutory nuisances would free up court time and minimise the amount of time spent by local authorities on pursuing individuals in respect of statutory nuisances.

Scrutiny by the Finance Committee

Background

174. The Parliament's Finance Committee considers the financial implications of legislation through scrutiny of financial memorandums produced to accompany bills introduced in the Parliament. The Finance Committee has a systematic approach to its consideration of financial memorandums, applying a different level of scrutiny depending on the significance of the proposals for public expenditure.

Public Health etc. (Scotland) Bill

175. In relation to the Bill, the Finance Committee sought written evidence from organisations financially affected, using a standard questionnaire, and passed the responses received directly to the Health and Sport Committee, in advance of the Committee's stage 1 evidence session with the Minister for Public Health.

Written submissions from organisations financially affected

176. Written evidence was received initially from NHS Lothian, NHS Ayrshire and Arran and the Convention of Scottish Local Authorities. In light of the evidence received, the Finance Committee agreed to seek additional comments from health boards and from the Scottish Directors of Public Health Group. The Finance Committee subsequently considered the additional evidence received, decided to do no further work on the FM and agreed to write to the Convener of the Health and Sport Committee, explaining that initial concerns raised by NHS Lothian had subsequently been accepted by NHS Lothian as having been addressed.

Provision of facilities for disinfection

Background

177. Local authorities would have a duty to provide, or ensure the provision of, facilities and equipment (which may be mobile) for their areas in order to disinfect, disinfest and decontaminate things and premises, and to destroy things that are infected, infested or contaminated. This includes the means for transporting contaminated things to facilities and equipment for their destruction.

Remote locations

178. The Society of Chief Officers of Environmental Health in Scotland, whilst accepting that most local authorities would be fairly comfortable with their role as enabling authorities and be able to ensure the provision of the necessary facilities, raised concerns about some island and very rural authorities, where such facilities may not be readily available.

179. The Committee raised this concern, asking whether, on a small island, a contractor to a local authority could bring in such facilities when necessary, rather than there being a requirement to have them available at all times. The Minister for Public Health confirmed this to be the case—

> "Section 67 is about ensuring the provision of facilities. It will, in the main, be the responsibility of local authorities, but they need not have facilities available all the time or provide the facilities themselves—they need to ensure access to facilities when they are required."[102]

Mortuary provision

180. The written submission from Dundee City Council outlined a concern relating to funding for building new mortuaries. This concern was raised in the Committee's oral evidence session with the Minister for Public Health. Stating that "those fears are without foundation", the minister reassured the Committee that there is no requirement in the Bill for new mortuaries and no change to current financial arrangements is anticipated.[103]

181. **The Committee notes the content of the Financial Memorandum and the Scottish Government's responses on the issues raised.**

SUBORDINATE LEGISLATION

Report by the Subordinate Legislation Committee

182. The report by the Subordinate Legislation Committee (SLC) to the Health and Sport Committee drew its attention to the following points relating to subordinate legislation.

Powers of public health investigators

183. The SLC noted that subsection (3) of section 25 confers a power on the Scottish Ministers to make regulations, subject to negative procedure. These regulations can confer such powers on investigators as ministers consider necessary for the purposes of public health investigations. By virtue of subsection (4) of section 25, such regulations may modify any enactment, including the parent Act. The SLC was concerned that the scope of the power is too broad in that it could permit the substance of the investigatory powers to be altered in a manner inconsistent with the powers conferred by Parliament in the Bill. Should this power be accepted in principle, the SLC recommends that any exercise of the power that has the effect of amending primary legislation should be subject to affirmative procedure.

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[102] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 604
[103] *Official Report*, *Health and Sport Committee*, 20 February 2008; c 605

International health regulations

184. Section 89(1) creates a broad power, subject to affirmative resolution procedure, to bring forward regulations to implement, or make provision in connection with, the United Kingdom's obligations under the International Health Regulations in so far as they have effect in or as regards Scotland. The SLC understood from the Scottish Government that there were strong policy reasons why the IHR should be implemented in a uniform manner throughout the United Kingdom and that this was how it intended to proceed. However, it noted that it had not been possible for the Scottish Government to reach agreement on the detail of the powers necessary to deliver IHR at a UK level in time for inclusion in the Bill at introduction. The SLC noted that the Scottish Government indicated that this is a "marker" provision for the time being and that it intends to replace this wide general power with more detailed provisions which would still be subject to affirmative procedure. The SLC drew to the attention of the lead committee this very broadly framed power which is subject to affirmative procedure. It also draws attention to the Scottish Government's commitment to bring forward alternative proposals at Stage 2. Any such proposals will require to be scrutinised at that stage. The SLC considered that, if such amendments were not forthcoming, then it will give further consideration to limiting the scope of the power, as currently drafted, given that affirmative procedure offers no opportunity for consideration of amendments, but only approval or rejection of the draft regulations brought forward.

Enforcement of statutory nuisances (fixed penalty notices) under section 95

185. The SLC was concerned that the power created under section 95 could substitute a new period of time for payment and considered that this was a question of principle rather than one of an administrative nature and, in particular, if the period set out on the face of the Bill were to be reduced, this should be a matter for parliamentary approval. The SLC recommended that the Scottish Government be pressed to bring forward an amendment to provide that the exercise of the power proposed in section 80ZA(11)(e) of the 1990 Act should be subject to affirmative procedure following the model of the Smoking, Health and Social Care (Scotland) Act 2005.

186. **The Health and Sport Committee endorses the findings of the Subordinate Legislation Committee and invites the Scottish Government to respond in respect of each issue raised.**

CONCLUSION

187. **The Committee invites the Scottish Government to consider the observations and recommendations contained within this report and looks forward to the Government's response.**

188. **On that basis, the Committee is content to recommend to the Parliament that the general principles of the Public Health etc. (Scotland) Bill be agreed to.**

SUMMARY

Public health responsibilities

Health board and local authority competent persons
189. The Committee is satisfied that defining the health board competent person in secondary legislation is appropriate. However, the Committee also welcomes the Minister for Public Health's decision to consult further on the detail of this matter. (paragraphs 11 to 20)

190. The Committee is satisfied that defining the local authority competent person in secondary legislation is appropriate and that the Scottish Government's plans in this regard are reasonable in current circumstances. (paragraphs 21 to 23)

Joint public health protection plans
191. The Committee invites the Minister of Public Health to reflect on the proposal for joint public health protection plans to be prepared by health boards in consultation, rather than collaboration, with local authorities, in the light of the concerns raised by witnesses that this could represent a retrograde step compared with the current arrangements. (paragraphs 24 to 26)

Fees for general practitioners
192. The Committee notes the Minister for Public Health's explanation that the withdrawal of fees for general practitioners in respect of notification of diseases will not affect the workability of the Bill. (paragraphs 30 to 32)

Information to be reported
193. The Committee is satisfied with the explanations in relation to this matter and, notwithstanding the minister's subsequent letter of 28 February, invites the Minister for Public Health to reflect further on whether the patient's school or place of work should be reported, on the order of items included in the definition of the NHS identifier and on the issues raised by the Information Commissioner's Office. (paragraphs 33 to 42)

Health risk states
194. The Committee notes the concerns raised regarding the practicalities of notifying health risk states, the workability of the definition and implications for the future and invites the Scottish Government to reflect on the definition of health risk state and consider whether any amendment to it is necessary. (paragraphs 43 to 49)

Diagnostic laboratories
195. The Committee welcomes the Minister for Public Health's intention to amend the definition of director of a diagnostic laboratory and notes that the Scottish Government is giving further consideration, in consultation with the Food Standards Agency, to whether laboratories testing food and water samples should be covered by the Bill. (paragraphs 53 to 57)

196. The Committee was satisfied with the Scottish Government's explanation of the 10-day rule for notification by laboratories. Further, the Committee asked how the provisions of the Bill would apply in respect of tests performed in a laboratory

that is not within Scottish jurisdiction and welcomes the Minister for Public Health's agreement to look into the matter. (paragraphs 58 to 60)

197. The Committee welcomes the Minister for Public Health's commitment to lodge amendments at stage 2 to remove "any other clinically significant pathogen found in blood" from the list of notifiable organisms set out in schedule 1. (paragraphs 61 to 65)

198. The Committee asked about biosecurity arrangements in respect of tests performed in a laboratory that is not within Scottish jurisdiction and welcomes the Minister for Public Health's agreement to look into the matter. (paragraphs 66 to 68)

Public health investigations

Public health investigators
199. The Minister for Public Health acknowledged the concerns raised by the Committee about the relationship between the provisions to appoint a public health investigator and the earlier provisions to appoint local authority and health board competent persons and agreed to reflect upon the matter. The Committee notes the Minister for Public Health's subsequent letter, dated 28 February, giving a rationale for the section 21 provisions on the appointment of public health investigators, but believes that there is a need for more clarity and encourages the minister to reflect further on the matter. (paragraphs 69 to 72)

Public health investigation warrants – summary application procedures
200. The Committee notes with surprise that court procedures referred to in the Bill are not competent; is dismayed that a Bill could reach the stage of introduction in the Parliament with incorrect provisions; is disappointed that it is not clear whether the Scottish Government's proposed course of action with regard to this matter is as simplified as the proposal by the Law Society of Scotland; notes the Minister for Public Health's reassurances, and awaits with concern further correspondence clarifying the matter. Further, the Committee reserves the right to seek further evidence on this matter at stage 2, should the Bill progress to that stage. (paragraphs 75 to 80)

Compensation – appointment of an arbiter
201. The Committee notes that the Minister for Public Health acknowledged, in supplementary written evidence, the point made by the Law Society of Scotland that people should be able to select the Lands Tribunal for Scotland as an arbiter for compensation cases relating to public health investigations. The minister advised that the Law Society of Scotland's suggestions are being considered further and the Committee welcomes her commitment to lodge amendments at stage 2 if appropriate. (paragraphs 81 to 85)

Public health functions of health boards

Health boards' duty to give explanation
202. The Committee suggested that any exemption to the requirement to give an explanation should be subject to the caveat that, in situations where a requirement had not been given, it should be required that the explanation be given as soon as

practically possible. The Minister for Public Health agreed to give further consideration to the issues raised by the Committee about the exemption from the duty to give explanation. (paragraphs 86 to 89)

Medical examinations – right of appeal

203. The Committee is not satisfied with the Minister for Public Health's position that there would be no practical purpose in appealing a sheriff's decision to authorise the medical examination of a person other than to enable the individual to obtain compensation: suing for damages is a separate issue and seeking a remedy via judicial review under human rights legislation would be a very long and expensive process. Furthermore, the Committee does not accept the suggestion that an appeal would be unlikely to provide a test for other cases on the basis that any appeal would be restricted to the facts and circumstances of a particular appeal – the Committee believes that, if those facts and circumstances were similar to a prior appeal, the outcome of that prior appeal would be relevant to the appeal under consideration. Accordingly, the Committee urges the minister for Public Health to reconsider the position on this matter and to lodge amendments to the Bill to include a specific right of appeal following a decision to proceed with a compulsory medical examination, whether or not the examination has taken place. (paragraphs 93 to 99)

Exclusion and restriction orders

204. The Committee notes the Minister for Public Health's explanation of the difference in the extent of restriction to a person's liberty by exclusion and restriction orders compared with quarantine orders and understands the need for rapid action. Nevertheless, the Committee has some sympathy with the views expressed in the legal submissions. The Committee also recommends that the provision should refer to an order prohibiting persons from entering or remaining in "specified places" rather than in "any place", which could be considered confusing. (paragraphs 100 to 104)

Public health functions of local authorities

205. The Committee is content to note the provisions setting out the public health functions of local authorities. (paragraphs 105 to 108)

Mortuaries

206. The Committee is content to note the proposals in the Bill putting onto a statutory footing arrangements for the provision of mortuaries. (paragraphs 109 to 114)

Information on health effects of sun beds

207. The Committee acknowledges that the collaboration between Ken Macintosh MSP and the Scottish Government is an on-going process and is grateful to them for alerting it to their plans at an early stage, allowing evidence to be taken at stage 1. However, given that the evidence taken so far has unavoidably involved examining proposals without the benefit of sight of the proposed legislative provisions, the Committee reserves the right to seek further evidence once the amendments have been lodged, which may include licensing. Nonetheless, the

Committee welcomes the principle of the proposals outlined in the evidence at stage 1. (paragraphs 117 to 141)

Statutory nuisances

208. The Committee notes the Scottish Government's explanation of how fixed penalty notices will work in relation to statutory nuisances. However, the Committee remains concerned that the wording of the Bill would offer an offender "the opportunity of discharging any liability to conviction" in respect of an offence by payment of a fixed penalty and welcomes the Minister for Public Health's commitment to consider this matter. (paragraphs 142 to 149)

General and miscellaneous

Disclosure of information
209. The Committee welcomes the Scottish Government's undertaking to lodge amendments to the Bill to take into account situations where an authority may need to disclose information about an individual without that individual's consent. (paragraphs 154 to 156)

Regulations and orders
210. The Committee welcomes the Minister for Public Health's agreement to consider whether to include in the Bill a general requirement to consult appropriate stakeholders before regulations are drawn up. ((paragraphs 157 to 159)

Financial Memorandum

211. The Committee notes the content of the Financial Memorandum and the Scottish Government's responses on the issues raised. (paragraphs 165 to 181)

Subordinate legislation

212. The Health and Sport Committee endorses the findings of the Subordinate Legislation Committee and invites the Scottish Government to respond in respect of each issue raised. (paragraphs 182 to 186)

Conclusion

213. The Committee invites the Scottish Government to consider the observations and recommendations contained within this report and looks forward to the Government's response.

214. On that basis, the Committee is content to recommend to the Parliament that the general principles of the Public Health etc. (Scotland) Bill be agreed to.

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