OFFICIAL REPORT
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Citizen Participation and Public Petitions Committee

Wednesday 17 May 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 17 May 2023

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CITIZEN PARTICIPATION AND PUBLIC PETITIONS COMMITTEE

8th Meeting 2023, Session 6

CONVENER

*Jackson Carlaw (Eastwood) (Con)

DEPUTY CONVENER

*David Torrance (Kirkcaldy) (SNP)

COMMITTEE MEMBERS

*Foysol Choudhury (Lothian) (Lab)
*Fergus Ewing (Inverness and Nairn) (SNP)
*Alexander Stewart (Mid Scotland and Fife) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr James Adeley (Lancashire and Blackburn with Darwen)
Jackie Baillie (Dumbarton) (Lab)
Dr Simon Beardmore
Ann Edwards (Lancashire and Blackburn with Darwen)
Monica Lennon (Central Scotland) (Lab)
Michael Marra (North East Scotland) (Lab)
Dr Mark Sissons (Blackpool Teaching Hospitals NHS Foundation Trust)

CLERK TO THE COMMITTEE

Andrew Mylne

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Citizen Participation and Public Petitions Committee

Wednesday 17 May 2023

[The Convener opened the meeting at 09:29]

Decision on Taking Business in Private

The Convener (Jackson Carlaw): Good morning, and welcome to this meeting of the Citizen Participation and Public Petitions Committee.

First of all, we have a decision on taking business in private. Are colleagues content to take item 4 in private?

Members *indicated agreement.*

Continued Petitions

Human Tissue (Scotland) Act 2006 (Post Mortems) (PE1911)

09:30

The Convener: Agenda item 2 is consideration of continued petitions. PE1911, which is on a review of the Human Tissue (Scotland) Act 2006 as it relates to post mortems, was lodged by Ann Stark, who I believe is with us in the gallery this morning—you will have to forgive me, because my glasses are not that good, but I am aware of people at the other end of the room. Thank you for coming along this morning to observe our discussions.

The petition calls on the Scottish Parliament to urge the Scottish Government to review the Human Tissue (Scotland) Act 2006 and relevant guidance to ensure that all post mortems can be carried out only with the permission of the next of kin; do not routinely remove brains; and offer tissues and samples to next of kin as a matter of course. This morning, we will take evidence remotely from witnesses, because we will be exploring the relevant issues as they relate to practice in England, which the committee has been intrigued by in our previous considerations of the petition.

I am delighted to be joined this morning by Dr James Adeley, senior coroner; Dr Simon Beardmore, consultant radiologist; Ann Edwards, coroner services manager; and Dr Mark Sissons, consultant pathologist. Thank you all for giving us your time this morning and for joining us to discuss the petition, because the committee is genuinely intrigued to understand the different practice in England and why for the moment it is judged as being difficult to emulate in Scotland.

Having wished you all good morning, I will move to questions. I should say that our clerks will be keeping a careful eye on things, so please just indicate when you wish to contribute.

All of you provide a post-mortem scanning service in Lancashire and Blackburn with Darwen Council, and it is a collaboration between the county council, Lancashire Teaching Hospitals NHS Foundation Trust and a private scanning provider, Digital Autopsy UK. I understand that the whole arrangement has been in place since 2016 and was the first of its kind in the United Kingdom.

Can you, by way of introduction, provide a bit of background? What prompted the establishment of the service? Was it simply a good idea? Was there similar public concern about the arrangements that had been in place? Was it a matter of professionals coming together who believed that it

was possible to do things differently and in a way that better served the public interest? I am very interested in understanding how all this came about in the first instance.

Who is going to kick off? I am looking for one of our witnesses to volunteer.

Dr James Adeley (Lancashire and Blackburn with Darwen): I was the coroner in place in 2016. About two or three years before that, we looked into the future and realised that, because the number of pathologists was decreasing rapidly, we would not have any form of post-mortem service. That was coupled with research being developed, particularly in the University of Leicester, that showed that quite a lot of post mortems could be done through post-mortem scanning. It is not a panacea, but it can deal with a large number of cases.

We started to look at how to set up a service to achieve that. It was difficult—it was certainly the most complex work that I have ever done—and it required all of us, including Simon Beardmore and the local authority, to act in concert.

I will explain one of the driving forces behind the service. For those of you who have never been to a post mortem, I note that it involves the person's body cavities being opened and all their organs being removed. The organs are examined before being put in a plastic bag and put back in the abdomen. The body is then reconstructed. There have been advances in computed tomography scanning, but that procedure is still very invasive. Quite a lot of faith communities would not accept it, and families are upset by it. In my view, offering a different service is the way to go as technology develops.

Providing that service required everyone to act together. We wanted to provide a post-mortem scanning service based in a hospital next to the mortuary, with all the personnel undertaking the tasks being within the NHS. That was to be part of their job plan so that we did not have difficulties with ad hoc arrangements. The service was to run year in, year out.

When it comes to setting up such a service, the mechanics of it are not the problem. The issue is the past history of pathologists who have done post mortems and the fact that this is a new technique; it is an imaging technique, not an invasive technique.

I am not sure whether I am helping any more. Do you wish me to go in a different direction?

The Convener: What you have said is very helpful. At the start of your comments, you said that there was a rapid reduction in the number of pathologists. Can you elaborate on why that was the case? Has that reduction continued apace, or has anything been done to try to arrest that decline?

Dr Adeley: I will answer first and give my perspective, but Mark Sissons will also have a valid viewpoint, given that he is a practising pathologist.

About 15 or 20 years ago, the Royal College of Pathologists made a change. It used to be that a pathologist was required to undertake post mortems as part of their training. It was found that people were not going into the profession because they did not want to do post mortems, but pathologists were still needed to look at all the slides and biopsies from the living. Consequently, there is now a split training regime in which people are not required to undertake post mortems as part of their training—it is something that people volunteer for.

As a result, it tends to be older pathologists who have expertise of carrying out post mortems, and they are coming to the end of their working lives, so there was a fairly rapid reduction in the number of those pathologists. In Lancashire, the issue became incredibly acute over a short period of time, but the problem exists almost everywhere. Even now, we have only Dr Sissons and one NHS pathologist for a population of 1.4 million people. Given those numbers, we could not even mount an external body examination service, let alone a post-mortem service.

I will pass over to Dr Sissons so that he can give his view.

Dr Mark Sissons (Blackpool Teaching Hospitals NHS Foundation Trust): I agree with what Dr Adeley has said. The majority of trainee pathologists do not want to get involved with coronial work. There are many reasons for that, but the main one is that they are very busy with their laboratory-based work. There are lots of demands on the system. For example, there are a lot of cancer diagnoses to be done in laboratories, and there are timeframes associated with those. Therefore, most trainee pathologists do not want to get involved with coronial work, because it is almost like private work—people need to do it in their own time. The way in which things are organised means that any coronial work must be done in addition to the normal laboratory work that people are expected to do. For those reasons, the majority of trainees are just not interested in becoming coronial post-mortem workers.

The Convener: From what you have both said, it sounds as though there was a driving necessity to bring about a change in the arrangements that were in place. Every bit as much as clinicians and others thought that it was the right way forward, it sounds as though the previous arrangements

were potentially dangerously unstable in terms of being able to provide a service.

On that basis, I am interested to know whether, to your knowledge, in the interim since 2016, the practice that you have evolved has been rolled out to other parts of the United Kingdom outside Scotland. In so far as you were able to establish a service, will you tell us what the main challenges were in trying to bring about what you have achieved, as a general introduction to the questions that will then follow? I do not know who will volunteer to speak.

Dr Adeley: If I start and Dr Beardmore comes in afterwards, would that suit?

The Convener: Yes. That is fine. When questions are asked, to avoid us operating in a vacuum, it will possibly be helpful if I come to you first and you direct us to the colleague who you think would be most appropriate to answer.

Dr Adeley: Okay.

The pathology service for coroners was about to cease to function around that time. The set-up that we have here is quite different from the set-up in a lot of other parts of the UK. When Dr Beardmore and I set this up together, we took the view that, when you CT scan somebody, it is an imaging process and you get a series of images on a screen. There has been a lot of work comparing images against causes of death established at post mortem so there is correlation between the two. We decided that, when someone has enough experience as a radiologist of seeing scans against dead people, they are able to say, from looking at a scan, that a person has died from a particular disease. That is in much the same way as, over the past 300 years, pathologists have gained experience of looking at diseased organs.

My view was that, in most cases, we did not need to involve a pathologist with the radiology images. Post-mortem scanning does not always give the answer, and you do need to have pathology there—it is still a very important part of coronial practice for those cases in which you cannot make a diagnosis and in certain other areas, which I will come back to.

However, we had the problem that, first, there really were no pathologists; secondly, I could not justify a pathologist being involved, because they are needed for treating the living; and, thirdly, if it is an imaging modality, it takes too long to train a pathologist to understand the images. Consequently, as there is a shortage of pathologists, we would have been making things worse.

The other problem that we run into is that, given the volume of scans—the population in my area is about 1.4 million and we do 1,650 scans a year—if you add on the very low fees for a pathologist to review the radiologist's report, which would be £100 each time that they do that, you would increase your costs and slow down the process. For that reason, I took the view that I would ask the radiologists to report on this. That is not what is done in a lot of areas, where radiologists work as they do in the NHS when they are assisting the living. They provide an opinion and that is sent to a pathologist, who looks at the opinion and says, "Yes, I think that's okay," or, "No, I don't think that's okay." I have a problem with that due to the fact that they are reviewing what someone else has written, without reviewing the scans themselves. I wonder why they are involved at that point.

However, pathologists are very important for those cases in which post-mortem scanning does not produce a result. When that occurs, it depends how you scan, and there are two types of scan. We took the view that we wanted the scan that would provide the greatest number of diagnoses because, otherwise, if we had to go on to a post mortem to find a cause of death, the limiting factor was our pathologists.

09:45

The two types of scan are a plain scan, in which a person is simply put through a CT scanner, as they would be if they were in casualty, and an enhanced scan, which is what we have. In an enhanced scan, we perfuse the coronary arteries with dye, and we will sometimes ventilate the lungs. Dr Beardmore is better at that than I am.

That gives us a diagnostic rate of around 94 per cent, interpreting on the basis of the radiologist. If the radiologist is uncertain, we can go back to the clinician who treated the deceased at the time to ask them whether that accords with their views on the living. If they can be provided with negative findings, they will quite often be able to give more input into the cause of death.

Has this approach been rolled about across the UK? There is not another service like this one that runs on just radiologists. The rest run on pathologists and radiologists. More centres are doing it, but I think that the number is still less than 10. Dr Beardmore may know better.

You asked about the challenges in setting this up. The biggest problem that we ran into was that the pathologists quite rightly have the view that establishing the cause of death has been their purview for the past 300 years, and there is the consideration of how they will remain involved in the coronial process and whether they will be part of the post-mortem scanning service. A debate about that probably needs to be had between the royal colleges to sort it out. However, given the

fact that we are running out of pathologists, that seems to be going only one way.

The Convener: That is very helpful. Thank you.

Dr Simon Beardmore: Good morning. Dr Adeley has picked up on most of the things that I was going to say.

There are places around the country that do CT post-mortem services. Leicester does them—we did the training there—Oxford is doing things, and the private set-up is operating through Stoke, Stanwell and Birmingham way. Those are the ones that I know about.

Radiologists are quite adaptable. We can move from one sub-speciality to another, and most radiologists who have trained in CT scanning can quite easily report a scan of the dead as well as the living. From our point of view, there is not too much training needed to report on a scan of the dead.

We can turn scans around quite quickly. We can do probably one scan every half an hour and get a full report out to the coroner. We do one session a day Monday to Friday. Therefore, we do eight scans a day, which equates to around 1,500 scans a year. That is probably a quicker turnaround service than there would be with a traditional invasive post mortem.

The other thing that we can do as radiologists is remote report, so we do not have to be on site where the body is. Therefore, you could get a group of radiologists together in a different country if you wanted to, and they could report the scans remotely. As has been said, a non-invasive scan is better for religious beliefs and a lot of faiths that do not like invasive post mortems.

Are there any specific questions about radiology or the scan process that you would like to ask?

The Convener: Fear not. We will have a number of questions.

This is all incredibly technical. In some of your answers, you may well volunteer information that will come up again in questions that my colleagues will ask. It is quite a complicated subject, and we are keen to understand it as well as we lesser mortals can.

The conclusion that I am coming to is that there is variable practice, but the common feature no doubt is that the number of pathologists is reducing everywhere because of the way in which the service is structured and the voluntary nature of electing to participate in post mortems. That is an interesting consideration.

I will bring in my colleague David Torrance. We have been told by the Crown Office in Scotland that achieving the skill sets required to move to different technology would be incredibly difficult.

David Torrance (Kirkcaldy) (SNP): Dr Adeley, earlier you talked about training of pathologists and using radiologists.

As the convener has already said, the Crown Office and Procurator Fiscal Service has identified skills shortages within its workforce. Was there any need to upskill pathologists at Lancashire and Blackburn with Darwen?

Dr Adeley: Upskilling radiologists to read scans is a two-week course; it is just an adaptation of what they already do. They are looking at how bodies change after death, which is a special skill set, but it does not take a radiologist long to learn because they already have the basic skills. The course is therefore straightforward. It was taught to the 14 radiologists we use in Lancashire at the University of Leicester in two-week courses, in three tranches.

Upskilling the pathologists was not necessary. We give the pathologist the scan report and ask what they can see on a series of images. It gives them information about how to approach the post mortem and where they might wish to go. For example, if the scan report of somebody who has died suddenly says that it cannot see any bleeds within the brain, one might not need to go inside the head to examine it if one can find something else in the rest of the body that has caused the death.

The pathologists did not need to be retrained. They continued to do the job that they have always done.

David Torrance: So, no post-mortem imaging training was given to the pathologists at all.

Dr Adeley: We can do it one of two ways. We can train radiologists to look at the images, which is relatively quick because they are already skilled at doing that. If we want to run a service in which pathologists look at scans, that will require a considerable amount of training and effort. Pathologists are not skilled at looking at radiological images: it is not within their skill set. If we wish to approach it in that way, we can do so, but I do not know of anybody who is even considering that. Very few pathologists read scans. There is Dr Guy Rutty in Leicester and there is somebody in Oxford, but it is unusual to find a pathologist who does that. They have usually been in the process for a very long period of time, having started at the beginning where they would do the scan and then do the post mortem.

However, in the system that we run, and in most of the other operations in the UK—the six that Dr Beardmore mentioned—imaging is all reported by radiologists simply because of speed and ease of training. The scan can be given to the pathologist and they can read about what can be seen on it, and I do not think that they require any further

training for that, although perhaps Dr Sissons could help you with that.

Dr Sissons: Training pathologists to interpret radiological images is a non-starter. I do not think that there would be any enthusiasm for that. It is not appropriate for pathologists to be involved in reporting X-rays. They are chalk and cheese—the post mortem that we do and the radiological images are two different things, and that reporting is not something that pathologists would want to get involved in. They would be quite happy to read the report of the radiologist and take all that on board.

Dr Beardmore: Training for a radiologist to report scans of the living takes five years in this country. Once you have the skill set to report on a CT scan, it does not take too much to adapt to reporting CT scans of the dead once you have already done the training in interpreting CT scans. We did a three-day course in Leicester to show us the changes that happen after death. After that, we were fine to report on post-mortem CT scans. If you were to train a pathologist to report on a CT scan, it would take more than five years for them to become good at it.

David Torrance: I want to pick up on that point. In Scotland, radiologists are like hen's teeth and the NHS is under huge pressure. Is there any way that pathologists could be trained in post-mortem scanning in a shorter time? Could that form part of the training that pathologists do?

Dr Beardmore: I do not think that they have the willpower to do it. Most of the pathologists whom I have asked, "Would you be interested?", have said, "No," so I think that attempting to train pathologists to interpret scans is a non-starter.

David Torrance: Thank you for that.

I have a final question. Given the pressures on pathology post-mortem and forensic services, to what extent does use of post-mortem computed tomography scans reduce those pressures?

Dr Beardmore: The use of PMCT scans does not reduce the pressure on brain scanning of the living. Through training 14 of us, we have spread the workload between us, so that one radiologist does not take a big hit, so to speak. We do one session every two weeks, which is not too onerous.

You are quite right: there are pressures on scanning the living, just as there are on scanning the dead. That is the case across the board. There is a 10 per cent vacancy rate in radiologists in the UK. The only thing that I can think of is that, as radiologists, we can turn the scans around a lot more quickly than the pathologists would have been able to turn around invasive post mortems. Therefore, the process is slightly more efficient from that point of view.

The Convener: I want to go back over some of that territory. You have spoken about the fact that it is felt that it is a "non-starter" to consider retraining pathologists and that the desire for that does not exist among that community. You have alluded to the shortage of radiologists. To be perfectly candid, it is not a public secret that Scotland is acutely short of radiologists. For example, the 62-day cancer standard is not being met by any of Scotland's health boards. The waiting time for all the key diagnostic tests, including radiology, is not being met anywhere in Scotland. The statistics from December 2022 show that just 45.8 per cent of patients waited less than six weeks for their diagnostic test.

This is not necessarily a question that you can answer, but I wonder whether similar pressures were advanced in the arguments that took place when your service was set up. The Government might say in response to the petition, or to any initiative that we might subsequently seek to promote, that faced with an acute shortage of radiologists, its first priority should be the living and that any such proposal would divert and potentially further undermine our ability to satisfy or meet currents needs, or even to close the gap, as regards current provision. Was a similar sentiment advanced when you set up your service?

Dr Beardmore: There was a concern. However, not all radiologists report on cancer scans. For example, I am a musculoskeletal radiologist, so I am not under pressure to report on cancer scans; I deal mainly with bones and joints. We have quite a few interventional radiologists who do some reporting for us, too.

It is true that such pressure exists, so it is necessary to decide where you want deploy your experience, or in what areas you want your radiologists to be reporting. However, not every radiologist is a cancer specialist. There are a couple of people who report on cancer scans who also do post-mortem CT scans, but as I said, because there are 14 of us who are trained, we can spread the load between us to provide a service.

The Convener: That is helpful. Scotland has a 62-day cancer treatment standard. For my understanding, is there similar pressure in your area in respect of that discipline?

10:00

Dr Beardmore: Yes, there is pressure to get scans turned around. I frequently see emails saying, "Patient is back in clinic; we need a report

the next day", so we have the same pressures on us as you have in Scotland.

The Convener: That is helpful to know, because it sets in context what we are discussing. It means that our situation in that regard is not unique, and yet the provision has been established elsewhere.

Fergus Ewing (Inverness and Nairn) (SNP): Good morning. I have questions first on quality assurance and the efficacy of CT scans as opposed to conventional post mortems and, secondly, on the cost aspects.

On quality assurance, the petitioner claims that scanners are 99 per cent accurate in establishing the cause of death. However, a submission to the committee from the chief coroner highlights guidance on the use of imaging in post mortems. It references a joint statement from the Royal College of Radiologists and the Royal College of Pathologists on post-mortem cross-sectional imaging. I am told that the most recent version of that details the strengths and weaknesses of imaging in establishing the cause of death. For example, it details its accuracy in establishing deaths from trauma, stroke and heart disease and its limitations in diagnosing deaths from conditions such as sepsis and poisoning. I guess that I have—[*Interruption*.] Excuse me. I am sorry—I will just turn my phone off. My apologies, convener.

With that introduction, which I thought might be helpful to set the background, I have three questions. I will come to Dr Adeley first. First, how do PMCTs compare with traditional post mortems in terms of accurately establishing a cause of death? Secondly, can the witnesses detail the main strengths and weaknesses of using imaging in post mortems? Thirdly, what proportion of deaths could have their cause accurately established by using imaging?

Dr Adeley: Those questions are interrelated. With regard to peer review and the different types of post mortem—[*Interruption*.] I am sorry; my clock is chiming in the background. The review is not done by one pathologist sitting with another pathologist going through the same post mortem at the same time—there is no peer review. Also, unless samples are taken there is no permanent record—these things are not photographed—whereas with a post-mortem CT scan, the scans remain as digital images for as long as they are kept. We are required to keep ours for 15 years.

On quality assurance—I will ask Dr Beardmore and Dr Sissons to come in after me on this—there are different types of scans. A plain scan, for example in the case of heart disease, relies on the amount of calcium that is deposited in the arteries that supply the heart. That gives a score and tells us how likely it is that the person died from coronary artery disease. The technique that we use—in younger patients where clots in the heart are more likely—involves putting in a catheter. Because we are using a relatively much more invasive approach—imaging things with dye and catheters within the coronary arteries—our diagnostic rates are considerably higher.

As I said at the beginning, it is accepted that CT scanning is not a panacea. There are certain things that it does not do well. Sepsis in particular is one of those things. Sepsis is a generalised infection that runs throughout the body, and we need to look at the organs for that. If someone has been poisoned, we will quite often be looking at a Home Office post mortem, which is of a completely different character, but we might wish to instruct a post mortem that is performed by a pathologist directly. We would not go to a CT scan to begin with. There are academic articles that say that, in some circumstances, CT is better for things such as trauma but is not as good for other soft-tissue injuries.

The issue that I was running with when I was setting things up was that it really does not matter which system is better if there are no pathologists. That dictates the choice that is made. The situation in Scotland might be different, but if there is one option and it will do the job nearly as well in most circumstances, that is the choice that will be made. There are academic papers on that, if you wish to be referred to them.

On producing causes of death, we scan 1,600 deceased people a year. We are probably the largest scanning outfit in England and Wales. About 6 per cent of our scans go on to pathology. It is very useful to have pathology for things such as suspected sepsis and for when someone has had an operation. It is absolutely essential if people might have a genetic component to heart disease. In such cases, biopsies are needed to send to specialist pathologists. We also need to be able to take biopsies for people who have suffered from industrial disease in order that claims can be pursued.

It is not really an either/or question. Both approaches are needed, even if a post-mortem CT scan is going to be run.

Dr Beardmore: We give causes of death in 90 to 95 per cent of cases, but that does not necessarily mean that we always get it right. We run on the rule of the balance of probability, which means that we have to be right in 51 per cent of cases. As long as we are correct 51 times out of 100, we are still within the law. That is why we can give causes of death at a greater rate than some papers on the accuracy of post-mortem CT say.

As Dr Adeley said, CT is very good for trauma and spotting fractures, and at coronary artery

disease using a non-invasive approach in which we use calcium scoring, or a minimally invasive approach in which we pop in a catheter and put some dye down the coronary arteries. Both techniques are very useful.

The deaths of the majority of people who drop down dead without a cause of death relate to cardiac disease. We follow the rule of the balance of probability, which is why we can give the causes of death that we give.

A radiologist mindset that has to be got around is that, when radiologists report on the living, they have to be nearly 100 per cent accurate in what they say, whereas when they report on the dead, that level of certainty is not required. Therefore, a cause of death can be given even if the person is not 100 per cent certain that that is what caused the patient to die.

Dr Sissons: There is no doubt that computed tomography post mortems are very useful. They relieve the burden of a lot of invasive post mortems.

I get involved with industrial disease cases in which large samples of tissue need to be taken, maybe from the lungs. Those are the common cases that I deal with. It is important that young people who have died from heart disease have an autopsy or a limited autopsy to get samples of the tissues for expert analysis and genetic testing.

I come across cases in which the CTPM is incorrect. My main worry about CTPMs is pulmonary emboli, which are what happens when blood clots travel from the leg or pelvic veins and block the arteries in the lungs, causing sudden death. In my experience, there is no doubt that the CTPM misses some of those. From my point of view as a pathologist, in the cases that I work on, the one disappointing aspect is when I see pulmonary emboli that are not detected on a CTPM scan. However, I think that evolving techniques will improve that situation and, overall, the CTPM service is very useful. It solves the problem of invasive post mortems not being able to be done by pathologists, and it means that people are not waiting a long time for invasive autopsies to be completed.

Fergus Ewing: I will ask one supplementary question. I think that the witnesses will be aware that the petition that is before the Scottish Parliament was occasioned following the sudden death of the petitioner's child. The petitioner's child underwent a post mortem that was much more extensive in nature than the petitioner had originally thought it would be. Obviously, anyone's death involves grief, sadness and bereavement for their family, and the post-mortem issue is very sensitive. That is otiose—I do not need to tell any of the witnesses that, because they deal with the matter in their professional work.

However, obviously, the death of a child is particularly hurtful and causative of long-lasting, perpetual, eternal emotional harm, and that is really why we are taking evidence today. With that backdrop, are there any particular strengths or weaknesses in relation to the use of a scan after the death of a child, most especially an infant or young child?

Dr Adeley: The issue of children is a particularly problematic area because, after death, children do not scan in the same way that adults do. Children need to be put through an MRI scanner rather than a CT scanner; MRI scanners work on magnetism, whereas CT scanners work on X-rays.

The problem is that the number of unexpected child deaths is extremely small. The reason for that is that most child deaths are either expected—because the child has a long-term illness and has been treated within mainstream healthcare—or the death is completely unexpected and there is a criminal suspicion with it, in which case it will go down the Home Office post-mortem route. That leaves very few cases in the middle, where the death is not suspicious but is unexpected. The problem is in maintaining the skill set of the radiologists in doing enough of those cases to know that they are getting the right answer. When it comes to numbers, that situation is very different from scanning adults.

With regard to children who are older, as in the case of Mrs Stark's son, there is a particular concern around young adults who die suddenly, because there is something called sudden adult death syndrome, which is a collection of heart diseases, some of which might be genetic. Unless we take a biopsy for that, we will not be able to diagnose it, and the problem is that, because there is a genetic aspect, other family members might be at risk. In order to deal with that more effectively, we have just signed up to a pilot for limited post mortems, in cases in which samples need to be taken for genetic testing, which requires an invasive post mortem.

However, when we deal with such issues, we usually ask the family about their views about post mortems, because there is a range of views when it comes to how families approach the subject. Whereas some families are not bothered by it, some families are extremely distressed, particularly those in the faith communities.

10:15

In those cases, a conversation takes place between the coroner and the pathologist. The body will be scanned first and, if nothing can be seen from the scan of the head, the pathologist

will be asked to look at the heart. If they find the cause of death or if the heart looks abnormal—for example, if it is markedly enlarged—they will be asked to limit the post mortem to the areas that are most likely to produce a cause of death.

The difficulty with limiting the pathologist's investigation is that they might not see what they expected to see when looking at the slides using a microscope, so a cause of death might not be found. The process involves a series of unknowns when it is done in real time, and the investigations cannot be done quickly enough to avoid hanging on to a deceased person's body for a long time while all the investigations are conducted. The answer is therefore not straightforward.

Would Dr Beardmore or Dr Sissons like to comment?

Dr Beardmore: In our country, it is only specialist children's centres that do paediatric post-mortem scanning, and that is done only on a research basis. Therefore, as far as I know, such children still go on to have invasive post mortems. The reason for that is that, as Dr Adeley said, there are so few child deaths that places such as Preston will not get enough experience to be able to confidently report on such scans, because we do not see enough of them. That is the main issue relating to child deaths. By concentrating the expertise in children's hospitals, we might eventually be able to build up the experience to be able to report on CT and MRI scans in those circumstances.

Fergus Ewing: Thank you.

The Convener: My colleague Foysol Choudhury has a supplementary question.

Foysol Choudhury (Lothian) (Lab): As has been said, any death results in a sad time for the family. Do families have an opt-out option? For example, in some faith communities, people want the burial to take place as soon as possible. As the witnesses said in answer to the convener's questions, there is a shortage of professionals, so people might have to wait a very long time. What value is given to those families? How much information is given to them when organs are removed from the body?

Dr Adeley: We have very good relationships with faith communities. Our system applies to everyone, no matter their religion; if it applied only to the Muslim faith or the Jewish faith, that would be discriminatory. If there is a very good reason for an expedited post mortem—for example, for religious reasons, or because the family is travelling here from abroad—we will move the case through the system much more quickly.

We are well aware of the concerns of faith communities regarding post mortems and the body being a holy object. Faith communities are very much behind the post-mortem CT scanning. Mosques have raised money to pay for additional body storage.

In Lancashire, the average time between someone dying and their getting a post-mortem CT scan, if that is needed, is about three or four days. In most cases, a post mortem is not necessary. However, if it is necessary because there is no obvious cause of death, we have a conversation with the family and explain what we are doing. We have discovered that faith communities want two things. First, they want the burial to occur as soon as possible. Secondly, if that is not possible, they want us to provide information on how long the process will take, so that we do not cause social difficulties in relation to accommodating all the family members who come.

The tension usually arises when a young person—someone under the age of 60—dies suddenly and there is a concern that the death was caused by a genetic cardiac condition. If it is a single child and there is nobody else around, it is not going to affect anybody, so we would not do an invasive post mortem. However, quite often, families are quite large and there are brothers, sisters and cousins who might be at risk of inheriting that disease, which could be treated.

In those cases, I will have a conversation with one of the religious leaders and I will explain why we are doing that and why it is necessary—to stop the possibility of the next event occurring, which would be another family member dropping dead. It is not a decision that I ever take lightly, and each case is dealt with on its own merit. If you like, I can give you the contact details of the local Muslim burial societies, so that you can speak to them about how they find dealing with us, but they were very supportive of CT scanning because it is faster.

To give you an idea, we once put 18 bodies through the CT scanner in a single day. The radiology department asked me to never do that again, but it can be done. You would be lucky to get four post mortems done in a day. The reports come in that evening or the next morning. Dr Beardmore treats the living, and if he gets called away, we will wait. However, usually, the delay is 14 hours and no more. Usually, the report comes back on the same day. Does that answer your question?

Foysol Choudhury: It does, but the situation is never clear, because every case is different, as you have said. Most of the time, the family feel that they are not getting the information that they should be getting. There should also be an opt-out option. It is not clear whether the family is allowed to say that they do not want to go through all that difficulty.

The Convener: Thank you for that.

Before I bring in my colleague Alexander Stewart, I am conscious, Ann Edwards, that you have been sitting patiently with us this morning, so might I bring you in to make any general reflections on the comments and evidence that we have heard so far?

Ann Edwards (Lancashire and Blackburn with Darwen): Yes, thank you. Good morning. On our role as a local authority, we have a statutory duty to resource the coroner in order that he can carry out his judicial functions. My role is in relation to the finances. From a local authority point of view, the CT scanning service is cost neutral, so it does not cost us any more than the invasive post-mortem service did.

We have a number of key performance indicators that we use to monitor the service. I will give you some figures. Dr Adeley has already referred to these, as, I think, has Dr Beardmore. In 2022-23, 94 per cent of our scans showed a cause of death, which left 6 per cent that did not. Of our post mortems, 92 per cent were non-invasive; that is the highest non-invasive post-mortem rate in England. Do you have any questions around the finance side of it?

The Convener: We do, in fact. I was getting ahead of myself by saying that I would bring in my colleague Alexander Stewart, because my colleague Fergus Ewing, who spoke a moment ago, has some questions directly on the finance side.

Fergus Ewing: I will try not to be so long winded this time, but, as a lawyer, I always find that a bit difficult.

How do the costs of the post-mortem CT service compare with those of traditional post mortems? Secondly, are the post-mortem CT scans generally provided free of charge or is there typically an out-of-pocket payment? If so, what is that usually set at?

Ann Edwards: On your first question, our CT scanning service was set up so that it would be cost neutral against the invasive post-mortem service, so it costs us no more than it did when we were doing invasive post mortems. We use a private contractor that provides us with an end-to-end service. It provides us with the transport of the deceased from our satellite mortuaries to our scanning facility in Preston. That is all included in the price, which is cost neutral relative to that of the invasive post-mortem service.

Fergus Ewing: What is the additional cost or is there a range of additional costs?

Ann Edwards: Additional costs in what sense?

Fergus Ewing: I am asking whether a payment is asked to be made from the family in the case of extra costs for the CT scan, as opposed to the traditional invasive post mortem.

Ann Edwards: No; there is no cost to the family. The service is free of charge and is provided by the local authority.

The Convener: That is very helpful. Thank you very much. I bring in my colleague Alexander Stewart, who will ask some questions about tissue samples.

Alexander Stewart (Mid Scotland and Fife) (Con): Dr Adeley, you touched on the samples and biopsies that are taken. We have already heard from the Royal College of Pathologists, which talked about the potential challenges that are associated with tissue samples and any returns of those samples. Do you recognise the challenges that the Royal College of Pathologists described when it comes to returning samples? Have you had issues in that area? What are your views on the process?

Dr Adeley: I am unfamiliar with the challenges. If I explain what we do, it might answer the question in a roundabout way. What happens with any sample that contains even a single cell is that the family are asked what they want to be done with the sample when it is finished with. The family are given a number of choices. The coroner's officer will ask whether the sample could be retained by the hospital for medical research and teaching, or it can be returned to the family and their undertaker. Alternatively, they can elect for the sample to be disposed of by the hospital in a lawful and sensitive manner. Those are the three choices.

This applies with an invasive post mortem, not with CT scanning. After an invasive post mortem, the pathologist will fill out a document saying what they have taken in terms of organs, histology samples, blood and urine, then the coroner's officer will ask the family what they would like to be done with that. That will be fed back to the hospital where the post mortem took place, which will then deal with the samples in that way.

We have no problems with that process—it is very straightforward and it works very well. The only time that it causes problems is when the family elect to have the samples put back in the body before it is returned, because then the body has to be retained. For certain pathologists, we have a backlog of a year before we can get a report. Quite often, that can be managed so that the funeral takes place and a second funeral is held, when the grave is excavated down to the coffin and another casket is put on top.

I do not know about the challenges that have been raised by the Royal College of Pathologists,

but we have no problems with that system. It works almost faultlessly and with very little administration.

Alexander Stewart: That is very good to hear. The communication process was identified as an area of challenge, and you have explained what you do to inform the relatives, the next of kin or individuals who require information and how that is managed. The college found that there were sometimes barriers in communication and in making sure that individuals understood what was expected and what would happen to the samples. It identified that area in its evidence to us.

Dr Adeley: Ann Edwards used to be my senior coroner's officer, so she has first-hand experience of having conversations with families. If you would like to explain the difficulties that were raised, I am certain that she would be able to answer your questions.

Alexander Stewart: If I can, I will explain that to you, Ann. Reference was made to the complexity of the communication process as a potential barrier. The Royal College of Pathologists felt that offering relatives options for tissue sample handling—Dr Adeley explained how that process is managed—could present a barrier. Have you encountered any challenges around communications and the options for seeking informed consent?

10:30

Ann Edwards: No. In my experience, families sometimes need some time, which is absolutely fine. The coroner's officer will contact them, explain what samples have been taken, go through the options and then give them some time; you can go and explain it to them the following day. I understand that, especially when whole organs are taken, that is quite a big decision.

What families want to know will vary. For example, if the brain has been taken, we would explain to the family that it can take some time for the process to be gone through before the pathologist can look at the slides. Some families do not want to know that, whereas some families are really interested in the process. We are guided by the family when it comes to how much they want to know, but we will always inform them of exactly what has been taken and what their options are in relation to that once the pathologist has finished doing their tests. In my experience, I have not encountered any issues with that.

Alexander Stewart: Excellent. Thank you very much for that.

The Convener: Yes, thank you for that. In the written evidence that we received, the Royal College of Pathologists put up what the committee felt was almost a smokescreen—I do not think that that is too strong a word to use—in discussing the issue, by saying that a decision would have to be made that the tissues were no longer of use; that if the tissues were to be buried or cremated, that would delay the process; that if the tissues were not to be buried or cremated with the body, the options would need to be explained and understood; and that the process would be very complicated, which could lead to delays and to the family not properly understanding matters. You mentioned the Home Office; here, matters would be referred to the procurator fiscal. That would be a completely different type of event.

From what you have articulated, it seems as though an operational practice has been established where you are that has not led to a massive increase in cost and which has worked perfectly satisfactorily for all those concerned. That is quite an important piece of counter-evidence.

I am sorry—in summing things up, I hope that I have not editorialised anything that you said.

Ms Edwards mentioned brains. I want to come back to a couple of general issues that arose out of the petition that have not been covered in the commentary that we have had to date. In her petition, the petitioner asks that all post mortems

"can only be carried out with permission of the next of kin"

and that post mortems

"do not routinely remove brains".

What is your view on those two propositions?

Dr Adeley: Families are always involved in the decision on what post mortem is taking place. That will be explained by the coroner's officer. I appreciate that I might sound paternalistic here; I am not intending to be paternalistic. The problem comes when the family is fractured, which quite a lot of the families that we deal with are. Therefore, a coroner might be dealing with two or three different parts of a family, one of which will want a post mortem to be carried out.

In a situation in which one family member does not want a post mortem to be carried out and another one does and it is a question of genetic testing for heart disease, which somebody else might die from, giving the final choice to the family might cause all sorts of problems. The same issue arises when biopsies have to be taken for compensation for lung disease. We find that, with post-mortem scanning, there is nothing like the same level of concern. Now, if someone is under the age of 65—I think that that is the age—the most that will happen is that a very small incision will be made under their left collarbone for a catheter to be introduced. Other than that, there

will be no marks on the body. What Mrs Stark has described happening to her son seems to be a standard post-mortem practice, which is extremely invasive.

I do not know what your rules are, but if you are going to make the procurator fiscal responsible for establishing the cause of death, you would have to have some provision so that, if the family refused to have a post mortem undertaken, they are not required to proceed.

The final area where I would raise concerns is that that should not apply to a Home Office post mortem. If it did, a parent who is accused of killing their child could veto the ability of a Home Office post mortem to take place.

I hand over to Dr Sissons or anybody else who wants to speak on this particular point.

The Convener: Does anybody else want to contribute on that point? Before anyone else comes in, there was also the issue about brains being routinely removed.

Dr Adeley: I will ask Dr Sissons to come in after me. The Royal College of Pathologists has guidelines as to how a post mortem should be undertaken. Those will set out what steps should be taken, and the examination of the brain is one of the standard investigations as part of that.

Here, if we have done a post-mortem CT scan and we can see nothing in the head—there are certain conditions that you cannot pick up, including types of stroke—we can assure the pathologists to some extent that there is nothing going on there and that they should restrict their investigation to the other parts of the body.

The question as to why that is a routine procedure in its guidance is one that the Royal College of Pathologists would need to answer rather than coroners. We actually have to specify not to do that rather than to specify that it is something else.

Dr Sissons: That is where CTPM scanning helps. In my experience, if we have got a normal brain on the CTPM, I feel quite confident that I could proceed with the invasive autopsy without examining the brain in most cases.

I think that you are right. The Royal College of Pathologists' best practice is that you should always look at the brain. However, I think that CTPMs can really help to minimise that so that it need not be done on some occasions.

The Convener: Thank you. Again, that is very helpful to our consideration.

That brings us to the end of the questions that we wanted to put to you. I am enormously grateful. You are all very busy professionals and clinicians, and the time that you have given us to hear your evidence this morning really will help the committee considerably as we consider the petition and how we might take forward some of the issues in it. Thank you all very much for your participation. I say on behalf of everybody here in the Scottish Parliament how very much it has been appreciated.

I will move now to Monica Lennon MSP, who is joining us this morning and has joined the committee on previous occasions when we have considered this petition. Before the committee reflects on what has been heard this morning, which I think that we can all say has been very interesting, is there anything you would like to reflect on and add, Monica?

Monica Lennon (Central Scotland) (Lab): It is lovely to be back at the committee. Thank you for all your work on the petition. That was an excellent panel. The evidence was very interesting and I have been taking copious notes. Ann Stark, the petitioner, and her husband, Gerry, are in the gallery today. I highlight Ann's work in building research in Scotland and making connections with colleagues elsewhere.

On my reflections, convener, I was struck by our need to modernise, to keep pace and to address some of the future challenges. It was really interesting to hear the work that colleagues have been pioneering in the Lancashire region in England. Obviously, there are other examples down south. However, there is some really good practice there, and for us in Scotland—both the Scottish Parliament and the Scottish Government—there is a lot that I hope we can learn from.

It was interesting to hear from Ann Edwards that the service—which, as came across strongly, is being delivered in partnership with a number of different partners but working closely with communities—is cost neutral. That is an important point for all of us. Also, there is no cost to family members from having the scans undertaken.

On the workforce challenges for pathology and radiology, it feels to me like there is a framework that we can consider. If colleagues in the Scottish Government wanted to consider it, they might want to have a different approach. Clearly, there is a big role for a private contractor and the Scottish Government might want to consider something different.

We should remember why we are here. Richard Stark passed away almost four years ago. He was 25. That is no age at all. He was very loved by his family and it was only when Richard died that they started to realise and understand what can happen to each of us or to our loved ones when we die. There are big issues around bodily autonomy and choice. I heard colleagues say that

families are all different and there can be challenges within families. However, the issue is not only having information but informed consent, choice and dignity.

Before I came in, I was looking on my phone at the petition that Ann Stark lodged. I think that there are about 570 signatures on it now. The number has gone up quite a lot in the past couple of days because there has been some publicity about the work that the committee is doing. The more that we have such conversations, the more people want to get involved. The point was well made that some families might not be that bothered and do not want to know but, for others, the situation will be deeply distressing. Therefore, it is important that we bring the matter into the light.

As members know, there are different aspects to Ann Stark's petition. Today, the committee has rightly focused a lot on the experience of colleagues in England with the use of scanners. However, that reinforces to me the point that there are alternatives. Technology is advancing all the time. We have heard that not a lot of work is required to refine the skills of colleagues in radiology. We have a fantastic workforce across the UK, which gives me a lot of hope.

We could spend all day talking about the issues around human tissue and genetic testing that were brought out towards the end of the discussion. They are emotive issues and, if there are opportunities to inform other family members that they might be at heightened risk of a disease or condition, of course we want to get that information to them but, as the petitioner has always said, the approach needs to be proportionate. Routinely removing brains and doing fully invasive post mortems are not necessary.

As we have heard a number of times from colleagues, time is really important. It is the biggest resource that we have across the public sector. The teams that we have heard about today are dealing with the living and the deceased. They have incredibly important work to do and, if we can be more efficient and more people centred and can bring people's human rights into the matter, we should.

I am here because my constituents Ann and Gerry, who are sitting behind me, have had a horrific experience. It is bad enough to lose a loved one and to lose a child, but I would not want any family to go through the trauma that they endured after Richard died. That is why I am glad that the committee has been diligent in the work that it has been doing.

The evidence session brought out some of the challenges. Of course, no one expects what the petitioner is asking for to be perfect and a panacea but it strikes me that, in Scotland, we have fallen a bit behind. Really good practice is happening in Lancashire in particular. We need to learn from that. I hope that the Scottish Government will take that on board.

Because Ann is persistent, which I always encourage, she wrote again to every MSP in the past few days and had a tremendous response. The matter resonates with colleagues because we all have constituents and families. It is really about our humanity. We want to be able to learn lessons and apply them to future medical practice and so on. The topic has been neglected in Scotland and the research is underdeveloped, but we now have good evidence and engagement with colleagues across the UK. I thank the committee for its time.

The Convener: Thank you. Like you, I hope that our guests in the public gallery who are directly concerned with the issues have appreciated the evidence session that we have held this morning, which will certainly help to inform the committee. It seemed that, in a number of areas, there is clear opportunity for progress; in others, it might be more complicated.

In summation, colleagues, we will clearly want to further reflect on the evidence at a future meeting. We might anticipate that, following that consideration, we would then want to have the opportunity to put questions to the minister in relation to some of the issues that have been raised. Do members agree that we should seek to secure a session with the minister, and that, before then, we should have the opportunity to reflect further on the evidence that we have heard?

Members *indicated agreement.*

The Convener: I suspend the meeting briefly to allow for a changeover.

10:46

Meeting suspended.

10:48

On resuming—

Rest and Be Thankful Project (PE1916)

The Convener: We move to the further consideration of continued petitions. PE1916, which was lodged by Councillors Douglas Philand and Donald Kelly, calls on the Scottish Parliament to urge the Scottish Government to instigate a public inquiry on the political and financial management of the A83 Rest and Be Thankful project, which is to provide a permanent solution for the route. It is a cause célèbre with which the

committee is familiar, our having discussed it with regard to various petitions over a considerable period of time. No doubt Jackie Baillie, who joins the committee's proceedings this morning, has done so, too. I welcome Ms Baillie to the meeting.

We last considered the petition on 9 November, when we again agreed to write to the Scottish Government. Since then, we have received a response from Transport Scotland, which indicates that

"potential route designs"

for a permanent solution

"are being progressed",

with an expectation that a preferred route option will be announced "by Spring 2023".

As an aside, I recently read a novel in which somebody said that Stockholm does spring very nicely, to which the riposte was yes, but in July. Now that we are getting nearer to July, the Scottish spring might well be what we used to call summer. However, here we are.

Transport Scotland's response also notes

"the preferred medium term solution"

of improvements to the existing old military road, which was announced in December 2022. I remember visiting that with David Torrance a number of years ago for previous committee consideration of a petition.

We have also received a submission from the petitioners, highlighting concerns that improvements to the old military road might delay progress on a permanent solution as well as seeking information on Transport Scotland's timetable for progressing a permanent solution. As I recall, when someone gets to the end of the old military road, they are confronted with quite a tricky topographical consideration. It is very steep and windy.

Before I open up the discussion to wider comments, I am delighted to ask Jackie Baillie whether she would like to contribute anything at this stage. She is probably as perplexed as I am by the definition of spring.

Jackie Baillie (Dumbarton) (Lab): Good morning, convener. I am indeed perplexed by the definition of spring. Spring 2023 has now passed. We are ever hopeful, but I assume that we are now entering summer.

I recognise, as the petitioners do, that a new minister is in place and that budgets are tight, but the petitioners—and, indeed, the entire area—are keen to know whether there has been any slippage, what the timetable is for identifying a preferred solution and when the road will eventually be built. Understandably, the local aspiration is for it to be built by 2026, but the last time that a Scottish Government official opined on the matter, they said 2033. It is clear that there is a significant difference.

We are keen to understand what is going on, and the petitioners are keen to have an indication of the timetable and to know the magnitude of the slippage, if there has been any. It has to be said that they are slightly sceptical in that, although the investment in the old military road is welcome, it will be only a sticking-plaster approach, as a permanent solution has not been identified and progressed in good time. More money is being spent on a project that has consumed vast amounts of public money over the years without a permanent solution being in place.

I understand that the committee might not be entirely in favour of a public inquiry. However, the core of the petition is the petitioners' request for a public inquiry, because they do not think that value of money is being achieved.

We have a temporary solution in place at the Rest and Be Thankful that involves catch pits. Quotes for the cost of the pits started off at around £2 million to £3 million, but the cost is now over £100 million. There is no permanent solution in place, and the investment being made in the old military road is a sticking plaster.

When is this ever going to end? We would like dates for the preferred choice and when the road will be built and completed, and we would like to know what the slippage is. I recognise that there is a new minister, but the issue has gone on for long enough.

The Convener: Thank you, Ms Baillie. I think that that is reasonable. By 2033, even you and I might have retired along with other members of the committee.

Jackie Baillie: Speak for yourself, convener. [*Laughter.*]

The Convener: I find that increasingly hard to do these days, but I still try.

David Torrance, do you have any suggestions that we might make? It seems perfectly reasonable to try to find out where we stand, as we were given to understand that we would have heard something by now.

David Torrance: Like you, convener, I have visited the area and seen the measures that were put in place. We need to take the issue forward, because this has gone on for far too long. Officially, there are still 14 days of spring left, but I do not think that a report will be done in that time.

The Convener: We could certainly refer to that in any submission that we make. After all, we do not want another broken promise.

David Torrance: I suggest that we write to the Minister for Transport to seek an update on when the Scottish Government expects to announce a preferred route option for a permanent solution.

The Convener: Are we agreed? [*Interruption*.] Mr Ewing, are you agreeing, or do you want to comment?

Fergus Ewing: I was agreeing, but I was just going to request that we ask for some supplementary information, if I may.

The Convener: Please do.

Fergus Ewing: In the submission of 14 March, under the heading "Concerns voiced to me", the petitioners raise the following question:

"If the old military road improvements work well will this kick the permanent solution into the long grass?"

That has been mentioned, but another point, which I do not think has been mentioned, is:

"The selection criteria for the Medium-Term Solution did not consider ensuring we have a two way road which stays open when it rains and is free from traffic lights, road closures, and convoys—a fundamental requirement of the people who actually use the road, and we would have assumed is the role for which Transport Scotland exists".

I just wanted to read that into the record, because those are the petitioners' concerns, and our job is to get not only a general response from the minister but a specific response to what appear to me to be legitimate points that the petitioners have raised.

The Convener: Thank you. Are we agreed?

Members *indicated agreement.*

Train Fares (PE1930)

The Convener: PE1930, which was lodged by George Eckton, calls on the Scottish Parliament to urge the Scottish Government to ensure that a requirement of future rail contracts is for customers to be given information on the cheapest possible fare as a matter of course and to recognise the vital role of the existing ticket office estate in delivering on that aim.

We previously considered the petition on 23 November, when we agreed to write to the Scottish Government and Scottish Rail Holdings Ltd. Unfortunately, a response from Scottish Rail Holdings has not been forthcoming, but we have received a response from Transport Scotland on behalf of the Scottish Government, and members have a copy of that.

In its response, Transport Scotland highlights that the interaction of devolved and reserved matters

"will form part of the Scottish Government's Consumer Duty scoping work",

and that the Government is considering whether Scottish Rail Holdings will be covered by the consumer duty legislation.

Transport Scotland has also provided details of the on-going work to enhance smart ticketing across the public transport network, which includes the establishment of the National Smart Ticketing Advisory Board. The response also indicates that the fair fares review might shortly be concluding, if it has not already, to be followed by the launch of a public consultation on a draft vision for public transport.

We have also received a brief submission from the petitioner in which he welcomes the consideration of Scottish Rail Holdings being covered by the consumer duty legislation, while highlighting concerns about advertising of fares and the potential for the digital exclusion of certain groups or individuals.

Do members have any comments or suggestions for action?

Alexander Stewart: It is important that we get further information from the Scottish Government in relation to a number of issues. One is the advice that has been received from the National Smart Ticketing Advisory Board on how things are progressing; another is the anticipated timetable for the public consultation on the draft vision for public transport; and a third is, as you have said, convener, the action that is being taken to address issues of digital exclusion in the purchasing of rail tickets. It would be useful to have information on those issues to hand when we ascertain how we can take forward the petition.

David Torrance: I support everything that my colleague has said. Could we also write to ScotRail to seek information on its evaluation of the options for upgrading the infrastructure to support the use of contactless bank cards on the rail network?

The Convener: I am happy with that. Are colleagues content to proceed on that basis?

Members *indicated agreement.*

Patients with Autonomic Dysfunction (Specialist Services) (PE1952)

The Convener: PE1952 is on instructing Scotland's NHS to form specialist services for patients with automatic dysfunction—sorry, that should be autonomic dysfunction, which is quite different. The petition, which was lodged by Jane Clarke, calls on the Scottish Parliament to urge the Scottish Government to instruct Scotland's NHS to form specialist services, training resources and a clinical pathway for the diagnosis and treatment of patients exhibiting symptoms of autonomic nervous system dysfunction.

PoTS UK's recent submission disagrees with the Scottish Government, stating that many patients

"do not have access to the best possible care and support",

and that PoTS, or postural tachycardia syndrome, is

"not well recognised within the cardiology profession".

The submission highlights that there are no established pathways to diagnose and treat PoTS in adults across most health boards.

Chest Heart & Stroke Scotland's written submission notes that

"Nearly 200,000 people in Scotland"

have long Covid and that 76 per cent of long Covid patients had symptoms of dys—gosh, how am I going to say this?—dysautonomia. However, it states that patients with dysautonomia

"struggle to access medical support ... and people ... with PoTS often wait years for a diagnosis".

Chest Heart & Stroke Scotland calls for

"quicker and more co-ordinated diagnostic and treatment pathways"

for people with long Covid and for

"the creation of a clinical pathway that integrates with existing SIGN"—

or Scottish intercollegiate guidelines network—

"guidelines."

It also supports training for general practitioners and

"further scoping to ascertain the size"

of the need for specialist support for people with dysautonomia.

11:00

The written response from NHS National Services Scotland states that it

"would not anticipate"

being

"invited to commission a national specialist service,"

devote "training resources" or develop "a clinical pathway",

due to

"the broad range of local services and specialities"

around

"autonomic dysfunctions."

That was all quite technical, but important nonetheless. Do members have any comments or suggestions?

David Torrance: We should write to the Scottish Government, highlighting the issues raised in the written submissions from PoTS UK and Chest Heart & Stroke Scotland and asking whether it has received feedback on or evaluated its implementation support note. In particular, we should ask whether the implementation support note has increased knowledge of long Covid and PoTS.

We should also ask how diagnostic and treatment pathways for people with long Covid are monitored and tracked to ensure appropriate care is provided in a quick and co-ordinated way, including to people with dys—we have both got problems pronouncing this word, convener—dysautonomia. Further, we should ask whether it will request that training is provided to GPs on dysdyonomia—

The Convener: Dysautonomia.

David Torrance: Yes. Thank you.

The Convener: Are members content to proceed with that request for further information?

Members *indicated agreement.*

Home Reports (PE1957)

The Convener: Our next continued petition is PE1957, which calls on the Scottish Parliament to urge the Scottish Government to ensure that surveyors are legally responsible for the accuracy of information provided in the single survey and to increase the liability on surveyors to pay repair bills where a home report fails to highlight existing faults in the condition of the property.

We previously considered this petition at our meeting on 7 December 2022, when we agreed to seek the views of a number of organisations. We have received responses from the Scottish Law Commission, Built Environment Forum Scotland, the Royal Institution of Chartered Surveyors and the Law Society of Scotland. Copies of the responses have been included in our meeting papers for today.

Although BEFS saw no concern with the petitioner's suggestion that all home reports should include contact details for the Centre for Effective Dispute Resolution, the Royal Institution of Chartered Surveyors response noted that

"it is not"

currently

"possible to name a single specific third-party resolution service as this would indicate bias".

The responses from RICS and the Law Society noted an expectation that the Scottish Government will carry out a review of home

reports in the near future, which is a move that BEFS would support.

Do members have any comments or suggestions?

Alexander Stewart: It is important that we seek more information. I suggest that we write to the Scottish Government to seek information on its plans to review home reports, including the anticipated timetable for any review.

The Convener: I think that the evidence that we received talked about an expectation that the Scottish Government would conduct such a review. As much as anything, we need to establish that such a review is in prospect.

Fergus Ewing: It is worth establishing that, but I think that the detailed responses from BEFS, RICS and the Law Society clearly set out the parameters of the home report. As is confirmed by my experience as a solicitor, it is more than a basic valuation report, but it is far less than a detailed structural report, which would cost huge amounts of money. The limitations of the home report are clearly stated on it and, in practice, most solicitors are pretty good about advising clients about those limitations. Moreover, the surveyors have to have liability insurance and undergo professional training. The system is pretty well understood and works pretty well in practice.

Imposing a blanket strict liability, which is what the petitioner wants, would simply mean that the cost of a home report would go up exponentially in order to pay for the additional professional liability insurance premiums that would automatically ensue. I say that not because I want to prejudice the outcome of any review, but because it would be risky to raise the petitioner's expectations, although I understand that some individuals might have experienced hard cases. I cannot comment on individual circumstances.

The Convener: Mr Ewing's point highlights the conundrum that was at the heart of the debate when the Parliament sought to introduce home reports. Gosh, I think that they were introduced during my first session as an MSP—the 2007 to 2011 session.

Fergus Ewing: They existed far before then. The issues have certainly been debated for quite a long time. If there is to be a Scottish Government review, we should at least find out when it expects to hold it.

The Convener: Do members agree with that approach?

Members *indicated agreement.*

A82 Upgrade (PE1967)

The Convener: The next petition, PE1967, is on protecting Loch Lomond's Atlantic oak wood shoreline by implementing the high road option for the A82 upgrade between Tarbet and Inverarnan. A theme is developing here. The petition, which was lodged by John Urquhart on behalf of Helensburgh and District Access Trust and the Friends of Loch Lomond and the Trossachs, calls on the Parliament to urge the Scottish Government to reconsider the process for selecting the preferred option for the planned upgrade of the A82 between Tarbet and Inverarnan, and to replace the design manual for roads and bridges-based assessment with the more comprehensive Scottish transport appraisal guidance.

Jackie Baillie has remained with us in order to contribute to our deliberations on the petition again.

We previously considered the petition on 21 December 2022, when we agreed to write to Transport Scotland, Argyll and Bute Council, the Loch Lomond and the Trossachs National Park Authority and the Lochaber Chamber of Commerce. Since then, we have received responses from the national park authority, Transport Scotland and the council, which are included in the papers that are before us.

The response from the national park authority notes its concerns about the road design, with the caveat that a formal view will be provided once Transport Scotland finalises the proposal. It also highlights that, without further consideration of the details, it is not clear that the high road route would provide a more environmentally favourable option.

Transport Scotland has provided a lengthy and quite technical submission, which details its assessment process and the community engagement that has taken place on the A82 scheme to date. In particular, I draw members' attention to comments on an Audit Scotland investigation into concerns relating to the application of the Scottish transport appraisal guidance.

We have also received a late submission from the petitioner, which was circulated to members. It outlines their response to the submissions that we have received.

Before I ask committee members for their thoughts on how we should proceed, I invite Jackie Baillie to contribute to our deliberations.

Jackie Baillie: Thank you very much, convener. I point out that John Urquhart is in the gallery, such is the interest in the petition.

Far be it from me to pick up the convener on something that he omitted to say, but I invited committee members to come and have a look at the area in question. Admittedly, in doing so, I said that it was the summer—there are 14 days to go until the summer commences—but I look forward to a response and a wee trip up the side of Loch Lomond for the committee.

Whichever route is preferred—whether it is the low road, as Transport Scotland suggests, or the high road, as the petitioners' suggests—the issue is whether a STAG appraisal has been carried out. We are talking about a significant amount of investment, and such an appraisal

"is required whenever Scottish Government funding, support or approval ... needed to change the transport system"

is being considered. Through the STAG process, there should be wider consideration of the transport project, such as the benefits that would be accrued to people living in or visiting the national park. Consideration of place, not just project, is required. What local people want must be considered, and—dare I say it?—the project has significance because it is in Scotland's first national park.

I will take the points in turn. In its submission, Transport Scotland agrees that a full STAG appraisal has not taken place. Instead, it says that its approach was underpinned by STAG and DMRB principles. With the greatest respect to Transport Scotland, that is not the same. It is taking the principles and applying them but not doing a full STAG appraisal. It considers that that is

"consistent with STAG appraisal requirements",

but that is a bit like Transport Scotland marking its own homework.

The petitioners have raised questions about the costings of tunnels and exaggeration of costs. Cycle paths have also been included where there was no need for them and the costs of disruption have been underestimated. That all serves to distort the conclusions that Transport Scotland has reached.

A STAG appraisal would allow those issues to be corrected but, much more important, it would consider place issues as well. For one thing, it would consider the impact on the economy and the lives of people who live in Tarbert and Ardlui. It would also consider the impact on the national park, which we should treasure and conserve.

I will turn briefly to the national park authority's response to the committee. Perhaps it is the fault of our process, but it almost seemed to be responding as a statutory consultee. However, the matter is much wider than planning, so it is not about the authority's response as a statutory consultee.

It is fair to say that the national park authority does not like either option. It does not like the option presented by Transport Scotland, which would involve big swathes of road going out over Loch Lomond, which would be catastrophic, and it is clear that the authority also has concerns about the high road proposal. However, I submit that a STAG appraisal would help to work through that, unlike the short-cut approach that Transport Scotland has taken.

The matter is too important not to get right. I recognise that it is critical to hauliers from the Highlands and further afield who need to use the road, but they would equally want to get it right so that they get a decent route and we conserve our environmental heritage at Loch Lomond and the Trossachs national park.

The Convener: Thank you, Ms Baillie. Indeed, you pointed out to us on a previous occasion that we have a reputation for liking to get out and about from Holyrood and, in our response, we said that we might even manage to come and visit at some point. It is a little early to admonish us for not having managed to do that already. However, the recommendation about the STAG report is significant. Do members want to comment or make any recommendations on that?

Fergus Ewing: As always, Jackie Baillie has set out a strong case for that for which she advocates.

In considering whether we should recommend a STAG report be produced, I wonder whether we should get a little bit more information. I say that because the national park authority's submission raises about 10 points—Ms Baillie will know them well—all of which seem to me to be likely to involve very significant cost and difficulty. I am not suggesting that we should not recommend that there be a STAG report, but I would like to know how long it would take to get the report and what the process would involve without being obstructive to the matter in any way.

The petitioners' proposal would involve crossing the west Highland railway line twice, require various tunnels and steep land contours, affect sites of special scientific interest and water courses and involve crossing the Sloy power station pipes. I am fairly familiar with much of that area and it seems to involve such a level of difficulty that the STAG process might take a year or so.

I am sorry to go on a bit, but I raise that because I know that, throughout the west Highlands—not only in Jackie Baillie's constituency but the adjoining ones in Argyll and Lochaber—the road has long been the subject of an overwhelming

desire for improvements for all concerned, as I think that everybody would agree. I am not being obstructive to Jackie Baillie's proposal, but, if we are going to make the recommendation, we should know whether it will take three months, which would be fine, or three years. If it is going to take three years, I am not sure that I would want to support it.

Convener, I do not know whether it is appropriate to ask Ms Baillie for her comments on that; I have not had a chance to discuss that with her.

The Convener: I am content to invite Jackie Baillie to respond. I think that she indicated that she might like to make a further comment.

11:15

Jackie Baillie: Thank you. The petitioners would contest the level of complication that is being suggested, but the difficulty that I have is that there needs to be a reality check, because it looks as though, in its response to you, the national park authority is likely to object to the existing route. That will take time in itself. If that is the scenario that is being suggested—it is certainly what I read from its submission—we could be talking about ages, in planning terms, before that is concluded.

The STAG is the accepted way forward. I would not want it to be held up unduly—I do not think that anybody would—but the reality is that it is likely to be contested, regardless of which route is picked.

The Convener: That is fair enough. Thank you.

David Torrance: If we are going to visit Loch Lomond, we will be just as well to go up the road a wee bit to the Rest and be Thankful to see Jackie Baillie's other area.

Jackie Baillie: I would be delighted, convener.

David Torrance: I wonder whether we can write to the Minister for Transport to ask whether he will do a full STAG report on the second option and raise the concerns of the Loch Lomond and the Trossachs National Park Authority about the road design of Transport Scotland's preferred option. Could we also seek an update on the anticipated timetable for publishing the draft orders and associated environmental impact assessment report, including plans for the public consultation?

The Convener: Are we agreed on those actions?

Members *indicated agreement.*

The Convener: I also suggest that we look at the possibility of arranging a visit for those members of the committee who might like to visit the area. It is quite a complicated issue and a physical appreciation of all that is being discussed would probably assist members.

That brings us to the end of item 2. Thank you, again, Ms Baillie, for your participation.

New Petitions

Universities (Fair Access) (PE2009)

11:16

The Convener: Item 3 on our agenda is consideration of new petitions. Before I introduce each new petition, as I always do for those who might be following our proceedings elsewhere, I indicate that, as a matter of practice, we invite the Scottish Government and the Scottish Parliament's independent policy advice resource—the Scottish Parliament information centre—to offer comment on petitions. We do that because, historically, if we did not do that, that was usually what happened at the first meeting at which we considered the new petition. Therefore, we bypass that and we are therefore already considering the position with a degree of information having been obtained.

We are joined by Michael Marra, who has been sitting quite contentedly through some of our deliberations. In order to facilitate his day, we will move first to petition PE2009, which was lodged by Caroline Gordon, and which calls on the Scottish Parliament to urge the Scottish Government to ensure fair access to Scottish universities for residents in Scotland and the UK by reviewing university business models and Scottish Government funding arrangements.

The Scottish Government's response to the petition states that

"Scottish universities are autonomous institutions and as such are responsible for their own admission policies and selection criteria. The Scottish Government and Scottish Ministers are unable to intervene in universities' business models."

The submission emphasises Universities and Colleges Admissions Service data, published in January 2023, which shows that a near-record number of Scottish students secured a place at the University of Edinburgh. The Scottish Government aims to have 20 per cent of students entering university from Scotland's 20 per cent most deprived backgrounds by 2030. The submission highlights that 9.1 per cent of the University of Edinburgh's full-time first degree entrants in 2020-21 came from Scotland's most deprived areas.

The petitioner has responded to the Scottish Government's submission, stating that "many capable young Scots" are unable to attend due to

"chronic underfunding and poor government policy."

She notes that freedom of information requests have shown an 84 per cent increase in the number of Scottish domiciled applicants being refused entry to Scottish universities since 2006. The petitioner concludes with a call for the Scottish Government to conduct a review of its funding arrangements for Scottish universities and remove the cap on places to provide equal opportunities for all young people, regardless of their background.

As I said a moment ago, we are joined by Michael Marra. I invite him to speak to the committee before we consider how we might proceed.

Michael Marra (North East Scotland) (Lab): I pay tribute to my constituent Caroline Gordon, who joins us in the public gallery, for lodging the petition, which is now supported by many thousands of people, and for her continued determination to seek answers on this area from the Scottish Government. I thank the committee for the opportunity to speak to you today.

For more than 600 years, our universities have educated some of Scotland's best and brightest, from scientists and inventors to philosophers, authors and poets—the great people of Scotland who have lent so much to our history and progress as a nation. However, for many of our young people in Scotland today, the basic promise of a Scottish education has been broken. You work hard, you get the grades, you get in: that is the way that it should be for every Scot.

At First Minister's question time on 12 January, I raised my constituent's case, which is about a young man with outstanding grades to whom the doors of the University of Edinburgh were firmly shut. There were no grades that he could have achieved from five As to 50 As that could have prised those doors open. The policy of the Scottish Government has locked him out. Since then, my office has been inundated with emails and phone calls from parents and young people across the country sharing similar testimony, so I am clear that this is not a case of one university or one subject area. The sense of injustice is palpable.

My constituent and I are the strongest supporters of widening access to university in Scotland. The Parliament has seen marked progress in that area in recent years, but we have come from a very low base, whereby young Scottish people from the poorest backgrounds were far less likely to reach university than those from any other part of the UK. We should be clear that we are still well behind the rest of the UK in that, and that much progress still requires to be made.

The real issue of concern that is raised in the petition is the dysfunction of the business model that the Scottish Government imposes on our universities, which includes the cap on Scottish university students. It is combined with 14 years of no increase in the amount of money that is paid

per student to our universities. The alternative route that is being taken by many young Scots is to seek a place at a university in England. Many will make a life outside Scotland, will marry and will flourish, and my constituent and many other families will be hundreds of miles from their grandchildren, which is a human element of the issue that we must consider. We can all identify with that.

More broadly, for our economy and the betterment of our society in Scotland, these are losses that Scotland can ill afford. At best, this is a case of the unintended consequences of policy, which I recognise. The issue deserves better scrutiny in Parliament in terms of what might be happening as a result of policy and that is not the Government's stated intent. The committee could seek further information on that.

Perhaps I could be so bold as to suggest a couple of areas that might be of use to the committee in that regard. You might want to seek evidence from Universities Scotland and individual universities to ascertain the scale of the issue and find out whether certain universities or courses are particularly affected. That would perhaps allow the committee to develop a better understanding of the impact of the current policy on the number of young Scottish people who are being forced to leave Scotland to access higher education elsewhere and of the impact that that has on the country. Perhaps the committee might ask the Scottish Government what analysis it has undertaken of the consequences of the current policy for Scottish applicants in general. Importantly, I would hope that it would give an opportunity for the people who are impacted to have their voices heard in the Parliament.

Thank you for your time, convener, and for the consideration of the committee.

The Convener: Thank you, Mr Marra. I know that you have been raising the issues in Parliament with the First Minister. I am content with the proposals that you have made. Would members of the committee like to add any further suggestions?

David Torrance: I wonder whether we could write to the Commissioner for Fair Access to seek his views on the actions that are called for in the petition.

The Convener: That makes sense. Are we content to pursue the suggestions that Mr Marra has made, as well as the one from Mr Torrance?

Members *indicated agreement.*

The Convener: That will give us further information, and we will consider the petition again in due course. Thank you, Mr Marra, for joining us for your first appearance at the Citizen Participation and Public Petitions Committee.

Allotments (PE2007)

The Convener: PE2007, which was lodged by Carol Ann Weston, calls on the Scottish Parliament to urge the Scottish Government to increase allotment provision so that current waiting lists are fulfilled and all universal credit claimants are offered a free plot at their nearest allotment site.

Members will be aware that legislation on allotments is contained in part 9 of the Community Empowerment (Scotland) Act 2015. The briefing that we have received from SPICe highlights the post-legislative scrutiny that the Local Government, Housing and Planning Committee has undertaken on the matter. The committee noted that

"local authorities do not have enough resources to simply create large numbers of new allotments to meet all demand."

In addition to the challenges of land availability for allotments, the SPICe briefing notes that, in January 2023, more than 478,000 people were in receipt of universal credit in Scotland.

Responding to the petition, the Scottish Government recognises the on-going challenges that local authorities face in relation to allotment waiting lists and encourages local authorities to look at innovative ways to reduce allotment waiting lists. The Government response also provides information on the funding that it has allocated for community growing over the past decade.

In relation to universal credit, the Scottish Government states that there is no provision for it to provide an allotment to universal credit recipients in Scotland, but it lists a range of benefits that are managed and paid for by the Scottish Government for which universal credit is a passporting benefit.

Do members have any suggestions or comments on what we might do in light of the responses that we have received from SPICe and the Scottish Government?

David Torrance: When we have 470,000 people on universal credit, what the petition is asking is impossible for local authorities across Scotland to do. I know that Fife Council normally has 1,000 people waiting for allotments who are willing to hire them. It is a very difficult situation. I am quite happy to close the petition under rule 15.7 of standing orders, on the basis that the provision of allotments is primarily the responsibility of local authorities.

Alexander Stewart: Mr Torrance has indicated that there is a difficulty here, and there certainly is.

The idea of the petition is sound in some ways, but it is not practical in others. The problem that we face is that it would be virtually impossible. We are all aware of the difficulties that local authorities have at the moment; they even have issues with the space that they have for allotments and the land coverage that they keep.

The Scottish Government provides support and funding to enable groups to do some of those things in the community, and that is part of the equation. I concur with David Torrance: I do not see this progressing in the way that the petitioner wants, because it is not practical. It is not feasible in reality to achieve what the petitioner calls for.

Fergus Ewing: I endorse what my colleagues have said. What the petition calls for might be desirable in many cases, but to create a universal right would impose an obligation on local authorities that is simply unenforceable and undeliverable. We must always be mindful of supporting the petitioner as far as we can, but we also have to be mindful of the financial realities that local authorities face at the moment. They would not thank us for suggesting that we impose something that is plainly beyond their capability when they are under real pressure to deliver fundamental basic services across the board.

The Convener: We are agreed. We can all see the substance of the issue at hand, but I am struck by the Scottish Government's suggestion that local authorities look at innovative ways to reduce allotment waiting lists. I am struggling to think of what an innovative way of dealing with an allotment waiting list would be but, notwithstanding my puzzlement with that concept, I am afraid that I am reluctantly of the same view.

The very clear advice from the Scottish Government is that the matter is for local authorities to deal with and, as SPICe points out, the petition seeks to give an entitlement to several hundreds of thousands of people, which is impractical.

I think that we are agreed that although we understand the substance of the issue, we will close the petition under rule 15.7 of standing orders. Is that the view of the committee?

Members *indicated agreement.*

The Convener: I am sorry that that is not the decision that the petitioner will have looked for, but I thank them for raising the issue. We have put their concern on the record.

Mental Health Accident and Emergency for Children (PE2008)

11:30

The Convener: PE2008, which was lodged by Kirsty Solman, calls on the Scottish Parliament to urge the Scottish Government to provide funding to create a separate accident and emergency for children and young people presenting with mental health issues.

The Scottish Government's response to the petition details on-going work to support people experiencing poor mental health. It states that several mechanisms are in place to ensure that emergency mental health care is accessible quickly and as close to home as possible.

For example, the mental health unscheduled care pathway ensures that anyone presenting at A and E in a mental health crisis is properly assessed and cared for. Care plans are put in place that may include support from crisis support organisations or local mental health services, or admission to the hospital where necessary.

The redesign of urgent care programme ensures that each health board is providing access to a senior clinical decision maker 24 hours a day, seven days a week, for urgent mental health assessment or urgent referral to local mental health services.

The Scottish Government has published the child and adolescent mental health services national service specification, which outlines the provisions that young people and their families can expect from the NHS, including a 24/7 mental health crisis response service for children and young people.

In her response to the Scottish Government, the petitioner highlights that there are only two wards in the west of Scotland for those in crisis with their mental health and questions the effectiveness of speaking to a child or parent over the phone to assess their mental state. The petitioner also questions the rationale behind the redesign of urgent care programme, stating that the programme does not have sufficient CAMHS staff available. She also notes the lack of information on the locations of available hubs for children and adolescents struggling with their mental health.

The petitioner raises a number of challenges to and questions for the Scottish Government in response to its submission, details of which are available in the clerk's note.

Do colleagues agree that we will write to the Scottish Government requesting that it provides a clear view on the merits of what the petition is asking for as well as responding to the points

raised by the petitioner in her recent written submission, to which I have just referred?

Members *indicated agreement.*

The Convener: Thank you very much. That was the final petition this morning. We will now move into private session.

11:32

Meeting continued in private until 11:32.

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