OFFICIAL REPORT
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Health and Sport Committee

Tuesday 3 November 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 3 November 2020

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HEALTH AND SPORT COMMITTEE

28th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Laura Blane (Thompsons Solicitors Scotland)
Stuart McMillan (Greenock and Inverclyde) (SNP)
Willie Rennie (North East Fife) (LD)
Alan Rogerson (Forum of Scottish Claims Managers)
David Short (Association of Personal Injury Lawyers)
Professor Andrew Watterson (University of Stirling)
Humza Yousaf (Cabinet Secretary for Justice)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 3 November 2020

[The Convener opened the meeting at 10:00]

Liability for NHS Charges (Treatment of Industrial Disease) (Scotland) Bill: Stage 1

The Convener (Lewis Macdonald): Good morning, and welcome to the 28th meeting in 2020 of the Health and Sport Committee.

We have received apologies from Alex Cole-Hamilton. I welcome Willie Rennie as his substitute for this meeting. I also welcome Stuart McMillan MSP, who has joined us for stage 1 consideration of his member's bill.

I ask all members to ensure that their mobile phones are in silent mode.

I remind members that, when they are asking questions, they should indicate when they have finished their final question. Witnesses should type an "R" in the chat function if they want to respond to a question that is being answered by somebody else.

The first item today is evidence on the Liability for NHS Charges (Treatment of Industrial Disease) (Scotland) Bill at stage 1. I welcome to the committee Professor Andrew Watterson of the occupational and environmental health research group in the University of Stirling; Alan Rogerson, who is the chair of the Forum of Scottish Claims Managers; David Short, who is the secretary of the Association of Personal Injury Lawyers Scotland; and Laura Blane of the lung disease team at Thompsons Solicitors Scotland.

We now move to our first questions. As we do in the current circumstances, we will ask questions in a prearranged order. I will begin with the general principles of the bill. I would like to hear the views of all four of our witnesses on the general principles of the bill and whether employers should, in principle, be liable to pay national health service costs for industrial disease. I will start with Andrew Watterson.

Professor Andrew Watterson (University of Stirling): Thank you convener, and thank you for inviting me to the committee. The principles of the bill are pretty clear, and there will probably be fairly wide agreement. The bill addresses issues of social justice for the people who contract industrial diseases. That makes economic sense, because it will drive changes in the workplace that will make businesses and employers more effective. It is also an economic scheme that is relatively modest, and is doable. The principles are important because they are about driving improvements to reduce occupational ill health in Scotland.

The Health and Safety Executive has done some costings on the problem. Each year, something like £805 million goes on occupational ill-health costs. Of course, not all of that goes into the hospital sector.

Alan Rogerson (Forum of Scottish Claims Managers): Good morning, and thank you for the invitation to appear at committee. On the face of it, the bill seems like a good idea, but I am concerned that it would, as currently drafted, have many unintended consequences. Although it is well intentioned, the practicalities of recovering money for the NHS might be a lot harder than they first appear. I can give the committee examples later using parts of the bill, if questions allow it.

The Convener: That will be helpful. Thank you.

David Short (Association of Personal Injury Lawyers): Good morning, and thank you for inviting me to the committee this morning. In principle, the Association of Personal Injury Lawyers supports the bill, which follows the polluter-pays principle. However, I agree with Mr Rogerson that it could have unintended consequences, which we could go into later on. Overall, however, APIL's position is that, if we can get money into the NHS, particularly at this time, that should be done. We can discuss the unintended consequences a little bit later on.

Laura Blane (Thompsons Solicitors Scotland): I, too, thank you for the invitation to appear before the committee this morning.

Thompsons is broadly in favour of the principles of the bill, which is a logical extension of existing legislation for—[*Inaudible.*]—cost recovery. Industrial disease has been excluded from that until now because of the potential complexity and potential unintended consequences. However, as we are likely to discuss further, few such problems cannot be solved by taking a sensible and practical approach to them. Litigation in such cases is full of complexity, but most of it has been resolved by those who practise in that area of law, so there is no reason why legislation cannot also overcome the potential complexities.

As has been indicated, the administrative costs of setting up a scheme are likely to be modest. In the current climate, any recovery to the national health service of costs incurred by treating people who are victims of industrial disease must be welcomed. I echo Professor Watterson's view that anything that encourages better health and safety practices must be welcomed.

David Stewart (Highlands and Islands) (Lab): Good morning to all our witnesses. Would the bill have retrospective application? Perhaps David Short can kick off on that.

David Short: I do not see that working.

The Convener: The question is more about whether you believe that the bill might, in an unintended way, have a retrospective effect.

David Short: Should the bill become statute, it could deal itself with whether it would have retrospective effect. However, generally, new laws are not retrospective.

David Stewart: Thank you. Do any other witnesses want to comment on that?

Laura Blane: The bill's drafters have been quite meticulous in avoiding the possibility of retrospection. Lessons were learned from the Welsh attempt to take forward a similar bill, on which the Supreme Court quickly gave its view in terms of retrospectivity. In my view, there is no scope for the bill to have any retrospective effect.

David Stewart: I thank the witnesses for those answers. Are the witnesses confident that the bill would have no impact on the law relating to insurance, which is a reserved matter?

The Convener: Can Mr Rogerson start on that one?

Alan Rogerson: Yes. An exception is written into the bill that it should not affect insurance matters, but an insurance contract is a contract between an insurance company and the person who takes out the policy—the insured. The individual contract's terms and conditions determine whether the policy is triggered. A key aspect that we will probably come to later is that we are talking about insurance policies that are being taken out now that might be triggered many years, even decades, in the future. We have in the past seen arguments about the terms and conditions of policies that were written 50 or 60 years previously.

David Stewart: Thank you. My final question is this: what assessment has the panel made of the bill's legislative competence? I am sure that the witnesses are mindful of the Supreme Court judgment in 2015, which was referred to by Laura Blane, that the Welsh Parliament acted outside its legislative competence with the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill.

Laura Blane: The Supreme Court deemed that the Welsh bill was not within the competence of the Welsh Assembly. Of course, we cannot draw a direct comparison, because the Welsh Assembly operates on the basis of specific powers having been delegated to it, whereas the Scottish Parliament can deal with all matters that are not specifically reserved to Westminster.

I cannot see that the bill treads on the toes of any reserved matter. You touched on whether it treads on the toes of insurance, which of course is reserved. The bill does not affect the law on insurance; it does not require that an insurance policy be taken out to protect against recovery costs—although, as Mr Rogerson said, there will be implications for future policies. I do not think that it could be said that the bill touches on insurance as a reserved matter. It seems to fit most appropriately with health, which is not reserved to Westminster. I cannot foresee the bill causing difficulties in relation to competence or proportionality.

Alan Rogerson: I agree with Laura Blane. I see no legislative problem in relation to insurance, given how the bill is drafted.

Brian Whittle (South Scotland) (Con): I have an interest in the bill. Any bill that will potentially improve people's working conditions or help to stamp out bad practice on the part of employers is welcome. However, I speak as someone who owned a small company with only 22 employees. We always found it difficult to keep up with legislation; small and medium-sized enterprises differ from major employers in their ability to deal with such matters. I am not sure who to direct my question to; perhaps Alan Rogerson could start. Should there be a cap on the amount that an employer would be liable to pay in an industrial disease case?

Alan Rogerson: On your point about workplace health and safety, the bill is about penalties that will be levied many years in the future, and sometimes on companies that no longer exist, so there are perhaps better ways to improve workplace safety now, such as through better enforcement action.

There is a cap in place; NHS charges, in the context of road traffic accidents and workplace accidents that arise from a single cause, are on a sliding scale that is reviewed every year. Therefore, there is precedent for the approach. I can talk about the practical difficulties with the current scheme, which might be more problematic in respect of industrial diseases.

Professor Watterson: [*Inaudible*.]—that means that they are entitled to good information and advice, and it is a struggle for them. We would expect the regulators to provide that sort of support, upstream. An indirect but positive consequence of the bill is that it will focus attention on occupational ill health, which means that more information should feed into the system and SMEs should be better advised and supported.

Brian Whittle: I will follow on from that. Some industrial diseases manifest further down the line, including in relation to companies that no longer exist. Should the bill hold former directors of companies responsible further down the line? At the end of the day, directors are responsible for what happens within a company.

10:15

Laura Blane: Members are probably aware that there is likely to be another bill on corporate responsibility, particularly for fatalities that are due to health and safety breaches. I do not think that the bill that we are discussing should go that far. Legal responsibility rests with the corporate entity, which is the limited company, under the current law. The bill is not the mechanism to change that legal principle.

There remains the ability to restore a company artificially to the Companies House register for the purposes of litigation and to sue that company, with the insurance policy kicking in to make payments for any compensation or NHS costs, should that company be found to be responsible for the damage that has been done. The risk or threat of making directors responsible is more likely to lead to people finding ways of evading that responsibility. It is much safer for people to know that the company will be held responsible and have the protection of insurance policies through the premium that the company has paid, potentially for many years, to meet those liabilities.

The Convener: Thanks. David Short, do you have a view on the question?

David Short: I agree that the bill should not be extended to include directors' responsibility. Corporate and directors' responsibility is a complex area. It has been considered in the past, and it is very difficult to hold individuals responsible. As Laura Blane said, it is possible to restore companies to the register. There is also an insurer database, which was not the case in the past. If someone has a case, they can find the insurer and restore the company; it can be dealt with in that way. I do not agree with extending the bill to cover directors' responsibility.

Brian Whittle: The matter is very interesting and is something that we will have to look at a bit more. There is already legislation on director negligence; that must play in here, somewhere. I threw the question in as a grenade, so I will just leave the matter there.

Finally, would the cost of administering the scheme, compared to the amount that would be raised from the scheme, be prohibitive?

Andrew Watterson: We have more information than we had a few years ago. We can identify some of the healthcare costs, not just in relation to diseases such as mesothelioma, but in relation to other cancers that are not connected to asbestos, including bladder cancer. The healthcare costs—just the disease-treatment costs—of those would be considerable. The money that would be generated by the scheme that would go back into the NHS—that is important—would far exceed administrative costs.

There has always been a problem with occupational diseases, in that there is cost externalisation. Those who create the diseases and breach the laws—we are talking about cases in which there has been a breach of the law—do not pay, but everyone else does. The scheme would be a good way to recover that money. It seems that the costs of running the scheme would be modest. If they were to go up, that would be an indication that we have more problems and should be doing more on prevention. However, one would expect, if the bill operates as it is hoped it will, to see the number of claims being driven down because there would be prevention of the diseases.

We have much better evidence on what the disease-treatment costs would be and we know that they would be considerable and would far outweigh the administrative costs of the scheme.

Alan Rogerson: We should not lose sight of the fact that industrial diseases take a long time to come to the surface. What we are talking about is negligent exposure of a person, after the bill was enacted, that would result in an industrial disease further down the line. It could be years or decades later, especially in the case of long-tail diseases, such as those that are caused by asbestos exposure.

There are shorter-tail diseases, too, but even in such cases if, after the bill was enacted, a person suffered negligent exposure in year 1 it could be three years between that negligent exposure ending, and the person having realised the extent of the injury, sought treatment and made a claim for that industrial disease. It could be three or four years, easily, before there was any financial impact, so the scheme would have to be set up now.

The financial memorandum contains some very helpful data from Thompsons on the numbers and types of injuries. It might be possible to do a bit more work on the financial memorandum if there was more information about when exposure occurred and how long it takes for claims to arrive following exposure. My part of the industry sees only one small component of that, so I do not have any overwhelming data to confirm the figures. However, I would be happy to work on information on that so that I could provide the committee with some projections.

The Convener: That would be extremely helpful. Thank you very much.

Andrew Watterson would like to come back in.

Professor Watterson: I want to make the point that although it is right that a lot of occupational diseases take a long time to develop, that is not true across the board, as has been mentioned. For instance, occupational bladder cancer and some leukaemias can develop in a small number of years, and the treatment costs may be resolved relatively quickly. However, it is also fair to say that there could be long-term costs.

Tragically, in a number of cases of occupational cancers the treatments will not be successful, so there would be an outcome very early on.

Emma Harper (South Scotland) (SNP): Good morning. I am interested in obtaining information on the definition of "industrial disease" that is used in the bill. The explanatory notes explain that section 1 seeks to insert five new subsections in the Health and Social Care (Community Health and Standards) Act 2003, the first of which provides the main definition of "industrial disease". The second new subsection expands on that definition. Basically, a disease is "industrial"

"if it arises out of a person's employment, whether that is the injured person's own employment or the employment of someone else associated with that person, so long as there is a causal link between the disease and the associated person's employment."

Our briefing paper mentions that more than 70 prescribed diseases are known to be a risk from certain jobs. As a co-convener of the cross-party group on lung health, the Parliament's asthma champion and a registered nurse, I find the issue extremely interesting.

Do any of the witnesses have any concerns about the definition of "industrial disease" that is used in the bill? Laura Blane might want to answer first.

Laura Blane: I do not think that I have concerns. The word "industrial" might carry connotations that are not really for a modern age, in that it suggests heavy industry of the past, but I think that the wider definition, in which the phrase

"arising out of the employment"

is used, is wide enough to capture any potential disease that arises from modern employment. The word "industrial" is used consistently in benefits legislation and in all sorts of definitions of diseases of employment. The connotations are perhaps a little out of date, but the wider definition ought to capture a wide-enough scope of people being exposed to or going through processes that lead to disease or long-term injury in their employment.

Emma Harper: Might there be potential issues with identifying an industrial disease and its subsequent treatment? We have heard previously that many industrial diseases can take years to cause an injury or ill health. I am thinking about people working in sawmills who are exposed to sawdust, for instance, who do not make the correlation between their chronic obstructive pulmonary disease and a job that they had five, 10 or even 15 years ago. There are also issues with welders and inhalation of manganese. Are there any issues with identifying what caused a person's disease, especially when it is years down the line?

Professor Watterson: That is a very valid point. It is clear that there are difficulties, but the position is getting better. We are getting a much clearer picture now about how occupation might affect diseases such as those that Emma Harper mentioned, including asthma, COPD, bladder cancer and skin cancer. I agree that "occupation" would be the better word to use, if it were not for the reasons that we have just heard. Legally, people operate on the basis of the word "industrial".

If we look at something like asthma and exposure to various chemicals, the effects would probably be quite rapid. There is a wide range of lung diseases linked to asthma that can appear within weeks. There could be one exposure and the diseases would certainly appear within a couple of years. Long-term exposure to wood dust might be another matter, but we can build up a picture. That is what the Industrial Injuries Advisory Council does at the moment in the United Kingdom, although it is fair to say that its list of occupational diseases is quite limited.

Over the past couple of years, we have seen greater recognition that it will not just be workers who are exposed to asbestos who may present a problem to their relatives and families; other substances such as benzine, for example, could damage the foetus or affect children. However, as I understand the bill, the provisions would kick in only when those diseases are properly recognised. Knowledge will grow over the years and some occupational diseases may drop off, but new ones will come in and the bill will be well able to cater for that. Therefore, the definition of "industrial disease", which has been broadened out, is very positive.

Alan Rogerson: The question about the identification of the diseases and their subsequent treatment is a very good one. As I see it, one of the unintended consequences of the bill for the NHS is what I would describe as comorbid conditions. If a person presents at hospital, we are, in essence, asking the treating clinicians to establish what has caused the person to present on that day in order to work out whether it is a cost

that is recoverable under the bill. That can be an impossible task; we are trying to divide the indivisible if a person with asthma or a lung condition also has a history of being a heavy smoker, for example. We are asking clinicians to take time out from treating patients to decide whether their condition is due to the industrial disease or some other cause, and there could be many different causes.

Emma Harper: I am thinking about ways of mitigating that. If the list of industrial diseases was up to date—using robust evidence, obviously—we would then know whether something is an industrial disease. Keeping information up to date would be one way to overcome such outcomes.

How could the proposals relate to Covid? We hear about long Covid, which involves longer-term symptoms of exposure to coronavirus and might be experienced by healthcare workers, for instance.

10:30

Laura Blane: It is important to remember that the liability to repay NHS costs would be triggered only after the compensation process had been completed. The list of identified industrial diseases does not necessarily determine the outcome of civil litigation. In that process, causation is the key issue—whether the injury to the individual, whatever it might be, was caused by their workplace. That is not predetermined by whether the condition is on the prescribed list.

The law is flexible enough to adapt to and accommodate any new condition, and Covid is absolutely relevant now. However, causation is determined in the legal process by expert evidence and not by the treating doctors who have seen the individual—they get on with treating the individual regardless of the legal process.

Whether we were dealing with an industrial disease under the bill would be determined by the compensation process, which would trigger the repaying of costs. As I said, that is wide enough to accommodate any suggestion that an injury is associated with an occupation, regardless of the list of prescribed diseases. That is not to say that I do not think that that list should be as flexible and broad as possible in the context of industrial injuries disablement benefit and so on, but that is not necessary for the bill's purposes.

As for Covid, I think that it would, if the bill were—[*Inaudible*.]—potentially be considered an industrial disease, because we know that people are being asked to go back to the workplace before a proper risk assessment has been done and are contracting Covid as a result.

The Convener: I remind everyone please to mute or switch off devices other than the one that they are on for the meeting, so that notifications do not interrupt the recording.

Professor Watterson: I agree with several things that Laura Blane said. Covid should certainly be on the list, and that will be worked through. Belgium already recognises Covid as an occupational disease for healthcare workers, and that approach will probably need to be broadened. The question would go through the processes and mechanisms that are in the bill.

Emma Harper made a point about the list of occupational diseases, which I think will be updated. It is sobering to note that the UK has a very short list of prescribed industrial diseases, whereas the list is longer in France and Germany, although they use the same science. The number of asbestos-related cancers that are recognised in the UK is small in comparison with France. Canada recognises more than a dozen cancers as occupational diseases, whereas the UK recognises one, in effect.

We cannot just pop a disease into the list; nobody suggests that. A rigorous examination would be needed. If we were doing our job, the number of people who were affected by the growing list of occupational diseases would be small. There is an incentive for employers and for Governments to support employers by getting information out there to stop the use of the substances and processes that might cause occupational diseases. Many people would welcome an expansion of the occupational disease list.

Alan Rogerson: I support Laura Blane's comment about causation and legal liability being decided through the legal route; I agree with that entirely. My point was that we are asking the treating clinicians, in essence, to say whether the person who has presented to them is suffering the effects of industrial disease or some other cause. I draw parallels with my experience with NHS charges in relation to road traffic and workplace accidents, which are the biggest source of appeals down the line, when the person who is paying the compensation does not agree that the treatment that the person has had is all related to their accident.

That will be all the harder when we are talking about industrial disease that is the result of events that happened many years before. Cases will be by no means as straightforward as a case in which someone has a broken leg—and if that person spends numerous days in hospital, we have to work out what those days in hospital were for and whether the person sustained a complication that was unrelated to the accident.

David Short: I want to come in on two points, the first of which is the industrial nature of the disease in the context of employment. APIL's view is that the bill should not be restricted to employment. In dealing with disease claims at the moment, a voluntary protocol is followed, which the Scottish civil courts review indicated should be made compulsory. In that protocol, the definition of "disease" is much wider. What we seem to have in the bill is the diseases that are categorised as industrial diseases for industrial injuries disablement benefit and the like.

APIL's view is that the approach should not be restricted to the workplace. For example, 40 or 50 cases are currently being litigated as a result of the legionella outbreak in Edinburgh a number of years ago—many of those people had time in hospital. The outbreak was linked to an industrial site or sites. Another example is a case in which someone contracts a disease from a product—there was litigation against Johnson & Johnson in the United States in relation to cases of ovarian cancer that were allegedly caused by using baby powder. Lots of diseases can stem from using a product or from a workplace, but such cases would not come under the heading "employment".

My second point is about the difficulties that Ms Harper talked about and which Alan Rogerson pointed out. I do not often find myself agreeing with Mr Rogerson, but I certainly agree with a number of points that he has made today. If someone breaks a leg, they break a leg—and, as he said, even in those cases there can be complications and appeals. APIL is not part of such appeals, as we deal just with the compensation for victims. There are problems with assessing the level of disability that is the subject of the litigation. There is also a problem if there are multiple defenders. What proportion of the contribution to NHS charges does each company have to make? There are enough arguments going on between defenders already, and I worry that the bill will add another layer of complication, which could delay litigation for victims.

David Torrance (Kirkcaldy) (SNP): In written submissions to the committee, some people highlighted a potential unintended consequence in relation to insurance companies delaying compensation settlements due to the obligation to pay NHS costs for industrial disease. What impact could the bill have on the agreement of compensation settlements in cases of industrial disease?

David Short: This follows on from what I said to Ms Harper. Delays can come in when there are arguments between the defenders. As representatives of victims, we often find ourselves just standing back and watching the defenders throw bricks at one another.

In a straightforward asbestos case, such as a shipyard case, liability is not usually in dispute, so we know that we will be successful for the victim. However, the questions come in about what the disability is and who has caused it. At the moment, I understand that the defenders argue over £1 of contribution, on a percentage basis. I worry that, if defenders have to make further payments, they will dig in a bit deeper and argue more about contribution between the defenders, which will inevitably lead to possible delays, subject to court timetables.

Alan Rogerson: I almost find myself agreeing with David Short on some of those points, although my points about defenders are maybe not quite so bad.

We are talking about some of the unintended consequences of section 2 of the bill, which I see as problematic, as it could delay settlement offers for pursuers and result in delays for pursuers in obtaining their rightful settlement. Section 2 is about contributory negligence and the idea of defenders splitting up the cost of a claim. Contributory negligence is when a person might have contributed to their injuries by refusing to wear personal protective equipment or by not adhering to training that they have undertaken.

With road traffic accidents, it happens all the time that solicitors for the injured person will not commit in writing that they accept a level of contributory negligence, such as 25 per cent or even 10 per cent. The solicitors will not do that, because they fear that putting it in writing will mean that a professional indemnity claim will be made against them later for undersettling the claim.

The compensation recovery unit, which administers the scheme for road traffic accident and workplace accidents, requires written evidence at conclusion of the claim saying what the respective people agreed as a split in the cost of the claim. The unit uses that to split the NHS charges accordingly. If that written evidence and those agreements are not available, that just delays the claim for the pursuer, so the poor person who is due the compensation does not get it. Much of the time, the situation forces cases to litigate that do not need to litigate, which just lengthens the process and the cost for everyone involved.

Laura Blane: I do not deny that all those issues are present, but they are present currently for anyone—[*Inaudible*.] The reality is—[*Inaudible*.] In terms of the defender—[*Inaudible*.]—their contribution. The majority of disease claims are also—[*Inaudible*.]—because—[*Inaudible*.]—might otherwise get. So, the process of—[*Inaudible*.]—once the case has litigated there will be hearing dates set down in those cases, which will be about

the liability—[*Inaudible*.] On that hearing date—[*Inaudible*.]—defender—[*Inaudible*.]—subject for the court—[*Inaudible*.]—and they do get—[*Inaudible*.] So I do not—[*Inaudible*.] The defender is required to reach an agreement—[*Inaudible*.]—on the contribution—[*Inaudible*.]—on the matter—[*Inaudible*.]

The Convener: Thank you very much. I should say that, on that last answer, Laura, the sound quality was not terribly good, so we might ask you to put that in writing at some point after the meeting.

David Torrance: How could any unintended consequences of the bill be mitigated?

10:45

Alan Rogerson: I cannot see any way that the unintended consequences of the bill can be made right unless the bill is not brought forward. That is fundamental.

The bill must follow the same sort of process as the recovery scheme that exists in other areas, but this area is not as straightforward as others. That is why the briefing from the Scottish Parliament information centre said that when this matter was previously looked at, in 2006, as part of the changes that brought in the workplace NHS charges, industrial disease was too difficult to tackle then.

I do not think that it has since become any less difficult to tackle, especially when the Department for Work and Pensions and the compensation recovery unit are insisting on written evidence of agreement before apportioning a change to NHS charges. You are putting the onus on one defender who is paying the NHS charges for their exposure period, but there could be many other historic defenders before the act is brought in who are more culpable but who will not put pen to paper to agree the proportion. In many cases, the defender will have no option other than to leave the pursuer waiting for an offer. That is not right. The injured person must be at the heart of the process and should come first in our consideration.

George Adam (Paisley) (SNP): Ironically, my first speech as an elected member of Renfrewshire Council was on this subject, supporting what was then known as Clydeside Action on Asbestos.

We have seen how legislation can change business practices, particularly in health and safety. Do you believe that the bill would provide an additional incentive to improve health and safety practices in the workplace?

Laura Blane: I do not think that there is any guarantee of that, but the bill will reposition health and safety as a serious issue for employers of all sizes. Anyone running a business will take the financial impact seriously. If an additional insurance policy is required because of the bill, and if there is the incentive that premiums will be lower when someone has a good health and safety record, it makes economic sense for the employer to maintain a good health and safety record.

As well as considering the financial burden that they may have to bear, employers must also focus on health and safety practice in order to prevent these diseases developing.

David Short: Anything that helps health and safety in the workplace should be welcomed. There could be pressure from the insurer for the company to ensure that it follows health and safety guidelines as a condition of the policy. If that helps to save someone from developing a disease, people must welcome that.

Professor Watterson: I agree with what has been said. We have evidence from the United States, particularly from Massachusetts. When occupational diseases are identified there, there is an advice and support service that allows employers and regulators to work on ways and means of getting the causes of that occupational disease out of the workplace. That is a win, win, win. Diseases in workers are reduced, pollution is often reduced and companies usually become more effective and efficient because they invest in the best technologies and materials.

Simply by being passed, the bill would highlight the importance of not neglecting what goes on in the workplace and the impact that that has on health and, indeed, public health. That is a big plus.

George Adam: Do you believe that the bill will result in fewer industrial diseases in the future? Does it have the power to be able to cut them? I wonder whether Professor Watterson can answer that question.

Professor Watterson: I think that it does. We will see how the bill works but, if it works well, employers and workers will become more aware of the problems, and action will be taken to try to raise standards. If we do what we should do in the health and safety structure, we would expect to see occupational diseases and injuries being driven down. I would expect that to happen.

Alan Rogerson: I have a slightly contrary view, mainly because I see the consequences of industrial diseases appearing many years later. I do not think that the bill will have quite the impact on workplace conditions that better inspection and enforcement action would have.

Willie Rennie (North East Fife) (LD): It is widely believed that insurance companies will offer insurance policies in the future to cover the NHS contributions that may be coming as a result of the actions of their clients. What effect would that have on premiums? If we are going to have a law in Scotland that is different from that in the rest of the United Kingdom, what would that mean for insurance policies and for companies that straddle several parts of the United Kingdom?

Alan Rogerson: That is a good question. The problem is that we do not know what impact there will be many years down the line. Because of the way in which insurance policies work, it will be the insurance policy at the time of exposure—that is, after the bill has been passed—that will pay out many years down the line. We are trying to look at that, assess the risk, and say what insurance premiums will do.

I am a claims person, and my personal view is that the costs are so far down the line that we simply cannot tell. I think that it will be many years before we see any of those costs coming through and that there will not be any real guidance on setting premiums for a number of years. However, the uncertainty could well drive up premiums and lead insurance companies to charge additional premiums.

The point about other areas of the UK is quite a good one, because businesses cross borders. We could see people who have industrial diseases working in England and Wales but living in Scotland and coming back to Scotland for treatment in years to come. We simply do not know what will happen.

The uncertainty means that insurance premiums could increase on the chance that there will be an additional cost in the future off the back of the policies.

Sandra White (Glasgow Kelvin) (SNP): Good morning, everyone. I have found the discussion fascinating, and I thank my colleague Stuart McMillan for introducing the bill, particularly in light of the definition of diseases and the amount of information that we have received. I also thank our witnesses.

I was going to raise an issue that was not in my agreed questions, so the convener would not let me. I wonder whether mental health will come into this, in light of what is happening now, and people who work in bars and shops, for example.

Who would administer the scheme? Would it be administered from Scotland? Would the DWP administer it? I note that opinions differ on that issue. Stuart McMillan would prefer that the Scottish Government and UK Government come to an agreement, and for the DWP to administer the scheme on behalf of the Scottish ministers. However, the University of Stirling occupational and environmental health research group states that

"the Scottish Government published the document Creating a Fairer Scotland: A New Future for Social Security in Scotland. In these circumstances it would be contradictory"

for the DWP to administer the scheme.

In answers to previous questions on cost, I think that Laura Blane said that the administrative cost to the Scottish Government would be "modest", but the Association of British Insurers said that

"a separate recovery scheme operated by the Scottish Government would be more expensive, complex and less efficient."

Should the Scottish Government or the UK Government compensation recovery unit administer the new scheme? Given that the evidence is contradictory on that point, what are the advantages and disadvantages of each approach? What are the potential difficulties in administering the scheme for whoever takes on that job?

The Convener: You mentioned mental health as well, so the witnesses should feel free to comment on that, too.

Professor Watterson: Sandra White makes some interesting points. I agree that we should consider mental health, but that will be a difficult area. Some countries recognise some of the problems that are created there and have industrial disease compensation.

With regard to the CRU, things have moved on. The CRU started off well in the DWP, but people in England say that there are actually lots of problems with how it functions. A fresh approach would perhaps give an opportunity to avoid some of those problems, because it would mean that we get greater equity in the way that the scheme operates. While recognising the complexity of the matter, in some respects we might be able to start with a blank sheet for the administration processes. There will be opportunities as well as challenges for Scotland if the bill goes through.

Laura Blane: Mental health is a huge issue, especially currently. I revert back to what I have said previously: I do not think that mental health issues have to appear on a list of prescribed diseases before the legal compensation route is open to individuals. It is a difficult matter because stress cases, as they are widely known, are difficult to establish; it certainly would not be impossible for the existing law to be made wide enough to include those issues in the definition of industrial disease.

With regard to administration, from a purely practical perspective, a system is already in place that the CRU operates and that everybody

understands. It operates in terms of accidents and diseases and it would make sense for that to continue, with arrangements made separately.

Given that the bill covers Scotland only, modifications would need to be made to deal with the fact that it is about diseases and therefore more complex, and that it applies only to Scotland. I share Stuart McMillan's view: the CRU is there and set up and should be modified to deal with the provisions in the bill.

Alan Rogerson: I agree. If a separate arrangement is made in Scotland, all the systems have to be in place to support it, and staffing costs have to be considered. The financial memorandum touches on those and conservatively estimates them at £66,000 for three people in the CRU.

I come back to the issue of the hidden cost on the NHS as well, in relation to appeals and processes wherein hospitals would be asked to consider the appropriate treatment and decipher whether that treatment was linked to the industrial disease cost.

It would then be a lengthy and expensive process. Although we can tell how the compensation recovery unit works for road traffic accident victims, we are into unknown territory in relation to appeals for disease cases, and I think that they would be a lot more prevalent than has been allowed for in the financial memorandum. It will be some years before the level of recovery gets to a point where it is sustainable, if indeed that is ever reached.

11:00

Sandra White: I have a small follow-up question: if we do not have a separate scheme in Scotland and we marry up with the DWP scheme, would that cause problems for anyone who wants to make a claim? Would that be stymied?

Alan Rogerson: I do not see any problem at all with that; we are all well versed in the world of insurance in telling the DWP that we have a claim and giving it the details, and we do not have any issues with it checking with hospitals whether that person has had any treatment.

The Convener: I will call Donald Cameron in a moment and after Donald has asked his questions, I will ask Stuart McMillan, who is the sponsor of the bill, to put a question or two to the witnesses.

Donald Cameron (Highlands and Islands) (Con): I refer to my entry in the register of members' interests. I am a member of the Faculty of Advocates.

I will follow on from some of Sandra White's questions. The witnesses have touched on the subject of the financial memorandum. Are you confident in the cost estimates for administering the scheme, as outlined in the financial memorandum? It is estimated that a Scotland-only cost-recovery system would cost £66,000 per year, but Alan Rogerson touched on the fact that there is a view that that is a light figure and we might require more. Does the panel have a view on that?

Alan Rogerson: I have no information on the actual costs, so we have to take what is in the financial memorandum at face value, but it seems to be particularly light. The estimate of use of three people sounds reasonable, but there will surely have to be process changes behind the scenes to enable that. The estimate takes no account of the administration time for the NHS, or of the time of treating clinicians, if we ask them questions about treatment that is being administered or what that person was in hospital for. It is impossible to put a cost on all those hidden charges, but it puts the £66,000 in perspective.

Professor Watterson: I come back to the point that Alan Rogerson made earlier. I accept completely that there will be a lot of complexity in many cases, but in some instances things might be relatively straightforward, and we should take note of that. We did some work a while ago on hospital treatment costs for mesothelioma, about which I do not think there would be any debate. The Canadians and others have good templates in respect of a number of other occupational diseases in relation to which there would be little debate about treatment costs. In some instances it might be straightforward, but it could become very complicated.

Donald Cameron: This might be an obvious question to ask, but would it be right to suggest that the bill will simply increase the number of cases that are eligible for recovery of NHS costs? Are we likely to see more appeals and reviews? What might be the impact on costs, if that turns out to be the case?

Laura Blane: As a pursuers' solicitor, I am probably not in the right position to answer that. We take no part in the recovery process, which is for our counterparts and for the insurers. I will therefore pass that question to Alan Rogerson.

Alan Rogerson: I think that the bill will give rise to more appeals because, with industrial disease, it is harder to say that the treatment is directly related to that disease. There will undoubtedly be appeals, and any additional cost that is part of the process also lengthens the process. I return to the point about delay in the injured person receiving compensation, and increased costs in the system.

Insurers and the solicitors who act for defenders would appeal cases not just because they are being vexatious, but because they think that they have a point—that the treatment is not linked to the industrial disease.

David Short: As a pursuers' solicitor, like Laura Blane, I cannot comment on the actual costs, but I will say that, from a victim's point of view, the current scheme that is run by the Department for Work and Pensions is working. There is the odd glitch—although I defer to Professor Watterson, who seems to have some statistics to suggest that the scheme is not working—but from a victim's point of view, and judging from the cases that I deal with, the system works. If it's working, don't try to fix it.

Laura Blane: My understanding is that the appeals process and, indeed, the recovery process take place after settlement of a compensation claim, so I am not entirely convinced by the point about additional delay for the person concerned.

The Convener: I think that Alan Rogerson wishes to clarify his view on this point.

Alan Rogerson: Appeals have to happen after settlement; I was conflating that with reviews, when we ask the compensation recovery unit to review the treatment.

The Convener: I take this opportunity to invite Stuart McMillan, who is the member in charge of the bill, to ask our witnesses some questions.

Stuart McMillan (Greenock and Inverclyde) (SNP): Thank you, convener, and I thank colleagues on the committee and the witnesses for their questions and answers so far this morning.

I have a couple of questions. The first is for Mr Rogerson, who has said a couple of times that there would potentially be no major gain from the bill, in terms of finance for the NHS, for some years to come. Surely, however, a bill of this type would be extremely useful to have on the statute book now, for future proofing the issue and assisting with NHS treatment in the future.

Alan Rogerson: [*Inaudible*.]—future proofing. It is really for the committee and the Parliament to decide whether the numbers stack up in that respect. It has been difficult to find any analysis of exactly what the costs would be. That goes back to the point about the delay, or the latency period, as we call it—the delay between negligent exposure of the person to the thing that has caused the industrial disease and when the condition transpires.

We are talking about things happening many years, if not decades, down the line. That must feed into the decisions of the committee and the Parliament on whether you want to future proof things in this regard, whether the bill represents the best mechanism for doing that, and whether the set-up costs and the running costs are not to be taken on just now.

Stuart McMillan: I have a second question for Mr Rogerson. I assure you that I have a couple of questions for the other witnesses, too.

You commented earlier—Willie Rennie also touched on this in his questions—on the potential for confusion if there is in Scotland a process or system that is different to what exists elsewhere in the UK. However, most insurance companies already operate in multiple countries and under multiple jurisdictions. It could therefore be suggested that this limited addition to the statute book in Scotland and not elsewhere in the UK would not be overly onerous or confusing for the insurance industry.

Alan Rogerson: I would not say that it would be completely confusing for the insurance industry. What I would say is that because it is difficult to predict the cost, the uncertainty could lead to additional insurance premiums. I can offer no more information without knowing more about what the cost will be in the future.

However, we can look at other areas—for example, flooding. Insurance companies now have flood-mapping technology and can predict which areas are likely to suffer from flooding. The Government has also implemented a flood reinsurance programme to ensure that people in those areas can obtain insurance.

The point is that if insurance companies are trying to better their competitors by having better technology and pricing, a company may look at Scotland and say that a business with a Scottish postcode might have to pay an additional insurance premium for the additional risk involved.

Stuart McMillan: My final question concerns Professor Watterson's written evidence on behalf of the University of Stirling occupational and environmental health research group. It says:

"The bill's broadening out of what is understood by 'industrial diseases' is an important step forward. It should help to ensure neglected numbers of occupational diseases occurring among women and marginalised groups are finally fully recognised and recorded as the bill will be able to include diseases contracted beyond those in traditional male-dominated industries."

First, do the other witnesses agree with those comments? Secondly, do they believe that the bill has, in its ethos, an equality aspect built in, rather than its being an add-on? Bearing in mind the comments from Professor Watterson, do you think that the bill will increase the opportunities for women and marginalised groups to get justice and the assistance that they require?

Laura Blane: I come back to a point that I have made a couple of times. The definitions of disease and the sets of people that those definitions touch on do not really play into how the bill will operate in practice. The bill is all about whether or not there has been successful litigation. The law is currently wide enough to encompass anyone who has been negligently injured in the course of their employment or as a result of the employment of somebody else.

My speciality is asbestos disease. I am now seeing increasing numbers of women who are affected by asbestos disease because of its social history, which meant that women first became exposed 20 or 30 years ago and are now suffering the consequences of that exposure.

The bill, in itself, will not open up equality of opportunity to marginalised groups: law exists to do that. What the bill will do, as I said previously, is highlight all those issues, which are still relevant to anyone in Scottish society.

Alan Rogerson: I agree with that entirely. The bill does not promote equality; the existing legal framework does that. This goes back to use of the misnomer "industrial disease", which leads one to think of Scotland's heavy industrial past, as opposed to what we mean by disease now.

The Convener: I thank all our witnesses for a very full evidence session, which has been helpful to committee members. I thank Stuart McMillan for joining us; I am sure that he will have found it helpful, too. We look forward to dealing with the bill further in the weeks ahead.

Subordinate Legislation

Health Protection (Coronavirus, Public Health Information for Passengers Travelling to Scotland) Amendment Regulations 2020 (SSI 2020/328)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 19) Regulations 2020 (SSI 2020/330)

11:15

The Convener: Agenda item 2 is consideration of two made affirmative instruments in relation to coronavirus and international travel, which have been laid under sections 94(1) and 94(2) of the Public Health etc (Scotland) Act 2008, and are on international travel. As in previous weeks, we are considering emergency regulations that the Scottish ministers have made under section 122 of the 2008 act. Section 122(7) says that such regulations

"cease to have effect at the expiry of the period of 28 days beginning with the date on which the regulations were made unless, before the expiry of that period, the regulations have been approved by a resolution of the Parliament."

It is for the Health and Sport Committee to consider the regulations. We are looking at two sets of regulations today: the Health Protection (Coronavirus, Public Health Information for Passengers Travelling to Scotland) Amendment Regulations 2020 and the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 19) Regulations 2020. I am sure that our witnesses will be able to describe the purpose and effect of the regulations.

I welcome to the committee Humza Yousaf, the Cabinet Secretary for Justice, who is accompanied by Scottish Government officials Rachel Sunderland, who is a deputy director in the population and migration division; Jamie MacDougall, who is a deputy director in the test and protect portfolio; and Laura Duffy, who is a team leader in the community surveillance division. Thank you for joining us.

We have two instruments before us, on which members will have the opportunity to ask questions. I invite any members who have questions to please indicate accordingly by typing an "R" in the chat function. If members agree, my intention is to consider both sets of regulations together when we come to the debate on them. Therefore, members are invited to ask questions on any aspect of either set of regulations before the debate. I will start off.

Cabinet secretary, will you bring us up to date on the community surveillance aspects of the regulations, in relation to people who quarantine, and how that is being reported?

The Cabinet Secretary for Justice (Humza Yousaf): Good morning, convener and committee members. I hope that everybody is keeping well and keeping safe.

You are right, convener. The committee, and you in particular, have pressed the Government to do what we can to ensure that Public Health Scotland has available to it the resource to enable it to contact up to 2,000 people who are required to self-isolate. The figures come out every Wednesday, as you probably know. In the week ending 27 October, 9,234 people were required to quarantine and 3,355 of them were contacted. I am pleased that we exceeded the 2,000 mark and the 20 per cent mark that we have referenced before. That is positive.

You also requested that I ensure that the number of positive cases that are coming from international travel be included in the data; that figure is now included. The latest figures show that roughly 6.8 per cent—almost 7 per cent—of positive cases are coming from international travel. That has decreased from the natural peak that we would see in the summer, but we are not complacent about that, particularly because there might well be an upsurge, come the winter break.

I hope that that answers your question, but if you want further detail, I am happy to provide it.

The Convener: That would be helpful. I am sure that we will continue to keep the matter under review.

Emma Harper: I have a quick question about people who are travelling to airports in England such as Newcastle, Manchester and even Heathrow, and then on to Scotland. How proactive has the UK Government been with the Scottish Government to continue to trace, or support the ability to assess, how many people are coming into Scotland through other airports so that we can look at continuing to monitor and manage the numbers appropriately?

Humza Yousaf: On the general point about working with the UK Government on this particular issue, I would have to say that engagement has been constructive and positive and we are getting good access to information. There is a weekly call between the four nations that was chaired by Grant Shapps but has taken a slightly different format in terms of the Covid meetings chaired by Michael Gove. Nonetheless, there is still good engagement on the matter every week.

On the issues that Emma Harper raises, I make it absolutely clear that, regardless of which port of entry is used to come into the UK, if your destination is Scotland, your information will go from the passenger locator form to Public Health Scotland. If you have to quarantine, you will then become part of that cohort that might well be sampled that I referred to when I was answering the convener. You might then be sampled by Public Health Scotland. Regardless of whether you come from Manchester, Newcastle, or indeed any other port of entry in the UK, if your destination is Scotland, that is what will be on the passenger locator form and you will be required to self-isolate if you have to quarantine for 14 days. If that is in Scotland, that information will be passed on.

There were some teething problems in the very beginning, and I think that this committee went through some of them, but lately there have been no issues with information being passed on by the Border Force or the Home Office to Public Health Scotland.

Willie Rennie: I have given the justice secretary a hard time on the subject previously, so I am pleased that I will not have to do that today if the quarantine spot check rates are able to stay at that level. I thank the justice secretary for that information.

First, I am interested in compliance and the feedback from the sampling spot checks. What kind of feedback are we getting from that?

Secondly, there has previously been talk about testing at airports, partly to reduce the quarantine period from 14 days to 10 days, because there have been particular concerns that 14 days is a difficult length of time for people to comply with, and if we were able to reduce that we might get a greater degree of compliance. I want to be cautious and safe rather than just easing the situation. Could the justice secretary update us on both of those issues?

Humza Yousaf: I thank Willie Rennie for his questions. They are both very important.

On compliance, the weekly Public Health Scotland report shows that the total number of people who have had to quarantine from 22 June to 25 October is just shy of 150,000.

Public Health Scotland will try to get in touch with a person several times. If that fails, it will then pass that contact on to Police Scotland. Police Scotland has published those figures. The total number of travel regulations referrals from Public Health Scotland to Police Scotland has been 241. By and large, Public Health Scotland is managing to get through to the majority of people that it needs to contact. Remember that 150,000 is the total number and not the number of people who have been contacted—it takes a dip sample of that total.

That suggests that Public Health Scotland is not having too much difficulty getting in touch with people. Bear it in mind that everyone gets an email as well as a potential follow-up call. I meet Police Scotland representatives every week and they have not raised with me any challenges in relation to compliance. In fact, there have only been four fixed-penalty notices related to breaches of the travel regulations. Those figures have been published. That gives me a degree of assurance.

I will raise the matter again with Police Scotland at our meeting, which I think is on Thursday, and if any particular issues of interest to the committee are raised, I will write to the convener.

Testing is an important issue. Grant Shapps, the UK Government Secretary of State for Transport, has created what is called a global travel task force, to consider the issue of airport testing. There was a call with the four nations on the issue. My officials have been involved in discussions since that initial call. I am somewhat disappointed that there has not been more ministerial interaction and engagement. I intend to raise the issue when we have our four-nations call tomorrow. I am told that the work has been progressing and that, this month, there should be feedback to ministers, including in the devolved Administrations, on the UK Government's findings on airport testing.

The UK Government is proactively exploring the question that Willie Rennie asks, of whether the quarantine period could be shortened to seven or eight days and whether it should involve double testing. The challenge with double testing is that, if someone tests negative at the airport that could provide false assurance, which might affect behaviour patterns and could impact on compliance. If we do not do double testing, but test on day 7 or 8, we also need to consider how effective that is in comparison to 14 days' quarantine. There has to be a be a balance between considering whether people are adhering to the 14-day quarantine system as we would like them to and whether they are more likely to comply with a seven-day restriction if that is what it were shortened to. That is a very long answer to Willie Rennie's short question but I hope that I give him some reassurance that those questions are being asked. If I have a further update on that I will provide it to the committee.

Brian Whittle: Good morning. My question follows on from Willie Rennie's question on issues around compliance. You have said that everyone who has to comply with the quarantine requirements gets an email. The concern is how we ensure that there is compliance after that email. I have heard concerns, anecdotally, from quite a few constituents about the transfer of people from somewhere that is not Covid-safe into Scotland, which could have a significant impact on our Covid rates. How confident are you that, having been contacted, those who have to self-isolate are actually doing so? How can we ensure that the maximum number of people comply?

Humza Yousaf: I broadly share the concerns that Brian Whittle has heard from his constituents. I receive some such anecdotal information, too. That is why I look to Police Scotland. If people know that their neighbours have just returned from Spain and are not self-isolating, they should know that there is a fixed-penalty notice that could potentially be attached to that. Police Scotland tell us that some of the referrals relating to someone failing to self-isolate come from third parties; they do not all come from Public Health Scotland.

11:30

On the broader point, I agree with Brian Whittle that there are concerns—it would be wrong for me to suggest otherwise—including on the part of Government, around compliance fatigue. That applies in relation to our regulations more generally, not just the regulations on quarantine. Therefore, to return to my answer to Willie Rennie, if there is a possibility of shortening the quarantine period, and it is effective for us to do so, it is definitely something that the Scottish Government is willing to look at.

As I have said, that work is being undertaken at a UK Government level. We have been told that we will get information from it this month. Once I get an update, I will ensure that the committee is likewise updated.

The Convener: Thank you very much. As there are no further questions, we will move on to agenda items 3 and 4, which are the formal debates on the made affirmative instruments on which we have just taken evidence.

Are members content to have a single debate covering both the instruments? I see that members agree to that approach.

I remind members that they should not put questions to the cabinet secretary during the formal debate, and, of course, that officials may not speak in the debate. I invite the cabinet secretary to speak to and move motions S5M-23120 and S5M-23168, in his name.

Humza Yousaf: As always, I am happy to waive my right to speak to the motions, as we have just had a question-and-answer session about them.

I move,

That the Health and Sport Committee recommends that The Health Protection (Coronavirus, Public Health Information for Passengers Travelling to Scotland) Amendment Regulations 2020 (SSI 2020/328) be approved

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 19) Regulations 2020 (SSI 2020/330) be approved.

Motions agreed to.

The Convener: That concludes those two items of business, and we will report to Parliament in accordance with those decisions in support of the two motions.

I thank the cabinet secretary and his officials for their attendance.

European Union (Withdrawal) Act 2018

Alien Species in Aquaculture, Animals, Aquatic Animal Health, Seeds and Planting Material (Legislative Functions and Miscellaneous Provisions) (Amendment) (EU Exit) Regulations 2020

Food and Feed Safety and Hygiene (Miscellaneous Amendments)(EU Exit) Regulations 2020

11:34

The Convener: We move on to item 5, which is consideration of two consent notifications proposing that the Scottish Government gives consent to the UK Government legislating using the powers in the European Union (Withdrawal) Act 2018 in relation to two UK statutory Instruments.

The first instrument that we will consider is the Alien Species in Aquaculture, Animals, Aquatic Animal Health, Seeds and Planting Material (Legislative Functions and Miscellaneous Provisions) (Amendment) (EU Exit) Regulations 2020. We will consider the zoonotic diseases part only.

Do members have any comments on the instrument? Members will have observed that the supporting paper suggests that we make a point about the protocol on Ireland/Northern Ireland as part of our response to the Scottish Government, namely that we ask that it keeps us up to date on its engagement with UK Government ministers on the protocol. Is that agreed? Are we content for the Scottish Government to give its consent for UK ministers on this statutory instrument?

As no member objects, that is agreed.

The second instrument to consider is the Food and Feed Safety and Hygiene (Miscellaneous Amendments) (EU Exit) Regulations 2020, which we also considered at last week's meeting. Members will recall that we put a number of questions to the Government. We have received a letter in response to those questions from Joe FitzPatrick, which members will have seen. Do members have questions?

Sandra White: I draw members' attention to annexe B in our papers, which includes a letter to the convener from the Minister for Public Health, Sport and Wellbeing, Joe FitzPatrick.

I am pleased with the letter. As we can see, he has replied in great detail and mentioned the fact that the Government is "extremely disappointed"

that proposed amendments to the Agriculture Bill and The Trade Bill were not agreed to. He explains that in more detail, which I am sure members will have read. I am very content with the fact that he has confirmed

"that the UK Government will not schedule a debate for this affirmative SI until the Scottish Parliament has given a view"

on it and that the Government's position on genetically modified organisms

"remains the same in that GMOs for cultivation are permitted in Scotland."

I thank the clerks for helping me to write the letter to the minister, and I thank the minister for the reply. I am quite pleased with it. It goes into more detail on his disappointment that the SIs are still not there.

The Convener: Are there any other comments from committee members? As there are not, are we content for the Scottish Government to give its consent for UK ministers to lay a statutory instrument in the UK Parliament on this subject?

Members *indicated agreement.*

The Convener: That concludes the public part of the meeting.

11:37

Meeting continued in private until 12:20.

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