OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 5 March 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 5 March 2024

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

7th Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Simon Brown (Scottish Solicitors Bar Association)
Professor Sharon Cameron (NHS Lothian)
Superintendent Gerry Corrigan (Police Scotland)
Eddie Follan (Convention of Scottish Local Authorities)
Ross Greer (West Scotland) (Green) (Committee Substitute)
Colin Poolman (Royal College of Nursing (Scotland))
Dr Chris Provan (Royal College of General Practitioners (Scotland))
Lesley Sharkey (NHS Tayside)
Dr Sarah Wallage (NHS Grampian)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 5 March 2024

[The Deputy Convener opened the meeting at 09:18]

Abortion Services (Safe Access Zones) (Scotland) Bill: Stage 1

The Deputy Convener (Paul Sweeney): Good morning, and welcome to the seventh meeting in 2024 of the Health, Social Care and Sport Committee. The convener is unable to attend today's meeting physically and will join us remotely, so I will convene the meeting. I have received no apologies.

The first item on our agenda is two evidence sessions on the Abortion Services (Safe Access Zones) (Scotland) Bill. As Gillian Mackay is the member in charge of the bill, she cannot participate in the committee's scrutiny of the bill by virtue of rule 9.13A.2(b) of standing orders. Ross Greer will attend in her place as a committee substitute by virtue of rule 12.2A.2.

In the first evidence session, we will explore the impact that the bill would have on those who provide abortion services. I welcome our witnesses, who are all here in person. Professor Sharon Cameron is a consultant in gynaecology and sexual and reproductive health for NHS Lothian's Chalmers sexual health service; Colin Poolman is the director of the Royal College of Nursing in Scotland; and Dr Chris Provan is the chair of the Royal College of General Practitioners in Scotland. Thank you very much for coming.

Linda Hodges, representing private hospital abortion service managers, was due to give evidence this morning, but she has given her apologies, so we will engage with her through written correspondence.

We will move straight to questions from members. I invite Ivan McKee to ask the first questions.

Ivan McKee (Glasgow Provan) (SNP): Good morning. I would like to explore a couple of areas. First, have you or your colleagues encountered protests at your workplace? If so, what impact has that had, or can it have, on staff?

Professor Sharon Cameron (NHS Lothian): I will start. I am based at Chalmers sexual health centre, which is an integrated sexual and reproductive health service in Edinburgh city centre. It sits on the site of the old royal infirmary, beside a high school, the university, shops, a busy road with bus stops and so on, and it provides a wide range of sexual and reproductive health services—not just abortion care, but gynaecological services, menopausal services, comprehensive contraception, HIV care and gender identity care. I could go on.

Since 2011, we have provided abortion services to probably more than 2,400 women in the region. The protests that we have had have tended to occur on Monday mornings, with a group of perhaps four, on average. About 2018, however, the group increased in number to up to eight individuals, who stand or lean against a wall on the public street, separated from the patients' entrance of Chalmers by a fairly busy road. They are men and women who are in general a little bit older—probably over the age of 50.

The protests do not occur every week. They take the form of a display of images of fetuses, placards and anti-abortion messages. The protesters sometimes walk up and down the street and outside the patient entrance into the centre, handing out anti-abortion literature to passers-by, those accessing the clinics and the high school students in the adjacent school. That activity tends to increase during Lent. In 2020, we had a nocturnal illumination of images and anti-abortion messages with a fetus being projected on to the building. However, there has been a lull in that activity and I am not aware that there have been any protesters since before Christmas.

Some of the impact that the protests have been having has been indirect with regard to patients. Women attending the clinics have clearly been distressed, while others have been phoning up in advance of a consultation, anxious about entering the building and worried about protesters and perhaps media being there and their being filmed and watched. Some women—perhaps by virtue of the way in which they dress, which might link them to a particular group or minority ethnic group—have been particularly anxious about feeling judged while entering or, indeed, being identified by the protesters. Patients' feedback that we got at the time was that they were feeling targeted, anxious and harassed.

The protests impact on staff, too, who are concerned about patients feeling intimidated by the presence of the protesters and being less likely, therefore, to access services. Moreover, as I have said, the centre provides a whole range of services, including to young people as well as other vulnerable groups, and staff are worried that the protests might deter others from coming in.

Because the protesters stand outside other clinical buildings, such as the Edinburgh dental institute, and are adjacent to the Princess

Alexandra eye pavilion, staff are concerned that protesters might also be intimidating other patients and deterring them from using those services, too. They are also in close proximity to the public high school and are handing out distressing and false information.

There is also the direct effect on staff, who have felt frustrated by the presence of the protesters and by our being powerless to do anything about them. They feel frustrated and find it unacceptable that those people are having a protest about an essential healthcare service outside a healthcare clinic. As I have said, they are also anxious and concerned about patients being put off attending our services, and the situation has resulted in additional workload for staff as well as logistical changes. There is not just the anxiety that arises from having to make preparations when we know that there are going to be protesters but, in some circumstances, we have had to use staff to divert patients from the patient entrance to the staff entrance and then take them through the building, which requires the use of security cards. That can take up time and energy.

When it seems that a lot of protesters might be present, staff have had to make plans for women who might be collecting, say, medication for early medical abortion and to think about whether they might have to change where those women can pick up that medication.

We have had to spend time planning, looking at other clinics where they might be able to pick up medication and considering whether to use services such as courier services, which come with additional costs. A lot of time and effort has been put into planning how to maintain activity in the face of protests.

Protests have caused a chill in staff. They have been frightened at times about their safety. We are all well aware of cases in the USA in which abortion providers have been targeted, and some have been shot and killed. Abortion care is already a stigmatized area, as well. There is good evidence that staff who work in abortion services might not tell family and friends about what they do, and the protests add to that and to staff feeling that their role is undervalued.

As I said, bringing patients in through staff entrances is logistically challenging. We find that, when protests occur, they might attract other groups who are well meaning and want to come and protect patients. However, the net effect is that there are two groups of protesters in a rather busy area—as I have said, there are buses, it is a busy street, there are other clinical services and there is a high school next door—and you get the impression that you are working with a circus outside. It is not very conducive to patients coming in for their appointment; they fear that their privacy might not be guaranteed and, for some individuals, it takes some courage to attend a clinic appointment in the first place.

The protesters might be there regularly for a spell and then they might not come for months. I have said already that I have not been aware of any having been there since before Christmas. Although that has been lovely and it has been great to get on with business as usual, there is always the niggle at the back of the head about when they are going to come back, which is a chilling factor.

Colin Poolman (Royal College of Nursing (Scotland)): On the back of Professor Cameron's comments, I note that our members report the same. The unpredictability causes anxiety for people attending—both patients and our members, who are just attending work. A number of them have reported to us that they never get used to people being around and the leaflets and suchlike that they are shown. It is distressing having to pass that quite closely as you go into your workplace, just to get on with your work to provide healthcare.

Members report that it is not happening all the time, but that, in some ways, it makes it worse that they do not have predictability about when it will happen. There is also the impact that it has on colleagues, who support one another when it is happening. Some of the things that are said or seen get taken into the workplace and that creates an atmosphere in the clinic. Staff report that that creates a bit of tension for everybody when they are providing care, which in itself is not good for the patients, who are going through a difficult time and are accessing healthcare—that is what they are doing. Our members just want to provide healthcare as best they can for the clients whom they deal with.

There is a direct impact, and Professor Cameron has given the committee an insight into the day to day of that. Something that one of our members said sticks in my head. She said that, when the protesters are there, she is always shocked but never totally surprised, and that she never gets used to it. It is always distressing, and it wears people down, especially when it happens continually. We must never ignore the impact on members of staff, as well as on patients.

Dr Chris Provan (Royal College of General Practitioners (Scotland)): I support Professor Cameron's views and experience. I have not known any protests at primary care premises. The example that I am thinking of was at the Queen Elizabeth university hospital in 2018, I think, where there were demonstrations outside that you could hear in the waiting room. In such a situation, women are going through complex emotions and they should be able to go ahead with lawfully

seeking healthcare in an atmosphere that is not tense and is without noise disturbance. We fully support that. I want to emphasise that protests may delay women coming forward and, in such situations, it is best to go ahead as early as possible in order to prevent clinical and, most likely, emotional complications.

09:30

There is not a clear definition between hospitals and other healthcare premises, so we have to think ahead about what we define as a protected area. General practices can co-locate with other sexual health services and we want to allow patients to access all those services. I understand that Northern Ireland has a wider definition that includes areas that provide information, advice or counselling, so I make that general point about what places the bill will cover and about looking ahead so that we anticipate where protests might occur.

Ivan McKee: I will follow up a couple of points. Professor Cameron's reference to counter-demonstrators was interesting with regard to the atmosphere that that creates. A couple of you mentioned that false information is given out at protests and I would like to hear about some examples of that.

Professor Cameron: The leaflets usually show pictures and images of a very advanced fetus, which is very emotive, but the vast majority of women who attend the services are at a very early stage of pregnancy. The leaflets will also include false facts about the long-term effects of abortion. There is good evidence—guidelines from the Royal College of General Practitioners and the National Institute for Health and Care Excellence are based on the best evidence—that shows that there are no long-term effects of abortion in terms of adverse effects on fertility or in relation to breast cancer, but the literature that is given out will allude to false facts, myths and misconceptions such as those.

Ivan McKee: I ask for clarity on a question that was raised in the evidence session last week about the information that is provided in the clinics by staff about the options for women who come in.

Professor Cameron: If they are unsure of their decision, women have the option to discuss it further and get decision-making support. Women, for whatever reason, may struggle after an abortion; they can feel a variety of emotions. Post-abortion counselling is available through the national health service.

Ivan McKee: The last point that I want to raise is about the exemptions on trade union activity—picketing. It is clear that we are working our way through the issue and that there are human rights challenges on many sides. I would like to understand your perspective on the rationale behind a potential trade union exemption. Does what is in the bill meet those requirements? The right to trade union activity is a fundamental human right, as is the right to protest, so I would like to understand your perspective on how we unpick that.

Colin Poolman: It would probably be best if I pick that up. The proposals that are in the bill predominantly cover the ability to carry out picketing, as detailed in other legislation. They could be looked at; they are written quite narrowly, so you might need to look at broader issues such as trade union activity leading up to a ballot or trade unions trying to engage with membership.

There needs to be careful consideration of how those proposals have been drafted. Trade unions and professional organisations are very aware of where our members work, and when we are doing trade union activity, we make sure that we are not impacting individuals who are going to get care or whatever. That is very clear in our best practice guidance and suchlike.

We think that the bill as drafted is probably too narrow, because it just covers picketing. It should look at wider activity, especially activity in the build-up to a potential industrial dispute, for example.

Ivan McKee: Is there a risk that trade union activity could cause the same kinds of concerns that we have identified in relation to existing protests?

Colin Poolman: I am of course biased, because I represent a trade union and professional organisation. We are covered by clear legislation that makes us behave in reasonable ways when conducting a trade dispute. That is covered under United Kingdom legislation, which we adhere to absolutely by the letter. The two situations are very different. With trade union activity, usually, we are looking to speak to our members and not to the patients who are coming through the front door.

Ivan McKee: Thank you for clarifying that.

Ruth Maguire (Cunninghame South) (SNP): I want to follow up on that a bit. I totally acknowledge that the two activities are different and have different aims. However, I am reflecting on what Professor Cameron said about women perhaps feeling uncomfortable that there might be media attention and cameras. Walking past any group of people could be distressing, no matter what those people are doing. Mr Poolman, will you expand on that? Would union members picket a sexual and reproductive health clinic?

Colin Poolman: To my knowledge, that has never happened, not just in Scotland but across the UK. We have not picketed such clinics, because there has not been a trade dispute in that respect. However, that does not mean that it would not happen. With picketing, there is clear legislation on what you can do in relation to egress and access. With all due respect, the difference on this issue is about the images and so on that people put on placards. That absolutely would not be the case with picketing. You might have placards, but they usually have a message about—dare I say it?—more pay or whatever. Obviously, I would not compare the two situations.

Ruth Maguire: I want to press you on that a little, and perhaps bring in Professor Cameron. The bill will include people who do not have placards and people who are silently doing their vigil or praying, or whatever they want to call it. The issue is still about women not having to walk through a group of individuals to access their healthcare. Do you have a comment on that, Professor Cameron?

Professor Cameron: Protesters walk up and down the street and approach others who are walking by. In our service, protesters have at times even come into the reception. People who are coming to our service know who they are and what they are doing, and that is distressing. Media reports will talk about anti-abortion protesters being outside the clinic. People who are coming to our service can be caught on film or are worried that they will be caught on film. It does not matter whether the protesters are quiet; they are doing these activities and approaching people, and their presence is chilling. It is unpredictable.

Ruth Maguire: Thank you.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS GP and, particularly pertinently at this meeting, as a member of the RCGP.

I have basically the same question for Colin Poolman and Chris Provan. Colin, your submission says:

"RCN Scotland supports the intention behind the Bill."

Do you support the bill as it is written?

Colin Poolman: We think, for example, that clarification is needed in relation to the activity around the build-up to a trade dispute and a ballot—that needs to be thought about in the drafting. However, in relation to the bill, its principles and what it says on exclusions, yes, we support it.

Sandesh Gulhane: I am sorry, but could you explain the ballot part of that?

Colin Poolman: The exemption in relation to picketing is clear and is described. However, we believe that some thought needs to be given to the issue so that there are no unpredicted or unintended consequences. For example, in the lead-up to a trade dispute, staff would generally be spoken to about the options and whether they are going for a ballot. As you know, we have very tight trade union legislation in relation to carrying out industrial action. We would want to have the ability to have such discussions with staff.

If the definition is as narrow as it is at the moment, we believe that there could be some unintended consequences. Some employers could turn round and say that employees are covered under this legislation. Although employees would be taking part in trade union activity and not protesting about the provision of services or whatever, employers could misuse that potential in the act. That is why we think that provisions need to be carefully considered when drafting.

Sandesh Gulhane: We can pick that up with the panel, too. Chris Provan, your submission says:

"RCGP Scotland agrees with the purpose of the proposed Bill".

So, I ask you the same question: do you agree with the bill as it is worded?

Dr Provan: Yes, we agree with the general principles of the bill. We agree on the aspects relating to women's health plans, having easier access to services and not being discouraged from accessing them, and we agree on supporting staff. We fully support all of those aspects of the bill, and we also appreciate the part on the types of protests. We appreciate that silent protest can be intimidating. It is difficult to define, but any sort of presence in that area can be intimidating, and it potentially discourages women from coming forward.

I mentioned the definition of areas covered because one of the consequences may be that protests move to other areas. They could occur in primary care, aftercare, counselling and other settings. We have to think about the knock-on effect. Patients should also be able to access other services that are often co-located around sexual health services, such as rape crisis, counselling and support services. There should be no barriers to that. That is what we say in our submission.

Ross Greer (West Scotland) (Green): I will pick up on a couple of Ivan McKee's questions.

Colin Poolman—my first question is for you and is about the impact on trade union activity, short of picketing. I accept what you said about none of us being able to think of an instance where there has

been industrial action at a facility that provides abortion services. However, at other settings in which your members have taken industrial action across the UK, is it common to get complaints from patients about a perceived impact on them on entering a facility if there is a picket line outside?

Colin Poolman: We have just been through an intense period of industrial action across the UK, and I have to say that the reverse is true—patients are normally very complimentary and supportive.

During industrial action in England, Wales and Northern Ireland, we had one situation in which a member of the public took umbrage at people picketing, but there were no issues about egress or access that we found, and we investigated it further. That issue has not been brought to our attention.

Ross Greer: Professor Cameron, following up on what you said in response to Ivan McKee about the support that is provided, those who engage in protests say that one of their key reasons for doing so is that they are providing a discussion about alternatives to abortion that they do not believe is provided in healthcare settings. Will you expand on your answer to Ivan McKee about the process and the support that is available to women who come seeking abortion or reproductive healthcare services?

Professor Cameron: We know from evidence that the vast majority of women know what they are going to do as soon as they have a positive pregnancy test. Most women who come seeking abortion are sure of their decision, but there is a proportion who are not. Services exist to provide counselling to women who are unsure of their decision.

We also see women who want to end a pregnancy that might not be a pregnancy that is continuing, and the services manage women who are found to have a miscarriage. We also have many women who decide that they are going to continue their pregnancy, and the services support those women, too.

09:45

That speaks to one of the beauties of the Scottish NHS: we have all these links to other services. Sexual and reproductive health services are NHS services with good links with hospitals—some of the abortion services are actually set in hospitals, and are run by the departments of obstetrics and gynaecology, and, often, the abortion services staff are the same staff who work in the early pregnancy units or, depending on the size of the hospital, the maternity units. Those links mean that, if people want to continue their pregnancy, we can support them in that decision and give them access to antenatal care; we can support women who are discovered to have a miscarriage; we can link in with early pregnancy units to support people who turn out to have an ectopic pregnancy, which is a pregnancy outside the uterus; and so on. As I said, those links are one of the beauties of the Scottish NHS.

Our staff also provide counselling services that offer support around decision making and help the minority of women who, after an abortion, are struggling and need on-going support. As I said, for most women, the decision to have an abortion is one that they are sure of, but some women who decide to have an abortion are not sure about it and might later regret it—as is the case with many life decisions that we have to make. We have the services to support those women if they continue with the pregnancy or if, having had an abortion, they find that they are struggling.

Ross Greer: You mentioned the most commonly handed-out leaflet, which committee members are aware of and which includes misinformation about things such as the risk of breast cancer. Have you seen examples of that having an impact after it has been handed to a woman who is seeking an abortion? Have your staff had to have a discussion other than the one that was expected because of concerns about information in the leaflet?

Professor Cameron: Yes, staff have reported that there have been occasions where women have been upset because of the leaflet. It takes additional time to support and calm those women and ensure that they get evidence-based and true information and do not feel intimidated and harassed into continuing with a pregnancy that they do not want to continue with or cannot continue with.

Ross Greer: Dr Provan, what is your response to the protesters' claim that what they are doing is providing alternative support and information?

Dr Provan: Clearly, I disagree with that. Often, patients come to us because they have an existing relationship with us involving support through counselling. Our role is to non-judgmentally give the woman information so that she can make a decision about what she wants to do, given her particular individual circumstances. The protests distribute information that is scientifically incorrect, and we should prevent that. We want to ensure that the information that women receive is given to them by healthcare professionals who are trained and experienced in doing that, and that the process takes place in a calm atmosphere in which they can think through the issues, rather than doing so in an anxious state after having been through a protest.

Ross Greer: Thanks. I note your point that the protesters are not qualified healthcare professionals.

David Torrance (Kirkcaldy) (SNP): We probably all know the answer to the question that I am going to ask, but I will ask it in order to get the answer on the record. What impact will the introduction of access zones have on people accessing abortion services, people accessing other services at the facility, staff providing healthcare services and passers-by?

Professor Cameron: Staff are concerned that the presence of the protesters might be deterring individuals from accessing our services. Abortion services may be delivered in a hospital setting or in sexual and reproductive health services. The latter in particular might provide a wide range of services to a wide range of individuals with vulnerabilities, including young people. There is concern that protesters might be putting off individuals from attending who might struggle to access services. It is really important that we do as much as we can in Scotland and in the rest of the UK to improve access to sexual health services, and the presence of the protesters is working against that.

It is also important that women who want to have an abortion can access services as soon as possible, because there is very good evidence that abortion at earlier gestations is associated with fewer complications, less pain, less bleeding and so on.

It is also possible that the presence of the protesters might be deterring individuals from accessing the services not just in our building but in surrounding buildings. For example, protesters have been right outside the dental hospital. Are they putting off individuals from accessing it? Are they putting off individuals from accessing care at the Princess Alexandra eye pavilion? Are they putting off and causing distress to passers-by? We hope that the bill would prevent that from happening.

Colin Poolman: The issue is stigma and the impact that that has on patients. As Professor Cameron said, people are going to access healthcare, but they are making a difficult decision. It is an emotional time for the patients and their loved ones, and such protests might have an impact on them.

As I said previously, staff are having to pass the protests each day, which has an impact, too. They are being made to feel that there is something wrong with their work, even though they are providing compassionate care and the best healthcare that they can for people.

The issue is the stigma and people being made to feel that they are not doing something that is worth while, or whatever. That is how it comes across to them. The protests mean that the act of coming to work can be quite wearing for staff over time. That impact on staff, as well as the impact on patients, needs to be understood.

There could be an impact by dint of where services are based. At the end of the day, somebody who is due to access healthcare but is aware that there is a protest might not want to go near that place for whatever reason. That is a very personal thing, is it not? For example, people might feel that they will be asked for their views, and that might have an impact on them, too.

Dr Provan: I agree with what has been said. We want to improve access and prevent delays, especially for more vulnerable groups, which can include people from less well-off environments or from rural areas. We want to continue to improve access for those people, and protests can interfere with that.

The British Society of Abortion Care Providers has pointed out that some women might be tempted to obtain drugs on the internet or to go to non-regulated services. We do not know what is in those medications and that is not regulated, so doing that would be unsafe for them.

There is evidence from Australia that these schemes protect access, privacy, support staff and prevent misinformation, which is encouraging.

Finally, the issue affects not only clinical staff but support staff and administrative staff; we should remember them as well.

Emma Harper (South Scotland) (SNP): Good morning to you all, and thank you for being here today.

Dr Provan talked a little already about premises other than abortion providers—for example, general practices and perhaps even pharmacies. I would like to hear your thoughts on the definition of "protected premises". Is there enough in the bill to enable it to be future proofed or applied to other premises?

Section 7 refers to

"Extension of safe access zones"

and says that

"Scottish Ministers may approve an application made under subsection (1)".

Is there enough information there to allow more sites to have safe access zones?

Dr Provan: I am not sure. We want to be able to regulate in advance, in a sense. If a protest moves to a general practice that was previously not covered by the definition, more information on regulation would be needed. We would want to be ahead of the game, so that aspect might need to

be looked at, including consideration of what happens in other areas. I am not an expert in the matter, but we need to think about it, because there are often many other services around a facility—for example, counselling services—that might be affected.

Emma Harper: The bill proposes a 200m radius, but there will be places that will require a wider, or perhaps a different, area. Do you have any thoughts about the 200m limit?

Dr Provan: There is probably flexibility, in some ways, depending on the individual circumstances of the healthcare facility and its situation. I do not know about the evidence on the 200m radius, but that distance seems to be entirely appropriate.

Emma Harper: Legislation elsewhere specifies 150m or 50m, but 200m is proposed in the bill. Professor Cameron, do you have any thoughts on that? You talked about how your facility is a very busy place with a high school next door, so we might have to consider such circumstances.

Professor Cameron: Yes. It is important that the 200m would be a minimum, and that there would be flexibility to increase the radius and to enable consideration of new sites for delivery of abortion care.

Advances are being made in technology and in health services delivery; there were many during the pandemic. It is not inconceivable that, in the future, some services could be delivered from general practices, which is a model that is used in Ireland, or from pharmacies, which is a model that is used in Canada, in particular in remote and rural areas. We need to be cognisant of that and to ensure that the bill is future proofed so that we will not be in a situation in which we are trying to improve access for people who live in faraway places only to find that the very healthcare delivery site that could provide them with care is surrounded by abortion protesters.

Emma Harper: You spoke about extension, but what about reduction of safe zones? I read in a briefing that we need to consider that. How would that work if future ministers were against abortion? How do we ensure that extension and reduction can be continued and that we can provide safe access zones?

Professor Cameron: I cannot see why an area would be reduced. Regarding the services with which I am familiar, I think that a 50m zone would be far too small.

Emma Harper: Okay.

Colin Poolman: On extension of zones, there might be a situation in which an operator does not apply for an extension. My point is about the ability of trade unions and professional organisations to seek to get an operator to apply to ministers for an extension. That might be important.

It would absolutely come down to the local situation. As we know, there are complexities around where the clinic is at the Queen Elizabeth university hospital. It is not a stand-alone clinic—it is within a specific environment. It should be possible to consider such situations. From a trade union point of view, we would very much like to be able to have discussions with the operator of services, and we would like, in the legislation, an obligation on operators to consider making an application, if we were to approach them.

10:00

Emma Harper: I have a final question. Professor Cameron talked about women having to go in through the back door of premises. I suppose that a defined zone should include the detail that particular premises are required to allow people to access them safely through the front door without having to go through a safe-access process with identification badges, people being escorted and so on.

Professor Cameron: Absolutely.

Sandesh Gulhane: I want to pick up on what Chris Provan said about the potential for protesting outside general practices. We all do abortion in some way, whether through referral, or a doctor who has conscientious objections asking a colleague to take a patient. Would not a 200m zone around every general practice be quite a lot?

Dr Provan: It would, and part of the difficulty for the bill is in defining that, because we all have important involvement in counselling. People need to consider the balance and how far to go. I said that I am not an expert because I do not necessarily have a clear answer to that question, to be honest. However, we need a flexible way of anticipating what might happen and of making the definition future proof. Where abortions are carried out in the future might be less definable, because a lot of what we do can be done over the phone or remotely.

We have to make it clear that GP premises can be protected rapidly if protests happen outside them, but how that is done will need to be in the detail of the bill. I hope that that makes sense.

Sandesh Gulhane: Absolutely. The bill includes the 200m zone, and it includes what happens in people's own residences. I would like to hear the witnesses' opinions about the decision to say what people can and cannot do in their homes, given that we are talking about banning of picketing and of using pictures of fetuses in the street, for example. It seems to be sensible to include that, but my understanding is that the bill would be the

only such legislation that includes people's homes or private residences. What is your opinion of that?

Dr Provan: There is a balance of rights and responsibilities. It is a woman's right to have healthcare in a non-judgmental way, without being deterred in any way, especially if they are in a vulnerable situation, for whatever reason. We would not want a scenario in which pictures are put up around a person's house because it is within a zone. We support the bill, in that respect.

Colin Poolman: To add to Chris Provan's position, I say that it is clear that there needs to be a balance between protecting people's right to have a private conversation in their own home and the rights of patients and staff to access services without seeing distressing images. We think that the bill attends to that.

If the bill were to make any other provisions about private dwellings, an unintended consequence could be people trying to use that as a loophole in the legislation. That would need to be considered. A campaigning organisation from either side of the debate could buy a private dwelling and turn it into some sort of headquarters, which would certainly defeat the purposes of the bill.

Professor Cameron: To add to that, I note that I alluded earlier to how, during 2020, a nocturnal illumination was projected from across the street onto the Chalmers clinic building, with distressing images to do with abortion. That was very distressing for the staff and the patients who were attending services. Such things not being tolerated would be covered in the bill.

The Deputy Convener: Ruth, do you have any more questions?

Ruth Maguire: I have questions on the next theme.

I want to ask about criminal offences and penalties in the bill. I appreciate that that might not be your area of expertise, but I would value your opinions.

Some opponents of the bill have raised concerns that the behaviour that is captured in section 4, on criminal offences, is wide-ranging and unclear. Do you have any views on the clarity of the offences, as they are described in the bill?

Colin Poolman: I will go first. I do not have a view; that is not our area of expertise. You, as a parliamentarian, probably have a better and wider view of that. I do not want to offer an observation on that; it is not an area on which I am an expert or knowledgeable.

Dr Provan: We have already heard about silent vigils and physical blocking of people. We support prevention of those types of activities, although their range is quite broad. It would have to be clear that such silent vigils could still be very intimidating. That is our view, so we support what is in the bill.

Professor Cameron: Again, that is not my area of expertise, so I defer to the committee, but I think that repeated offences are more serious.

People who have experienced abortion protests in England have expressed concerns that the fines might not be sufficient to deter people who are supported by well-funded anti-abortion organisations.

Ruth Maguire: That is helpful.

We have alluded in this meeting to the various groups of citizens who access sexual and reproductive health services. It would be helpful to understand who is most impacted by stigma and by being put off. I am thinking back to when the Prohibition of Female Genital Mutilation (Scotland) Act 2005 was passed by Parliament. Many minority ethnic women whom we spoke to at that time found it difficult to access sexual and reproductive health clinics, just because of the breadth of services that they were offering. That group of individuals comes into my head when I think about people being put off. Can you tell us about other groups?

Professor Cameron: As well as that group, young people might not have the skills to be able to navigate healthcare services, and people with disabilities and, in general, women who live at a distance from services might be put off.

Ruth Maguire: That is helpful.

Carol Mochan (South Scotland) (Lab): I want to come back to human rights. I value the views that you have given us so far, which have really come through in the questioning.

It is important that we get the balance right for people. Am I right in saying that you feel that the bill provides a proportionate balance between the rights of people to express themselves and protection of people who are accessing healthcare? Would you say that the bill sets that out in a fair way?

Dr Provan: Yes—we support the measures in the bill.

Colin Poolman: It is a really difficult issue, but the bill is proportionate in that respect. Although, as with any legislation, how it is operated will be the proof, we believe that the bill, as it is laid down currently, does the right thing.

Carol Mochan: That is helpful. The next point that I want to make is about the 200m radius. Witnesses have discussed whether operators should be able to increase the size of zones

proportionately. There has also been discussion about whether it should be possible to reduce their size. Do you have a view on that?

Professor Cameron: Knowing the physical locations of services in hospitals and of sexual and reproductive health services, I cannot see that the size could be reduced. One could imagine that, in the future, when services cease to be offered altogether, the protection would cease. However, looking ahead to how service delivery and technology might change, there should be flexibility for zones to be expanded.

Colin Poolman: Operators should have that power. Trade unions and professional organisations should be able to ask the operator for extension of an area if we believe that there is a reason for that. However, it should be for the operators to decide in the light of circumstances—it comes down to the circumstances in which services are provided.

Carol Mochan: Some human rights organisations have suggested that operators should have to ensure that the balance is correct and that they should take evidence from staff if there is a continuing impact. How would it play out in the future if operators had to continue to speak to staff and assess the legislation's impact?

Colin Poolman: Operators should speak to staff anyway in every situation to ensure that they are provided with adequate support in respect of their part in the situation. As Chris Provan pointed out, this affects not only the clinicians who provide a service, but many other associated staff who work in the services. Employers should have a duty to consult their employees about the impact of restrictions that are placed on protest or demonstrations.

Professor Cameron: It is really important that the administrative requirements on a service are not heavy. Protesters already have an impact, and I have alluded to the workload in considering how we might change our operations in order to provide service continuity. Such work takes capacity from clinical care.

Some services are larger than others. In the Highlands and Islands, services might be very small. It is not fair to expect providers that have small staff numbers—or even those that have a large staff—to spend a lot of time on, and to put a lot of administrative work into, continually reviewing, completing forms and making applications—especially given that protesters come and go. They might be there for a time, but then might not come again for months. It is really important that the process is as simple as possible.

Dr Provan: I agree that the process needs to be simple. It should not be the responsibility of the staff. There should be a right for patients to seek healthcare services without delay and reduction of barriers should be encouraged. I would not like people to have to prove that there is a problem before it is tackled. We should anticipate and prevent problems in the first place.

Carol Mochan: That is helpful. Thank you very much.

Sandesh Gulhane: Professor Cameron, I will also put this question to the solicitor who will give evidence in the next group of witnesses.

If the bill is passed, somebody will have to pick up the phone and call the police if something distressing happens or if there are protesters, and they will have their name recorded, whoever they might be. Might that put people off, or has it put people off, calling the police?

Professor Cameron: We know from feedback from our staff that patients sometimes do not want to call the police, even if they have been distressed by the presence of protesters, because they will perhaps be linked with having attended a service in association with abortion. I cannot see that there would be an issue with a member of staff calling the police: staff are already frustrated because they feel that there is little that they can do. I think that they would accept calling the police if the legislation were to be breached.

The Deputy Convener: Are there any other matters that members of the committee have not raised so far that the witnesses feel a need to mention?

Professor Cameron: Prior to abortion being legalised in 1967, it was a leading cause of maternal death. That is not the case any more, particularly because of the advent of medical abortion and women having good access to it in the very early stages of pregnancy. It is an extremely safe procedure.

The World Health Organization says that abortion is essential healthcare: we need to protect access to that essential service. We do not want to go back in time, to women being unable to access that essential service. It is really important to keep that in mind.

The Deputy Convener: I thank the witnesses for their contributions to the committee's work.

10:16

Meeting suspended.

10:23

On resuming—

The Deputy Convener: I call the meeting to order. We will continue our first agenda item with a

second evidence session on the Abortion Services (Safe Access Zones) (Scotland) Bill. In this session, we will explore the impact of the bill for those who will be responsible for the enforcement and management of safe access zones.

I welcome our witnesses to the meeting. Simon Brown is vice-president of the Scottish Solicitors Bar Association; Superintendent Gerry Corrigan is from specialist operations in G division of Police Scotland; Eddie Follan is chief officer in health and social care at the the Convention of Scottish Local Authorities; Lesley Sharkey is director of midwifery at NHS Tayside; and Sarah Wallage is lead clinician for abortion at NHS Grampian.

We will move to questions from members of the committee.

Ross Greer: I will start with a question for Sarah Wallage and Lesley Sharkey, if that is okay. I will repeat a question that I put to the previous panel—I am not sure whether you caught that section of the discussion. I am interested in your views on the misinformation that protesters outside clinics share. The committee is aware of the most common leaflet, which includes misinformation about the risk of breast cancer, and the impact that that has not just on people who access services but on your staff. Do your staff need to have conversations to reassure patients about what they have seen in those leaflets? One of the protesters' core arguments is that they offer information on alternative support that they do not believe is on offer inside your facilities.

Dr Sarah Wallage (NHS Grampian): Yes, that can have an impact on patients. It is not just about information that comes from protesters; it is about online information as well. I would argue that thorough information is available online, particularly on the new NHS Inform site, but we sometimes have to counter misinformation with patients who are requesting an abortion or with other people who attend the service and mention the misinformation.

Ross Greer: Is the situation similar for you, Lesley?

Lesley Sharkey (NHS Tayside): Yes. However, I suppose that things are different from NHS Tayside's perspective, because there are not a huge number of protesters in our area. I am sure that we will come on to that.

Sarah Wallage picked up on the information on the internet, which everyone can access. Although I understand that the bill does not cover that area, people can get medical information from a variety of sources nowadays. We would always direct those conversations to the medical professionals or specialist nurses and midwives who provide that service.

Some of that is about unpicking societal attitudes and misconceptions about abortion. Misinformation has an impact around the country, but there are not a huge number of protesters in Tayside.

Ross Greer: It has been mentioned that the protests are largely, but not entirely, concentrated in Glasgow and Edinburgh but, because of social media as well as news coverage, people are aware of them throughout the country. Even at facilities where protests rarely or never take place, do you find that women who seek to access your services are aware of the protests? Do they perceive a risk? Is there worry and concern on their part that the day that they turn up to access your services might be the day that 40 Days for Life is there?

Dr Wallage: Yes. We have few protests in Aberdeen and Grampian, but we have had patients saying in their first contact with the service, which will be a telephone call, "Will there be protesters outside?" Even though protests are not happening locally, the fact that protests have been reported and seen on the media affects people who seek to access the service.

Lesley Sharkey: The situation is very similar in Tayside. It has been a number of years since protesters have been outside the hospital or places where abortion healthcare services are provided.

Society has changed with regard to abortion care. We heard in the first evidence session that the abortion law has been in place for 50 years and people have been able to access such services.

In the earlier session and last week, people talked a lot about the fact that it is key and crucial for the bill especially to consider the impact of protests not just on people who are accessing services right now, but on people who accessed services 30 or 40 years ago and might still be holding trauma from that. The women or their families could come into hospital premises and be confronted by imagery or people who are protesting. What barrier does that put up? Although we are protecting abortion services at the moment and future proofing them, it is also about the responsibility around healthcare for people who have already accessed our service.

Ross Greer: Finally, if there is a protest outside one of your facilities, the threat of a protest or awareness that one might be coming up, what does that mean in practice for you? Do you have to do things differently? Do you have to provide different information to people who are accessing the service? What is the impact on you and your staff? How do you deal with the protest or the threat of one?

Lesley Sharkey: As was picked up in the earlier session, we focus a lot on clinical staff who are providers of abortion care. We also heard about admin staff. However, porters and security staff in hospitals would often be the first port of call if there were any concerns about the safety of staff in relation to protests. We have to think about that and assess the risks. As we have heard, the first port of call for staff would be to contact security and phone the police. Then we would look to our Police Scotland colleagues to take over the security aspect.

Ross Greer: Would you like to add to that, Dr Wallage?

10:30

Dr Wallage: I agree. There would be a risk assessment to consider how we would manage the protest. A protest affects the whole building and not just the abortion service. It affects everybody who works in the building, which, for us, includes staff in cardiology and physiotherapy services—a huge number of people could be affected. We would involve NHS security and make sure that we had contact with the police if that is needed.

Ross Greer: That takes us neatly on to Gerry Corrigan and the impact on the police, but I believe that colleagues will cover that.

The Deputy Convener: Feel free to do that.

Ross Greer: Obviously, the issue has been going on for a long time, but it has become much more high profile over the past five years or so. Campaigners initially spoke to the police and local authorities about what could be done locally. The reason why we have ended up where we are is that there is a general belief that the existing law and the powers of councils are not adequate to deal with the issue.

Superintendent Corrigan, will you say a little about the point that, when people have complained to the police in the past, they have received the response that protesters are not breaching any current law and that therefore officers are unable to take enforcement action unless there are very specific behaviours that cross a line?

Superintendent Gerry Corrigan (Police Scotland): I agree that there is no existing legislation that deals with the ethos of what the bill is trying to achieve in trying to protect people who are legitimately accessing healthcare services so that they can do so unhindered. There is legislation that can be used if people go to those premises to protest and then cross a line of what is acceptable in terms of criminality. That will always be open to some sort of interpretation, because it will depend on, for example, what the pictures look like and what the wording is like. A whole lot of circumstances will need to be considered in thinking about whether a crime has been committed. If it has, we can take action at that point.

What I am trying to say is that, when there is a protest—when it is actually happening—and specific behaviours are taking place, we probably have legislation to deal with it at that point. However, at the moment, we do not have legislation on the preventative element to allow us to create and enforce a safe space, which would be done through engagement and communication. Therefore, I believe that a gap exists.

Ross Greer: If protesters arrive outside a facility and there are complaints and your officers are called, how would officers deal with that under the law as it stands? At the moment, it is entirely legal to stand on the road opposite the Queen Elizabeth university hospital in Glasgow or the Chalmers centre and protest but, very regularly, when protests occur, your officers are called. How long would officers attend for, and what would they be looking for? Would they speak to the protesters about what is and is not allowed and leave again? Would they stay for some time? As it stands, protesters can be there for 40 days. I presume that your officers would not attend all day every day for 40 days. What happens when they are called out?

Superintendent Corrigan: When they are called out, officers will attend and assess what they are faced with. If there is a small number of protesters—we often see around a dozen—and they are peaceful, we would generally engage with them to find out their intentions and how long they intend to stay. If we get the feeling that the protest is static and peaceful, we would probably be quite happy to leave them to it. We would perhaps visit every two or three hours, just to make sure that nothing had escalated. We would also engage with people in the premises to make sure that they are aware of the protest outside and reassure them that, if they see it escalating, they can give us a call and we will take it from there. In general, if a protest is peaceful, settled and static, we will leave the protesters to it, with a couple of safeguards in place, in case it escalates.

Ross Greer: In the previous evidence session, Professor Cameron gave us the example of images being projected on to a facility from a distance. I understand that you might not want to talk about specific incidents that have happened in the past but, in general, are your officers currently able to take any action if somebody is projecting images of a fetus or anti-abortion messages—whatever it might be—on to a hospital from a distance? Obviously, buildings have windows, and some of those images would enter the facility.

Superintendent Corrigan: We could attend the premises from where something is being projected and try to engage with the householder or whoever and ask them to turn the equipment off. However, that would be voluntary; we would not have the power of entry to enforce that. That said, as the legislation stands, I do not think that we would have that power either. We would need to apply to a sheriff, via the procurator fiscal, to get a warrant to enter the premises and seize the equipment or get it turned off.

Ross Greer: To clarify, what if people were doing that from a public highway rather than from a private property?

Superintendent Corrigan: That would be different. We could take action, seize equipment and consider the legislation as it stands at that point. However, if that was done from a private property, unless there was a specific power of entry in the legislation, we would need to apply through the procurator fiscal and sheriff to gain access to that private property to take action.

Ross Greer: That is really useful. Thank you.

Ivan McKee: I have a brief follow-up question on that, just to clarify a point. We have a quote from Police Scotland's submission in our briefing notes. The submission says:

"The Bill has been reviewed and"

Police Scotland's

"position remains that existing powers and offences ... are sufficient to address any unlawful behaviour which may arise in the vicinity of a health care premises as a result of such protest."

How does that square with what you have just said? I want to ensure that we understand exactly what the position is, for the record, if that is okay.

Superintendent Corrigan: Yes. I was reading that. Our submission says:

"to address any unlawful behaviour".

For me, the clarification about that is that we are going to change what is lawful. At the moment, standing silent outside a clinic is not unlawful, and we would not be able to take action on that, because it is not an offence. However, if we are trying to change what can take place outside a clinic and the bill makes that action unlawful, we do not have the powers to deal with that.

Ivan McKee: I suppose that it is a tautology and a statement of the obvious. If it is lawful, it is lawful; if it is not, it is not.

Superintendent Corrigan: Yes.

Ivan McKee: I kind of see what you are saying, but I suppose that it comes across as a statement that you do not think that more powers are required to deal with the situation. Thanks for that clarification.

Emma Harper: I wish a good morning to you all, and thank you for being here.

I am interested in issues around protected premises and their definition. I know that healthcare provision varies across Scotland, so the 200m zone might need to be extended for certain parts.

Our briefing notes say that the Convention of Scottish Local Authorities

"expressed its support for the provision to extend safe access zones as necessary".

However, they also mention that COSLA talked about

"further stakeholder engagement to explore how information about protected premises, and their surrounding safe access zones, could be effectively communicated to interested parties".

I am interested in any thoughts about the definition of protected premises and whether 200m is, in your opinion, adequate.

Eddie Follan (Convention of Scottish Local Authorities): There is probably a need for wider engagement on that point. From a local authority perspective, we took the feedback that we got from elected members to two of our boards—the communities board, where elected members represent local authorities, and the health and social care board—and the question was asked whether 200m is enough in some respects. The bill contains a provision to extend the zone, if need be, depending on the circumstances in each area, and we would support that. In general, we support the provision, but I do not have a lot of detail on the specifics.

Emma Harper: In the earlier evidence session, Professor Cameron talked about people having to come in through a back door and be escorted, which means that there is the issue of access and people needing ID to open doors and so on. Lesley Sharkey, what are your thoughts on the perimeter of safe access zones—so that people are not approached or harassed—where that requires access to alternative entrances to the front door?

Lesley Sharkey: We are keen to keep the perimeter at 200m, precisely for that reason. There are many points of access to various providers' healthcare facilities. The way that hospitals and healthcare establishments are built nowadays—and have been for the past 50 years—means that people can enter in various places.

We would not expect someone who was coming in for a hip operation, for example, to be taken in

through a back door, as you said. Therefore, why should we expect anyone who enters any healthcare establishment to access services to come in through a different door from the public entrance? Going through the back door creates connotations with regard to abortion services.

Buildings have different entrances, which might look different as you walk in. For example, staff entrances might not be as welcoming to the public and there might be storage facilities there. For women who are accessing such services, that situation does not place value on the healthcare that they are provided with.

The point about future proofing is a key one. Healthcare is expanding and, it is hoped, moving towards a place where it is much easier for people to get the right care in the right place at the right time. As we have heard, that means that abortion services will not necessarily always be provided in a hospital setting. In Tayside, the majority of medical abortions, which means those at under 12 weeks and given by medication, are provided at home.

Therefore, although we provide that medication through a hospital setting at the moment, that might not be the case in the future. It could be provided through a pharmacy, GP surgeries, clinics or other kinds of providers. Therefore, we also need to be able to protect those places.

Emma Harper: Therefore, the future-proofing aspects of the bill's provisions need to ensure that there is the flexibility to allow for GP practices, pharmacies or other locations to be included, based on application and ministerial approval. Is anything missing from the bill with regard to expanding or even reducing the premises that are covered?

Lesley Sharkey: I think that flexibility is the key word. Another key aspect is probably the pace at which an application can be put to ministers and approved. As always, we do not know what we do not know. Although we are trying to future proof things, protesters might decide to protest in other places, such as GP surgeries. A 200m buffer zone around a GP surgery seems to be quite a significant area, considering who else would be entering the premises and given the right to peacefully protest. I suppose that, if an application could get a rapid response, the system would be flexible enough.

Ruth Maguire: Good morning. Thanks for being with us. I have questions about criminal offences and penalties, which are probably mostly for Gerry Corrigan and Simon Brown, but I am happy to hear from other witnesses.

Opponents of the bill have raised concern that the behaviour that is captured in section 4 is wide ranging and unclear. What are your views on the clarity of the offence?

Simon Brown (Scottish Solicitors Bar Association): In section 4(1), I think that the term "influencing" is the one that would cause the biggest difficulties. I do not think that "preventing or impeding" would need much clarification, and "harassment, alarm or distress" would contravene existing laws. The term "influencing" would pose a problem.

10:45

On that basis, to make the legislation a success you would have to focus much more on an exclusion zone and any behaviour—if it is designed for the purpose of influencing other people—within that exclusion zone being an offence. That should be relatively easy to establish because, by their nature, these people are coming to protest. Although we are hearing scare stories about people being arrested for praying silently in the street, the protests that I have seen so far have involved placards, banners and posters, because the people are trying to make a point. If you can identify somebody as making a point of protesting within an exclusion zone, I do not foresee a difficulty in prosecuting that. Speaking from a defence point of view, I think that that would be hard to defend.

Ruth Maguire: Superintendent Corrigan, do you have anything to add?

Superintendent Corrigan: In reading section 4(1), my sense is that, in terms of the protests that I have seen at the Queen Elizabeth university hospital, for example, it feels competent from an operational point of view. I take Simon Brown's point that the word "influencing" would perhaps require a bit of interpretation. My sense is that it would take a bit of writing in the police report to the procurator fiscal to outline the overall circumstances, such as people praying silently, and how they could have the effect of influencing. It feels competent.

Ruth Maguire: We heard from the previous witnesses about how even silent praying can cause distress and anxiety and can impede people going into clinics. How would a police officer determine what somebody was praying about silently?

Superintendent Corrigan: I guess that, in providing evidence to the prosecutor about what the person was doing, it would just need to involve a physical description of the person's demeanour, as opposed to going into the realms of what they were thinking.

Ruth Maguire: Would Police Scotland have any concerns about enforcing legislation that was about what somebody was thinking?

Superintendent Corrigan: Yes. I am certain that that is not an area that we would go into, encroach upon, ask about or try to describe at all. That is an area that we would stay clear of.

Ruth Maguire: Do you think that the offences in the bill have a lower evidential requirement than that of existing offences, such those relating to harassment or threatening behaviour?

Superintendent Corrigan: My sense is that the offences are broadly comparable to the description of a breach of the peace or a statutory breach of the peace. They feel comparable to that, so they would be covered.

Ruth Maguire: Thank you. That is helpful.

Section 5 would create an offence relating to behaviour from property that is within a safe access zone but not covered by it, where that could be seen or heard from the safe access zone. Are there any existing offences that are similar in nature? Do you have any opinion on the proportionality of that measure?

Simon Brown: I cannot think of anything that is similar in nature. If you are talking about the example that was given earlier of projecting something on to a building, I think that that would be an offence under the terms of the bill, because it would create an influence within the exclusion zone—the impact of the behaviour would be within the exclusion zone. As the law stands, I cannot think of an example of a crime involving behaviour outside that influences behaviour inside.

As Superintendent Corrigan says, I think that a lot of the conduct that it is envisaged that the bill will capture would be captured by breach of the peace. Section 38 of the Criminal Justice and Licensing (Scotland) Act 2010 is the statutory breach of the peace, but breach of the peace itself would be more relevant in these situations, because it involves a more subjective test, whereby the complainer says, for example, that they were placed in a state of fear and alarm.

I will go back briefly to the earlier point about silent prayer. I do not expect that you will get people leading a defence of, "I was not committing an offence—I was thinking about my shopping list." These people are here to protest, and they are going to say, "I was there to protest—that is what I was doing." They will always take a case to trial and will, I imagine, not pay a financial penalty; instead, they will seek to be imprisoned to raise awareness of what they are saying. I think that that is a likely outcome.

Superintendent Corrigan: On the point about items being displayed on private property, I would just point out that, if there were a contentious march through a city centre, say, and someone displayed a flag of the opposing side on their private property, that would probably be an offence under breach of the peace. It does not come under specific legislation as such, but, given the behaviour that such a move could incite in those on the march, it could be a breach of the peace. In that sense, the offence is not entirely unique.

Ruth Maguire: Simon Brown alluded to this in his previous response, but the previous panel suggested that the fine element could be paid by what are sometimes quite well-funded anti-abortion groups, which means that it is not going to act as a deterrent. Do any of the panel members have a view on that? I will come to you first, Simon, as you mentioned it.

Simon Brown: That will almost certainly be the case. It is unlikely that any of these protesters will pay the fine themselves.

As I said earlier, however, I think it unlikely that they will pay a fine in any case. The closest analogy that I can give is those who protested against nuclear submarines and, indeed, some of the Just Stop Oil protesters in England and Wales. They do not pay the fine, because they get imprisoned for not doing so; they get headlines for being taken off to prison, not for the fine being paid silently. That is the whole point of it.

Ruth Maguire: If no one has anything to add, I have a final question. In its response, Police Scotland notes that the fine-only approach has implications for the power of arrest. Can you explain for the record what those implications might be, and how they might influence decisions on enforcing these laws?

Superintendent Corrigan: I note that there is no power of arrest under the bill—or, at least, it is silent about the power of arrest with regard to protesters. That is fine—it is something that we can work with. In my view, the power of arrest is still there, but, given the fine element, we just need to consider the seriousness of the offence when we think about custodial outcomes from police custody, whether the person goes to court and how quickly that person will be released.

Ruth Maguire: Can you expand on that a bit and give us an example? I know that that will be difficult, given that this is a new thing.

Superintendent Corrigan: Generally, we have a presumption of liberty; we will try not to arrest someone and instead will use other means or release people from custody very quickly. However, protest is a slightly different matter. If we arrest someone at a protest, take them back to a police office and then release them, they can just

go back to the protest. Obviously, such an approach is not working.

Practically speaking, then, I would say that, if a person were to be arrested at a protest, we would try to keep them in custody until the protest is finished—certainly for that day—to avoid that very situation in which the person just goes back to the protest. However, we would probably not keep the person in custody for court the next day, because the fine provision would indicate that the offence was relatively minor.

Ruth Maguire: Thank you.

The Deputy Convener: Ivan McKee, do you have any further questions?

Ivan McKee: I think that everything has been covered, convener.

The Deputy Convener: I call Dr Sandesh Gulhane.

Sandesh Gulhane: I declare an interest as a practising NHS GP.

Perhaps I can start by asking Sarah Wallage a question that I asked the last panel. I asked it because I was approached by somebody working in an abortion service who said to me that she and other members of staff she knows of have been put off calling the police because they do not want their names to be out there and associated regularly with complaining. Do you recognise that as a potential issue?

Dr Wallage: I would not have thought so. We are fortunate in Aberdeen in that we have not had to contact our local police, but I would have thought that, for a staff member, that would just be part of the job. Might it be possible for such calls to be recorded as coming from NHS Grampian rather than from an individual staff member? I wonder whether there might be precedent for that and whether it would remove those kinds of concerns. I would have thought that our team would feel that being on record as having made that call is part of the role—we might rotate among us so that different people would call at different times. We have not felt that that would be a problem. If the protest is happening, it is part of the job to report it.

Sandesh Gulhane: That neatly comes on to my question to Simon Brown and Gerry Corrigan. Is it the case that you have to put down the name of the person who has made the complaint or, for the purposes of this legislation, could it just be the department, the area or the place, as Sarah Wallage has just said?

Simon Brown: I do not think that you need a name for a complaint, but if the case proceeds to trial, you will need a witness—somebody to come to court to say that they saw person X doing behaviour Y.

In theory, depending on how the act is ultimately worded—if the exclusion zone is an exclusion zone and it becomes an offence simply to protest within it—having good closed-circuit television coverage, where you see that the person is within the zone, holding a placard and clearly protesting, should be sufficient to run a prosecution. From a defence point of view, I would find that hard to argue. However, if you are saying that someone was upset by the conduct, then, ordinarily in a breach of the peace case you would need somebody to come to court to say that they were upset by that conduct.

Sandesh Gulhane: Absolutely. However, if somebody turns up with a placard—let us say that there is no CCTV—and you need witnesses, could it be that it is the department that makes the complaint and the witnesses only come forward to further the case?

Simon Brown: You would need to ask the fiscal officer about that. Speaking from a defence point of view, I do not see how that would be a difficulty. For example, CCTV is normally presented as evidence and gathered by the local authority, and it is normally agreed to, because the local authority provides a certificate that its CCTV operator took that CCTV. In theory, I can see no difficulty with a named organisation saying that it provided CCTV. However, if you are going above and beyond that and talking about a complaint about subjective conduct, you would need somebody to speak to what that conduct was.

Superintendent Corrigan: Likewise, we do not need a name if someone phones in. That is not required.

I would add that, if someone phones—it can be anonymous—and says that they can see 20 people gathered 100m away, they are probably not witnessing any specific person doing anything. I mention that because, when the police arrive, the evidence for the prosecution might be coming solely from the police officers and not from the person who phoned in.

Simon Brown: I have seen files that mention police officers who viewed CCTV and said, “I have viewed the CCTV and I can see person A committing this offence, and that is person A in court.” Therefore, officers do not have to see the offence itself. That would be competent.

Sandesh Gulhane: I want to go back to the question about silent prayer. We have already heard that the impact that that has had on people has been described to us at a previous session. If someone calls to say that there are five people standing in a circle, how can you, as the police, deal with that if you are not going to ask them

what they are doing and whether they are protesting or praying?

Superintendent Corrigan: In relation to the bill, in their report to the Procurator Fiscal Service, the police officer will probably need to describe the picture that you have illustrated—the overall circumstances, the people's location, their demeanour, how they are standing, whether there are any other signs or placards, and so on. It is about painting a picture of what the people are actually doing.

I do not think that we could go down the road of asking people what they are thinking or what their thoughts are. That feels really uncomfortable. Even asking them why they are there at that point in time would probably, from a defence point of view, mean that we are beginning to question them and trying to complete the crime, which is also fraught with difficulties. It is getting into the realms of interviewing people at the location without offering them legal advice or cautioning them, and there are some difficulties with that.

11:00

Sandesh Gulhane: Can I ask a question specifically about that? If one was stopped while driving a car, would the police officer not be entitled to ask, "Do you know why I have stopped you?" Is that not similar?

Simon Brown: They can ask, but you do not have to answer.

Superintendent Corrigan: That should not be asked. Going back to the protest, if we are asking people why they are there and what they are thinking, we are beginning to gather evidence that will help with the prosecution case. If a police officer stops a car and asks the driver, "Do you know why I stopped you?", that is probably more of a conversational thing as opposed to trying to gather evidence to complete the criteria of the crime.

Sandesh Gulhane: Okay. Thank you.

I suppose that your answers to the final question that I would like to ask will be subjective, seeing as we have not passed the bill yet. In your opinion, will the bill, in the way in which it is written, provide women and staff who attend abortion clinics with the protections that it intends to provide? If not, what would you like to see added or taken away?

Simon Brown: As it is written, the bill should go a long way towards providing the relevant protections, but there will be practical things that will have to be done. Having a clearly delineated exclusion zone will be a big help, and, as I have said, CCTV will also be a big help. Having both of those things in practice should make prosecutions relatively straightforward.

You asked whether there is one thing that I would add. I think that you should be looking at something similar to the current provisions in relation to domestic abuse, whereby non-harassment orders can be granted. Once a person has been convicted, I think that you would like the prosecutor to ask the court to impose an order on that person not to go within an exclusion zone at any hospital for a period of time. That would provide the police with a reason to arrest a person simply for being there without doing anything, and that should cut down the number of protesters over time.

Superintendent Corrigan: I agree that the bill goes a long way towards providing a safe space for women to access services. There were protesters at the Queen Elizabeth hospital yesterday, and I am sure that, if the bill had been passed, they would not have been there. I guess that that is the difference. Generally, the people who protest on the topic are law abiding, so I think that they would take cognisance of the law and adjust their protest site accordingly, which would create a safe space.

Ross Greer: I want to follow up on the point about silent prayer and intent so that I understand it correctly. I am trying to figure out how unprecedented the proposals are, because that is the argument that some folk are making. I understand that the comparison that I am drawing is not like for like, because it concerns stalking and harassment. It is not illegal to stand silently outside somebody else's house, but my understanding is that, if you are doing it as part of a pattern of behaviour in which you are stalking the individual, that is already an offence under the law. Police officers are already being asked to make judgments about intent in not entirely dissimilar circumstances, are they not?

Superintendent Corrigan: I do not think that we can give an opinion on the issue of silent prayer. We need to provide facts for prosecution. All that we can do is provide a picture of what we see—someone standing silently and solemnly, for example—and describe their demeanour and body language or what their body is doing. With regard to the bill, we can say why that would be intimidating for someone who was attending an abortion clinic and why that might influence their decision as to whether to proceed, bearing in mind the overall circumstances of its being an abortion clinic. However, I do not think that we could possibly start to enter into what a person's thoughts were or—

Ross Greer: I probably did not word that question particularly well. I appreciate entirely that, were the bill to pass, police officers would be asked to do something that is relatively difficult. However, the point that I was trying to get at is that

we already ask that of the police in a range of other circumstances, do we not? Some attempt is needed to understand a person's intent. The example that I am giving is that you can stand silently outside somebody's house and it is not a crime but that, if you are doing it as part of a pattern of behaviour of stalking and harassing the individual in that house, that is part of an offence. We already ask police officers to make such judgments in the first instance. Obviously, we then ask the procurator fiscal and the courts.

Superintendent Corrigan: Yes. Harassment as part of domestic abuse is probably a good example of that. If an ex-partner was standing silently outside someone's house, that would clearly feel intimidating. Therefore, there are comparisons with that situation.

Ross Greer: That is useful. I asked that partly so that I could understand just how unprecedented the proposals would be, given my lack of familiarity with other areas of the law.

David Torrance: Good morning. Mr Brown, does the bill successfully balance competing rights under the European convention on human rights?

Simon Brown: I think that it does. I imagine that any final wording of the bill will be very similar to the legislation that was passed in Northern Ireland, which was tested against the ECHR in the Supreme Court and which the Supreme Court said was compatible. Therefore, if it is worded similarly to that legislation—I fully anticipate that it will be—I cannot see there being a difficulty.

The right to protest is enshrined in the ECHR, but there are limits placed on that. From memory, at least two Scottish judges—Lord Reed and Lord Carloway—were sitting in the Supreme Court, and the view of the Supreme Court was that the restrictions were appropriate in the context. Therefore, the short answer is that, if this legislation is in a similar form to the Irish legislation, I cannot see why it would not be ECHR compatible.

David Torrance: May I quickly go back to the issue of silent prayer? I have a real problem with that. If a person or a group is standing there and they are asked what they are doing and they say, "Look, on religious beliefs, I am praying for my auntie Mary," or whatever, how are you going to prove different? Would you ever get a conviction for that?

Simon Brown: I think that that is true, but I go back to the analogy with stalkers that Mr Greer used. I am a defence solicitor, not a prosecutor. When I am defending somebody against those charges, inevitably the defence will be, "I wasn't stalking. I was standing there having a cigarette," or, "I was standing there checking my messages."

However, in these situations, you are talking about people who are actively going to that place to protest and will accept the fact that they are there to protest—otherwise, there is no point in their protesting. I do not think that people are going to say, "I wasn't here to protest against abortion. I was here to pray for my auntie Mary." Otherwise, what would be the point of their being there?

Therefore, although I can see that being a difficulty in theory, in the particular circumstances that we are likely to deal with, I do not think that that will arise, because people are going there to protest and they are going to say that they are there to protest.

Sandesh Gulhane: Just for the record, let us say that I want to go and protest outside an NHS Tayside building about the Professor Eljamel case and all the things that have been happening and say that that is unacceptable. I would be breaching a 200m zone, obviously, because I would be trying to get as close to the hospital as I could. Are you absolutely happy that that protest would not in any way fall under this bill?

Simon Brown: Would your actions influence people who were going for abortions? They would not know why you were there, so, if your actions influenced them, they might come under the bill.

Sandesh Gulhane: I imagine that I would have a sign about Eljamel.

Superintendent Corrigan: I do not think that there is a distinction. Looking at it from the point of view of the person who is accessing the services, probably all that they are going to see from a distance as they approach the premises is someone or people with placards. At that point, they will take it that that is what the protest is about, rather than something else. There is a difficulty if the protest is for something completely different.

Sandesh Gulhane: That is a huge concern to me. The situation may be obvious at the Chalmers centre in Edinburgh, for instance, because there are only so many services that are provided there, but I am not sure that it is the point of the bill to prevent people from turning up to protest about other issues at a big hospital that provides a lot of services. Are there any mitigations or ways that we could prevent such protests from coming under the bill?

Simon Brown: You would have to give some freedom to the procurator fiscal to make a reasoned decision. If the offence cannot be made an absolute offence, anything will be caught in it. We were discussing an example before I came to this meeting. In theory, a mother pushing a newborn baby through the busy entrance to a hospital to receive postnatal care could be viewed

as influencing somebody going there for an abortion, as she will see that newborn baby, even though the two things are entirely unrelated. You have to give some prosecutorial discretion to allow for a conclusion that the legislation is not for the given situation, so it should not be prosecuted. Provided that you allow that element of discretion, there should not be a problem. Presumably, other protests can be agreed in advance, and an agreement can be made to hold them in a particular area—and hopefully not to have two protests overlapping.

Sandesh Gulhane: Would it be possible for you to write to us with some ways of wording that?

Simon Brown: I could do that, yes.

Sandesh Gulhane: Thank you.

Emma Harper: I will pick up on that point. Colin Poolman from the RCN was on the previous panel. Taking the scenario of a labour dispute, such as we have seen, with someone approaching a hospital to receive a service and seeing placards and folks standing in scrubs, we would need to ensure that some language in the bill allowed the unions to make a protest about wages or terms and conditions, or whatever. How would we ensure that, if I was approaching the hospital from a distance, I would not assume that what I could see was an anti-abortion protest?

Simon Brown: I do not know how you could do that. The bill already refers to the "peaceful picketing" provisions in the Trade Union and Labour Relations (Consolidation) Act 1992. You could, no doubt, expand on that for other protests. You are moving away from legal terms to reality here. There is no way, in reality, to control what somebody who is going to access a hospital thinks when they see a group of people 300 or 400 yards away and they do not know what they are doing. That is just life. If somebody accessing services is aware that there will be no one there who is trying to target them specifically, that must ease their mind, to some extent.

Emma Harper: So, passing the bill would provide assurance to people accessing healthcare services that they will not encounter protests influencing them in accessing the service.

Simon Brown: I think that that is the point of the bill. You cannot stop somebody wondering whether they are seeing a protest or a group of people waiting for a bus 500 yards away. All that you can do is make the situation easier. I do not think that you can ever eliminate such problems.

The Deputy Convener: Are there any other issues in relation to the bill that have not been covered in questioning by members that you wish to express a view on?

Dr Wallage: I have a question about one of the exceptions in section 6—I am not sure that I understand what it is getting at. There is an exception for "another person" working within the protected premises, and I am not sure what the thinking is behind that. I hope that this would not happen, but it struck me that that could mean that a cardiology team, say, could protest within a hospital and they would be an exception. I may completely misunderstand that section, however.

11:15

The Deputy Convener: We will certainly note that point, and we will try to establish more detail on that potential intersection. As there are no other points that witnesses would like to raise, I will now touch on the financial provisions of the bill and on what financial impact the bill could have. Do the witnesses feel that the anticipated financial impact of the bill is proportionate to its purpose?

Simon Brown: I do not have a particular view. I imagine that we would not be talking about a huge number of prosecutions, given the level of protest that we see at present. I think that the number would be in the tens rather than anything over and above that.

Eddie Follan: For the record, there are no financial implications for local authorities.

Superintendent Corrigan: It would have a small implication on us because of training and bringing people up to speed, but doing so will be relatively straightforward, so the impact will be minimal.

The Deputy Convener: Thanks for those points of clarification. Unless any other member wishes to make a further point, I am happy to rest there. Thank you all very much for your attendance today. We appreciate your contribution to the committee's work.

Subordinate Legislation

National Health Service (Optical Charges and Payments and General Ophthalmic Services) (Scotland) Amendment Regulations 2024 (SSI 2024/38)

11:16

The Deputy Convener: Our next item of business is consideration of subordinate legislation. The committee has four negative instruments before it today. The first is the National Health Service (Optical Charges and Payments and General Ophthalmic Services) (Scotland) Amendment Regulations 2024. The purpose of the instrument is to increase, by 1.68 per cent overall, the value of NHS optical vouchers accepted or used by a supplier in Scotland on or after 1 April 2024. It also brings into effect various administrative changes relating to the provision of general ophthalmic services—otherwise known as GOS—on and after 1 April 2024.

The policy note states:

"NHS optical vouchers provide financial help towards the purchase of new glasses or contact lenses for eligible persons, including children aged under 16, those aged 16 to 18 and in qualifying full-time education, those on a low income and those who require complex lenses. Some people are also eligible for an NHS optical voucher for help with the cost of repairing or replacing glasses or contact lenses."

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 27 February and made no recommendations in relation to the instrument. No motion to annul has been received in relation to it. As no members have comments to make in relation to this negative statutory instrument, I propose that the committee does not make any recommendations in relation to it. Do all members agree?

Members *indicated agreement.*

National Health Service (Common Staffing Method) (Scotland) Regulations 2024 [Draft]

The Deputy Convener: The second instrument is the National Health Service (Common Staffing Method) (Scotland) Regulations 2024.The purpose of the instrument is to specify the minimum frequency at which the common staffing method is to be used in relation to specific types of healthcare and the staffing level and professional judgment tools that must be used as part of the common staffing method for specified kinds of healthcare provision.

The policy note states that the instrument is required to specify that the common staffing method must be used no less than once annually in relation to certain types of healthcare. It also states:

"The regulations also specify the specialty-specific staffing level tools and the professional judgment tool that should be used as part of the common staffing method for specified kinds of healthcare provision. 10 specialty-specific staffing level tools are named in the instrument alongside the particular kind of healthcare provision for which each tool is to be used."

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 27 February 2024 and made no recommendations in relation to it. No motion to annul has been received in relation to it.

Members will note that the Royal College of Nursing wrote to the committee raising certain specific concerns in relation to the drafting of the instrument. The letter from the RCN also raises a number of wider issues that the committee may wish to consider as part of its future post-legislative scrutiny of the Health and Care (Staffing) (Scotland) Act 2019.

In relation to the correspondence that we have received, I propose that we write to the Scottish Government, requesting that it address the specific points that were raised by the RCN, and that we consider the instrument at a future meeting. Do members agree with the proposed action?

Members *indicated agreement.*

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2024 (SSI 2024/44)

The Deputy Convener: The third instrument that we are considering is the Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2024. The purpose of the instrument is to amend the Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2006. The instrument will increase the charges, otherwise known as NHS charges, that are recovered from persons who pay compensation—the compensators—in cases in which an injured person makes use of national health service hospital treatment or ambulance services.

The increase in charges relates to an uplift for hospital and community health services—HCHS—annual inflation. The policy note states that the instrument will allow for

"new NHS charges to apply in cases where compensation has been made in respect of incidents that occur on or after 1st April 2024",

with NHS charges being

"revised annually ... to take account of the Hospital and Community Health Services ... pay and price inflation ... The Scheme is administered on behalf of Scottish Ministers by the Compensation Recovery Unit ... of the Department of Work and Pensions ... in accordance with an agency arrangement under section 93 of the Scotland Act 1998."

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 27 February 2024 and made no recommendations in relation to the instrument. No motion to annul it has been received.

No member has indicated that they wish to comment on the instrument. I invite the committee to agree that it does not wish to make any recommendations in relation to the instrument. Do members agree to that?

Members *indicated agreement.*

Social Care and Social Work Improvement Scotland (Cancellation of Registration and Relevant Requirements) Order 2024 (SSI 2024/45)

The Deputy Convener: The fourth and final instrument is the Social Care and Social Work Improvement Scotland (Cancellation of Registration and Relevant Requirements) Order 2024. The purpose of the instrument is to ensure that the Care Inspectorate can propose to cancel the registration of a care service under section 64(1) of the Public Services Reform (Scotland) Act 2010 or report certain local authority-provided care services to Scottish ministers under section 91(3)(b) of the 2010 act, following a breach of section 7 and/or section 8 of the Health and Care (Staffing) (Scotland) Act 2019. The 2019 act will come into force on 1 April 2024.

The policy note states that the instrument specifies new grounds on which the Care Inspectorate

"may propose to cancel the registration of a care service, namely that the service is being, or has at any time been, carried on other than in accordance with section 7 and/or section 8 of the 2019 Act. It also specifies the requirements imposed by sections 7 and 8 of the 2019 Act as relevant requirements for the purposes of section 91(5)(c) of the 2010 Act."

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 27 February 2024 and made no recommendations in relation to the instrument. No motion to annul it has been received.

No member has indicated that they wish to comment on the instrument. I invite the committee to agree that it does not wish to make any recommendations in relation to this negative instrument. Do members agree to that?

Members *indicated agreement.*

The Deputy Convener: At our next meeting, on 12 March, we will continue to take evidence as part of the committee's stage 1 scrutiny of the Abortion Services (Safe Access Zones) Scotland Bill.

11:23

Meeting continued in private until 12:05.

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